



SAINT FRANCIS COLLEGE

Physical Examination Forms

Personal Information

(Please Print)

Today's Date: ____/____/____

Name _____ Sex: M F
Last First MI (Circle One)

Date of Birth: ____/____/____ Age: ____ Soc.Sec.#: ____ - ____ - ____

Sport(s): _____ Year: Fr So Jr Sr
(Circle One)

Cell Phone:(____) _____ Local Phone:(____) _____

Local Address: _____

City State Zip
Mothers Name: _____ Phone:(____) _____

Fathers Name: _____ Phone:(____) _____

Home Address: _____

City State Zip

Emergency Contact

Name _____ Relation: _____

Daytime Phone #: _____ Evening Phone #: _____

Personal Physician: _____ Phone #: _____

Medical Insurance Information

Indicate the status of your personal health insurance coverage. If covered, the information indicated below **MUST** be provided for ALL applicable policies. Please Check the line that is applicable to you.

1. ____ I am not covered by a health / accident insurance policy.
2. ____ I am covered by my own health / accident insurance policy.
3. ____ I am covered by my parent's health/ accident insurance policy.
(If you check this line you **MUST** fully fill out Section A)

****Section A** (Fill out only if you Checked the third line above)

Use the parent that your health insurance policy is under.

Name of Parent: _____ SS#: _____ - _____ - _____

DOB: ____/____/____

Insurance Card Information

Company Name and Address: _____

Group #: _____ Policy #: _____

Secondary Policy

Company Name and Address: _____

Group #: _____ Policy #: _____

I acknowledge that I have received a copy of the certificate of insurance, and have received, reviewed, and understand the information on the handout entitled "Student Athlete Insurance Coverage," which is a description of the accident insurance policy and claim procedures covering all student athletes at St. Francis College. I also acknowledge that the information that I have provided above is accurate and complete.

Signature of Athlete: _____ Date: _____

SAINT FRANCIS COLLEGE

Medical History Form

Name: _____ Age: _____

Last

First

MI

Circle Y (yes) or N (no) – please explain if you circle Y (yes)

1. Are you currently taking ANY medications? Y N _____
(Please list and why) _____
2. Are you presently taking vitamins or dietary supplements? Y N _____
(Please list) _____
3. Do you have any known allergies (medicine, bee stings, latex, etc)? (Please list) Y N _____
4. Do you wear glasses, contact lenses, safety glasses, or hearing aid? Y N _____
5. Do you have a history of dental injuries? Y N _____
6. Have you been diagnosed with asthma, seizure disorders, diabetes, or other chronic illness? Y N _____
7. Have you recently been diagnosed with mononucleosis, hepatitis B or C, HIV/AIDS, or any other severe infections diseases/viral infection? Y N _____
8. Have you had any surgical procedures? Y N _____
9. Have you had any significant musculoskeletal injuries requiring a doctor's visit, x-rays, or MRI? Y N _____
(include sprains, strains, fractures, and dislocations) _____
10. Have you had any injured connected to sports requiring missed practices/games? Y N _____
11. Have you had any hospitalization/surgery not explained above? Y N _____
12. Do you have any know deformities, such as curvature of the back? Y N _____
13. Are you aware of any serious family illness (diabetes, bleeding disorders, etc)? Y N _____
14. Have you ever felt dizzy, lightheaded, or passed out during or after exercise/activity? Y N _____
15. Do you only have one of two paired function organs (eye, kidney, testicle/ovary)? Y N _____
16. Have you ever had a heat related illness? Y N _____
17. Have you ever suffered a head injury/concussion and/or loss of consciousness? Y N _____

Medical History Form Continued

18. Has a family member under the age of 50 died suddenly from non-traumatic cause? Y N _____
19. Are you aware of a family history of Marfan Syndrome? Y N _____
20. Do you have any family history that we should be aware of? Y N _____
21. Have you had any known exposure to Tuberculosis? Y N _____
22. Do you have a history of chest pain, cardiac disease/symptoms (Tests: EKG, stress tests)? Y N _____
23. Have you ever felt depressed? Y N _____
- a. If yes on a scale 1-10, 10 being the most, 1 being the least, what # would you place yourself in? _____
24. Have you ever had a hernia? Y N _____
25. Do you have any current health problems that you would like to discuss with the doctor? Y N _____
26. Have you ever been told by a physician to restrict your sports activity or not to participate in sports? Y N _____
27. Do you believe there is any reason why you should not participate in intercollegiate athletics at Saint Francis College? Y N _____
28. Do you have any current health problems which could impair your sports performance? Y N _____

Any Further Explanations: _____

I hereby affirm that the information provided will be kept strictly confidential and I have provided answers to the questions, which are complete, accurate, and truthful to the best of my knowledge.

Athletes Signature: _____ Date: _____

Assumption of Risk and Consent for Treatment

I understand that there is an inherent risk of injury associated with my participation in athletics, and that this injury may lead to permanent disability or death. In the event of routine or emergency health examinations, diagnostic procedures, treatment of illnesses and/or injuries, permission is hereby granted to treat the student athlete above by the St. Francis College Sports Medicine Staff, physicians associated with the college, and other facilities as needed.

Signature of Athlete: _____ Date: _____

Signature of Parent: _____ Date: _____
(Only required if athlete is a minor)

Drug Testing

You may be drug tested anytime throughout the calendar year while you are an athlete at Saint Francis College. Testing is done by the NCAA, Saint Francis College, and USA Track & Field every year. Please make sure you are aware of all banned substances which can be found on the NCAA website or the Sports Medicine Facility. Also make sure you read your Saint Francis Handbook for details on the consequences of these offenses. Please sign below saying that you have read and understand these materials.

Signature of Athlete: _____ Date: _____

Signature of Parent: _____ Date: _____
(Only required if athlete is a minor)

Medication Information

Any Medication that you are taking you must let the Sports Medicine Staff know and supply us with a script from your doctor to be put on file. This is important for the following reasons; so that we know any side effects they may have on your performance, knowing if there will be any interactions between any medications we may give you, and also because if we do not have these scripts and you are drug tested you will take a chance in failing the drug test with all the consequences. Please sign below saying that you have read and understand this statement.

Signature of Athlete: _____ Date: _____

Signature of Parent: _____ Date: _____
(Only required if athlete is a minor)