



# McKENDREE UNIVERSITY PREPARTICIPATION EXAM

Date \_\_\_\_\_

Name \_\_\_\_\_

last first middle

Sport \_\_\_\_\_ Year in college \_\_\_\_\_

Social security number \_\_\_\_\_ Birthdate \_\_\_\_\_

Local address \_\_\_\_\_ Local phone \_\_\_\_\_

Parent's name \_\_\_\_\_ Parents phone \_\_\_\_\_

Parent's address \_\_\_\_\_

In case of emergency notify (name and phone) \_\_\_\_\_

## MEDICAL HISTORY

	yes	no	If yes, explain:
1. Current medical problems	___	___	
2. Presently taking medications (include birth control)	___	___	
3. Allergic to medicine, bee stings, food, etc.	___	___	
4. Any prior surgery	___	___	
5. Any prior hospitalizations	___	___	
6. Wear glasses or contacts	___	___	
7. Have chipped/missing teeth or bridges	___	___	
8. Any heart disease, murmur, or extra beats	___	___	
9. Any wheezing during exercise	___	___	
10. Any fainting or dizziness while exercising	___	___	
11. Any loss of consciousness, concussion, or head injury	___	___	
12. Any history of seizure or convulsion	___	___	
13. Any bone or joint injuries/surgery	___	___	
14. Any serious family illness (heart attack before age 50 diabetes, bleeding disorders, etc)	___	___	
15. Know date last tetanus shot	___	___	
16. Ever been disqualified medically to participate	___	___	
Personal Habits			
1. Smoking or chewing tobacco	___	___	
2. Use of alcohol, beer, wine	___	___	
3. Use of marijuana, cocaine, etc	___	___	
4. Use of steroids	___	___	
5. Any eating or menstrual disorders	___	___	

I certify that the above information is correct to the best of my knowledge.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICAL EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Vision: (R) 20/\_\_\_\_ (L) 20/\_\_\_\_ w w/o aid

Other testing:	Normal	Abnormal Findings
1. Skin	___	___
2. HEENT	___	___
3. Lungs	___	___
4. Heart	___	___
5. Abdomen	___	___
6. Musculoskeletal	___	___
7. Neck & Back	___	___
8. Hernia/Genitals	___	___

### Recommendation:

1. Clearance without restriction
2. Clearance deferred Reason \_\_\_\_\_  
\_\_\_\_\_
3. Clearance with restriction Reason \_\_\_\_\_  
\_\_\_\_\_
4. Disqualification Reason \_\_\_\_\_  
\_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Additional Comments: