



PREPARTICIPATION PHYSICAL

Concordia University Athletic Training

Please return forms to: Concordia University
Attn: Athletic Training
11400 Concordia University Dr.
Austin TX 78726

This Form is to be completed every year in which you participate in athletics at Concordia University Texas. Please print legibly and fill out the form in its entirety.

Athletes Name: _____ Sex: _____ Age: _____ Date of Birth: _____ Class: F So Jr Sr

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Medical History: Please answer all questions below. Explain "YES" in space provided.

Yes No	Have you had a medical illness or injury since your last check up or physical. _____	Have you ever had any of the following.	Yes No Dizziness during exercise. _____
Yes No	Have you been hospitalized or had surgery in the past year. _____		Yes No Passing out during exercise. _____
Yes No	Are you currently taking any prescription or nonprescription medication. _____		Yes No Chest pain during exercise _____
Yes No	Do you have any allergies (eg. pollen, medicine, food, insects) that require medical treatment. _____		Yes No Heart murmur. _____
Yes No	Has any family member been diagnosed with heart problems (eg. enlarged heart, hypertrophic cardio myopathy, long QT syndrome, Marfan syndrome, or abnormal heart rhythm) or died suddenly. _____		Yes No Racing heart or skipped heartbeats. _____
Yes No	Have you ever experienced coughing, wheezing, shortness of breath, or difficulty breathing during exercise. _____		Yes No Other heart problems. _____
Yes No	Has a physician ever limited your sports participation due to a heart problem. _____		Yes No High cholesterol. _____
Yes No	Have you have been knocked out, become unconscious, sustained a concussion, or other head injury. _____		Yes No High blood pressure. _____
Yes No	Have you have been treated for or diagnosed with sickle cell trait or sickle cell disease. _____		Yes No Diabetes _____
			Yes No Asthma _____
			Yes No Anemia _____
			Yes No Epilepsy or seizures. _____
			Yes No Infectious mononucleosis _____
			Yes No Hepatitis/liver problems _____
			Yes No Kidney disease _____
			Yes No Heat illness _____
			Yes No Stinger/burner _____
			Yes No Frequent or severe headaches _____

Immunizations: Record the date of your most recent immunizations.

Tetanus _____ Chicken Pox _____ Measles _____ Hepatitis B _____

Females Only

When was your first menstrual period. _____ When was your most recent menstrual period. _____

How much time do you normally experience between menstrual periods. _____ How many periods did you experience last year. _____

What was the longest time between you've experienced between periods. _____

Physicians Report: To be completed by a physician.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: Right _____ Corrected / Uncorrected

Left _____ Corrected / Uncorrected Wears: Contacts / Glasses

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart Auscultation of the heart in the standing position			
Heart Auscultation of the heart in the supine position			
Heart- Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

On the basis of this examination and in the absence of medical reason for disqualification, I judge this individual able to participate in physical activity including intercollegiate athletics if they so choose.

This individual is not cleared for activity due to: _____

Name (Print): _____

Date of Exam: _____

Signature: _____

Phone: _____

Pre-participation physical must be completed and on file with the athletic trainer before athletic participation can begin.

