***This form must be filled out and completed by a licensed physician or his/her designate***. Student athletes must have this physical examination within 6-8 weeks prior to the start of the Fall semester. Information on this form will be made available to college officials as deemed necessary for the student’s well-being. **PLEASE PRINT or TYPE.**

**SALEM COLLEGE RETURNING ATHLETES – PRE-PARTICIPATION FORM**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**SS #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_ **Sex:** Male Female Trans **Sport(s) You are Playing**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **MEDICAL HISTORY UPDATE QUESTIONAIRE TO BE COMPLETED BY STUDENT-ATHLETE** | **YES** | **NO** |
| Are you currently taking any medications for any physical or mental condition?  If YES - Please List: |  |  |
| Have you taken any supplements since May 1st to help you lose or gain weight or even to improve performance?  If YES - Please List: |  |  |
| Have you sustained any NEW injuries or medical conditions/ problems or illnesses since May1st? |  |  |
| Have you sustained any RE-INJURY or aggravation of a medical condition after May 1st? |  |  |
| Do you have any on-going or lingering injury or illness at this time? |  |  |
| Have you had to have any surgery for any reason after May 1st? |  |  |
| Do you suffer from any known allergies or had any new allergic reactions after May 1st? |  |  |
| Do have any breathing problems or respiratory problems with exercise? |  |  |
| Do you have documented hypertension or high blood pressure? |  |  |
| Have you experienced any problems with exercising in the heat? |  |  |
| Have you experienced the loss of paired organ or loss of function of any organ in your body? |  |  |
| Do you have a documented heart murmur or any kind of heart/ lung condition? |  |  |
| Do you have the presence of/ or documented Marfan Syndrome? |  |  |
| Have you sustained a head injury or concussion after May 1st? |  |  |
| Have you experienced any seizures or convulsions after May 1st? |  |  |
| Were you in an auto accident or a work related accident after May 1st?  -------------------------------------------------------------------------------------------------------------------------------------------    If YES to the above question are you involved in a lawsuit for the accident YES NO (circle} |  |  |
| Have you experienced any of the following ***DURING*** or ***AFTER*** exercise or athletic activity?  Circle those that apply?  **Shortness of Breath Fainting Almost Blacking Out Headache Nausea**  **Pounding Chest Wheezing Chest Pain Asthma Attack Dizziness** |  |  |
| Do you have any **NEW** problems or condition(s) that the Salem College medical staff should be made aware of? |  |  |

If YES, to any of the ABOVE questions, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing below I agree that I have reviewed and answered each question above. I affirm that very question is answered completely and is correct to the best of my knowledge and no answers or information have been withheld. Furthermore, I give consent for this examination and I further understand that athletics Involves vigorous physical activity. The physician examination can only evaluate my current condition as presented.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN FOLLOWING REVIEW OF MEDICAL HISTORY UPDATE**

Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ HR: \_\_\_\_\_\_\_\_\_

\*Cardiac Evaluation should be AHA 14-point evaluation or the Pre-Participation Physical Evaluation Monograph, 4th edit.

|  |  |  |  |
| --- | --- | --- | --- |
| **REQUIRED** | **NORMAL** | **ABNORMAL** | **FINDINGS & COMMENTS** |
| **HEART/CARDIOVASCULAR** |  |  |  |
| **LUNGS/PULMONARY** |  |  |  |
| **NECK/BACK** |  |  |  |
| **SHOULDER** |  |  |  |
| **KNEE** |  |  |  |
| **ANKLE/FOOT** |  |  |  |
| **CHEST/ABDOMEN** |  |  |  |
| **BACK/SPINE** |  |  |  |
| **OTHER: Orthopedic Problems** |  |  |  |
| **Optional Examination items unless history indicates a need** | | | |
| **HEENT** |  |  |  |
| **LYMPH NODES** |  |  |  |
| **SKIN** |  |  |  |
| **NEUROLOGICAL** |  |  |  |
| **HERNIA** |  |  |  |
| **OTHER – List:** |  |  |  |

**CLEARENCE:**

**Cleared** for FULL PARTICIPATION: YES NO (circle one)

If NO – **Cleared only after** completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NO - Then NOT cleared due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Recommendations/Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician Name/Extender Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_**

**Address or Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: ( ) \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_**

**Return both pages to: Head Athletic Trainer Salem College 601 South Church St. Winston-Salem, NC 27101**