UCCS Club Sports
UNIVERSITY OF COLORADO
COLORADO SPRINGS

Student Name_____ Student ID # _____
Last First MI

DOB:_____ Today's Date:_____

HT_____ WT_____ Temp_____ Pulse_____ Respiration_____ B/P_____

Vision (R) 20/____ (L) 20/____ OU 20/_____ Corrected Y N Pupils: Equal ____ Unequal ____

	Normal	**Abnormal Findings/Significant Normal Findings**
Medical		
Eyes/Ears/Nose/ Throat	☐ PERRLA; EOMI; TM's translucent (B); mmm; neg erythema, exudates or edema	
Neck	☐ Supple; FROM; neg lymphadenopathy or thyromegaly	
Heart	☐ S_{1-2} (+); RRR; neg murmur	
Lungs/Chest	☐ CTA; A&P (B)	
Abdomen	☐ Soft; non-tender; BS (+) 4 quad; neg HSM	
Neuro	☐ CN II-XII intact; DTR's symmetrical (B), ___ +/4+; tandem gait; neg rhomberg	
Skin	☐ Neg HSV, lesions, tinea corporis	
Musculoskeletal		
Neck	☐ FROM, neg deformities	
Back	☐ FROM; neg scoliosis, neg disc herniation	
Shoulder/arm	☐ FROM; N/V intact	
Elbow/Forearm	☐ FROM; N/V intact	
Wrist/Hand/ Fingers	☐ FROM; N/V intact	
Hip/Thigh	☐ FROM; N/V intact	
Knee	☐ FROM; N/V intact	
Leg/Ankle	☐ FROM; N/V intact	
Foot/Toes	☐ FROM; N/V intact	

Other:

CLEARANCE

	Cleared
	Cleared after completing evaluation/rehabilitation for:
	Not Cleared for: _____ **Reason**: _____ **Recommendations**:

I certify that I have examined this student and that, on the basis of the examination and the student's medical history as furnished to me I find him/her free of disease or physical limitations EXCEPT as may be noted above. Pertinent medical history was reviewed with student as part of this physical examination. **(NOTE EXCEPTIONS ABOVE!)**

_____ _____ / _____
Examiner's Name (print or stamp) **Examiner's signature** **Date**

Examiners Phone # ( ) _____

Physical Examination Form

Student Name:_____ DOB:____/____/_____ Gender: M F Student ID#_____
Last First MI MO Day Year (circle one)

Address:_____ Phone #: ( )____-_____ Today's Date:____/____/_____
Street City State Zip MO Day Year

Parent/Guardian/Spouse Name:_____ Primary Care Physician:_____
Last First MI

HEALTH HISTORY

This section is to be carefully completed by the student and his/her parent(s) or legal guardian before participation in interscholastic athletics in order to help detect possible risks* *Please explain all 'Yes' answers on next page.

1. Have you had a medical illness/injury since your last checkup or sports physical	Y / N	11. Is there a personal or family history of Sickle Cell Disease or Sickle Cell Trait?	Y/N
		Have you ever become ill from exercising in the heat?	Y / N
2. Have you ever been hospitalized overnight?	Y / N	Do you cough, wheeze, or have trouble breathing during or after activity?	Y / N
3. Have you ever had surgery?	Y / N	Do you have asthma?	Y / N
4. Are you currently taking ANY prescription or over-the-counter medications, pills, or inhalers?	Y / N	Do you have seasonal allegries that require medical treatment?	Y / N
5. Have you ever taken any supplements or vitamins to help you gain/lose weight or to improve performance?	Y / N	12. Do you have any special protective or corrective equipment or devises that aren't usually used for your sport or position (e.g. knee brace, special neck roll, foot orthotics, retainer, hearing aid, etc.)?	Y / N
6. Do you think you are in good health?	Y / N	13. Have you had any problems with your eyes or vision?	Y / N
7. Have you ever had a rash or hives develop during or after exercise?	Y / N	Do you wear glasses, contacts, or protective eyewear?	Y / N
Have you ever been dizzy or passed out during or after exercise?	Y / N	14. Have you ever had a sprain, strain or swelling after an injury?	Y / N
Have you ever had chest pain during or after exercise?	Y / N	Have you ever broken or fractured any bones or dislocated any joints?	Y / N
Do you get tired more quickly than your friends do during exercise?	Y / N	Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes **circle** the appropriate and explain on back of this sheet. Head Neck Back Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Finger(s) Hip Thigh Knee Shin/Calf Ankle Foot	Y / N
Have you ever had racing of your heart or skipped heartbeats?	Y / N		
Have you ever had high blood pressure or high cholesterol?	Y / N		
Have you ever been told you have a heart murmur?	Y / N	15. Do you want to weigh MORE or LESS than you do now?	Y / N
Has any family member or relative dies of heart problems or of sudden death before age 50?	Y / N	Do you lose weight regularly to meet weight requirements for your sport?	Y / N
Is there a family history of heart problems in a close relative younger than 50 (enlarged heart, cardiomyopathy, electrical conduction problem, abnormal EKG or abnormal heart rhythm)?	Y / N	16. Do you feel stressed out?	Y / N
Have you ever had a severe heart infection (myocarditis, peridcarditis)?	Y / N	17. Record the dates of your most recent immunizations (shots) for: Tetanus _____ MMR _____ Hepatitis B _____ Chickenpox _____	
Is there a family history of Marfan's Syndrome?	Y / N	**FOR FEMALES ONLY**	
Has a physician ever denied or restricted your participation in sports for any heart problem?		18. When was your first menstrual period (age)? _____	
8. Have you ever had a severe viral infection within the last month (e.g. mononucleosis)?	Y / N	When was your most recent menstrual period? _____	
9. Do you have any current skin problems (e.g. itching, rashes, acne, warts, fungal infections or blisters)?	Y / N	How much time do you usually have from the start of one period to the start of another period? _____	
10. Have you EVER had a head injury or concussion?	Y / N	How many periods have you had in the last 12 months? _____	
Have you ever been knocked out, become unconscious or lost your memory?	Y / N	What was the longest time between periods in the last year? _____	
Have you ever had a seizure?	Y / N	Please list any and all allergies: (medications, pollen, food, insects, etc.)	
Do you have frequent or severe headaches?	Y / N	Please list any medical conditions:	
Have you ever had numbness or tingling in your arms, hands, legs or feet?	Y / N	Please list any and all current medications: (include name, dosage, and how often you take it)	
Have you ever had a stinger, burner or pinched nerve?	Y / N		

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Please explain all 'Yes' answers from Health History section in the space below.

Club Sports Medical Clearance Form

I certify that I have examined _____
(First Name – Middle Initial – Last Name)

and that, on the basis of the examination and the student's medical history as furnished to me I find him/her free of disease or physical limitations EXCEPT as may be noted below. Pertinent medical history was reviewed with student as part of this physical examination. **(NOTE EXCEPTIONS BELOW.)**

Club Sport: _____

CLEARANCE	
	Cleared for all sports
	Cleared after completing evaluation/Rehabilitation for:
	Not Cleared for: _____ **Reason:_____** **Recommendations:**

_____ _____ / _____
Examiner's Name (print or stamp) **Examiner's signature** **Date**

Examiners Phone # ( ) _____

**** Return completed form(s) to the Wellness Center Front Desk or the Club Sports Athletic Trainer. Forms can be faxed to 719-255-4446, Attn. Club Sports****