FLORIDA PALMS UNIVERSITY

I. Student-Athlete Information and Medical History

Student-Athlete's Info

Name:		Sport:	
Date of Birth:	Sex:	Year Completed:	Marital Status:
Address:	City:	State:	Zip:
E-Mail:		Phone:	

Parents' Info

Father	Mother
Name:	Name:
Address:	Address:
City/State:	City/State:
E-mail:	E-mail:
Phone:	Phone:

Person to Notify in Case of Emergency

Name:	Relationship:
Phone:	Email:

Allergies: (Medications, Food, Environmental, Insect bites/stings)

Allergy	Reaction

Medications Taken on a Regular Basis:

Medication	Dose	Frequency

List any Surgeries/Illnesses/Hospitalizations in the Past 2 Years

Medical Reasons for Hospitalizations	Date	Type of Surgery

Family Physician:	Office Phone:
Office Location:	Date of Last Medical Exam:

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Do you have or have you been told you have any of the following?

Condition	Y	N	Condition	Y	N
Asthma/Exercise Induced Asthma			Heat Related Illness (Exuastion/stroke)		
Mononucleosis			Epilepsy/Seizures		
Diabetes			Nose Bleeds		
Excessive Fatigue with Exercise?			Exposure to Tuberculosis (TB), HIV, Hepatitis		
Concussion/Loss of Consciousness			Sickle Cell Disease		
Chest pain, discomfort or palpitations?			Fainting spells or dizziness with exercise?		
Excessive or unexpected shortness or breathe with exercise?			Loss of/Impaired-organ function (eye, kidney, testicle, spleen)		
History of heart murmur?			Elevated Blood Pressure		
Family history of sudden death or someone in the family?			Family history of severe cardiac disease or heart condition?		
Family history of Martan's disease?			Diabetes		
MEN:Hernia or Hernia Surgery?			WOMEN:Positive pregnancy test in the last year?		

List any Orthopedic Injuries Within the Past 2 Years

Injury	Y	N	Date	Comment
Head/Neck				
Back				
Shoulder				
Arm/Elbow				
Hand/Wrist				
Knee/Ankle				
Other				

Nutrition, Drugs, Food Supplements, and Miscellaneous Agents:

Have you ever used the following:	Never	Occasionally	Frequently
Stimulants (Benzedine, Amphetamines, etc)			
Chewing Tobacco, Snuff or Smokeless Tobacco			
Cigarettes, Cigars or Pipe			
Vitamins			
Diet Pills			
Alcoholic Beverages			
Amino Acids (Energy Drinks)			
Any other diet, nutritional or performance drug			

I certify that all the above information is true and accurate to the best of my knowledge. I have no abnormality, limitation or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in collegiate athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Student-Athlete Signature Date

FLORIDA PALMS UNIVERSITY

II. Athletic Training Medical History Questionnaire

(Confidential Medical Information)

PERSONAL INFORMATION

Name:			Sport:	
Today's Date:	Age:	Sex:	Height:	Weight:
Address:	City:		State:	Zip:
E-Mail:		Phone:		
Parent/Guardian:		Address:		
E-Mail:		Phone:		

PERSONAL HISTORY: Answer all questions. Explain YES answers below or on back with a corresponding number.

Have you had…	Y	N	Have you had…	Y	N
Infectious Mononucleosis			Recurrent Diarrhea		
Jaundice			Eye Injury Disease		
Hepatitis			Wear Glasses During Competition		
Diabetes			Wear Contacts During Competition		
Epilepsy/Seizures			Ulcers		
Rheumatic Fever			Abdominal Pain		
General Surgery			Hemorrhoids		
Tonsillectomy			Urinary Tract Disease		
Appendectomy			Hernia		
Hives			Wear Dental Appliance		
Eczema			Disease/Injury Joints		
Acne			Low Back Injury		
Dizziness/Fainting			Neck Injury		
Frequent Headaches			Shoulder Injury (ie. Dislocation)		
Head Injury/Concussion			Elbow Injury		
Hearing Loss/Impairment			Hand/Wrist/Finger Injury		
Sinus Infection			Hip Injury		
Recurrent Tonsillitis			Knee Injury		
Recurrent Strep Throat			Ankle Injury		
Bronchi's			Foot Injury		
Pneumonia			Surgery Related to Joint Injury		
Chronic Colds/Cough			Fracture in Last 2 Years		
Hay Fever/Asthma			Pin, Screw, Plate in body		
High Blood Pressure			Bone Grail or Spinal Fusion		
Recent Loss/Increase Weight			Special Braces, Splints or Pads?		
Heart Murmur			Other		

	Yes	No
Have you had any serious injury/illness, broken bones, surgery, or hospitalization other than already noted?		
Do you have any other medical concerns other than those noted?		
Are you allergic to any drugs, serum, medication, food, insects, etc? Explain below.		
Are you taking any medication or allergy shots on a regular basis?		
Have you ever been advised by a medical doctor not to participate in any sport? Explain below.		

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II. Athletic Training Medical History Questionnaire

(Confidential Medical Information)

Number	Explanation

Number	Medical Changes Since Last Year

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Student-Athlete Signature Date

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III. Physical Examination

Name:			Sport:		
Today's Date:	Age:	Sex:	Height:	Weight:	
Body Comp:	Pulse:		BP:		
Vision: R 20/	L 20/	Corrected: Y N	Glasses: Y N	Contacts: Y N	

Medical	**Normal**	**Abnormal**	**Comments**
Appearance			
Skin			
Eyes			
Ears/Nose/Throat			
Lymph Nodes			
Dental			
Heart			
Lungs			
Abdominal (Hernia, masses, tenderness)			
Genitalia Males Only (Hernia, testicles)			
Musculoskeletal	**Normal**	**Abnormal**	**Comments**
Neck			
Back			
Posture			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Lower Leg/Ankle			
Foot/Arches			
Flexibility			
Strength			

CLEARED: _____ **Restrictions:** _____

_____

_____

NOT CLEARED: _____ **Reason:** _____

_____

Recommendations: _____

_____

Name of the Physician (print/type): _____

Address: _____ Phone: _____

Signature of Physician: _____