



McKENDREE UNIVERSITY PREPARTICIPATION EXAM

Date _____

Name _____

last first middle

Sport _____ Year: Freshman / Sophomore / Junior / Senior / 5th Year

Date of Birth _____ Cell 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. Ever been disqualified medically to participate	_____	_____	
16. Know date of last tetanus shot	_____	_____	
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 understand that I am responsible for reporting any injuries or illnesses to the institutional medical staff, including the signs and symptoms of concussions

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

Student Signature _____ Date _____

Height _____ Weight _____
Blood Pressure _____ Pulse _____
Vision: R 20/ _____ L 20/ _____ w w/o aid

PHYSICIAN'S EXAMINATION

	Normal	Abnormal
1. Skin	_____	_____
2. HEENT	_____	_____
3. Lungs	_____	_____
4. Heart	_____	_____
5. Abdomen	_____	_____
6. Musculoskeletal	_____	_____
7. Neck & Back	_____	_____
8. Hernia/Genitals	_____	_____

Additional Comments:

Recommendation:

1. Clearance Without Restriction
2. Clearance Deferred Reason: _____
3. Clearance With Restriction Reason: _____
4. Disqualification Reason: _____

Physicians Signature _____
Date _____