



Sport/Activity: \_\_\_\_\_ 20\_\_\_\_

A. NCC-ID#: N \_\_\_\_\_ NAME: \_\_\_\_\_ (Print) (Last First M.I.) ADDRESS: \_\_\_\_\_ Street Address City State Zip Code PHONE: (\_\_\_\_) \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

B. PERSONAL HISTORY - (To be filled out by student)

Table with 9 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Rows include Heart Murmur, Heart Disease, Tuberculosis, TB Skin Test, Diabetes, Muscle/Joint Problems, Broken Bones, Hernia, Asthma/Wheezing, Kidney Disease, Paralysis, Fainting, Sickle Cell Disease/Trait, High Blood Pressure, High Cholesterol, Convulsive Disorder, Speech Disorder, Allergies, Vision Problems/Wear Glasses, Other.

Medications: \_\_\_\_\_ Have you ever been involved in an accident that resulted in a physical disability? If yes, explain. \_\_\_\_\_ Have you ever failed a physical for a job, school or military service? If yes, explain. \_\_\_\_\_ When was the last time you saw your Family Physician for other than a check-up? Date: \_\_\_\_\_ Have you ever been hospitalized/had an operation? Date: \_\_\_\_\_

- Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past two (2) months? YES  NO 
• Have you ever taken over-the-counter herbal supplements or products to help gain or lose weight or improve your performance? YES  NO 
• Have you ever passed out during or after exercise? \_\_\_\_\_ YES  NO 
• Have you ever been dizzy during or after exercise? \_\_\_\_\_ YES  NO 
• Have you ever had chest pain during or after exercise? \_\_\_\_\_ YES  NO 
• Do you get tired more quickly than your friends do during exercise? \_\_\_\_\_ YES  NO 
• Have you ever had racing of your heart or skipped heartbeats? \_\_\_\_\_ YES  NO 
• Has any family member or relative died of heart problems or of sudden death before age 50? \_\_\_\_\_ YES  NO 
• Has a physician ever denied or restricted your participation in sports for any heart problems? \_\_\_\_\_ YES  NO 
• Have you ever had a head injury or concussion? \_\_\_\_\_ YES  NO 
• Have you ever been knocked out, become unconscious or lost your memory? \_\_\_\_\_ YES  NO 
• Do you have frequent or severe headaches? \_\_\_\_\_ YES  NO 
• Have you ever had numbness or tingling in your arms, hands, legs or feet? \_\_\_\_\_ YES  NO 
• Have you ever had a stinger, burner or pinched nerve? \_\_\_\_\_ YES  NO 
• Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)? YES  NO 
• Do you want to weigh more or less than you do now? \_\_\_\_\_ YES  NO 
• Do you lose weight regularly to meet weight requirements for your sport? \_\_\_\_\_ YES  NO

FEMALES ONLY: When was your first menstrual period? \_\_\_\_\_ When was your most recent menstrual period? \_\_\_\_\_ How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_ How many periods have you had in the past year? \_\_\_\_\_ What was the longest time between periods in the past year? \_\_\_\_\_

Student's signature (if under 18, Parent/Guardian's Signature) \_\_\_\_\_

NCC-ID#: N \_\_\_\_\_ NAME: \_\_\_\_\_  
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C. SCREENING

Tuberculin Skin Test (PPD intradermal only)

Date Given \_\_\_\_\_ Date Read (48-72 HRS) \_\_\_\_\_ Result in mm \_\_\_\_\_

\*Hx ⊕ PPD (Mantoux) Test: Date: \_\_\_\_\_

\*POSITIVE reactors to TB Test must submit written results of Chest X-ray report (PA & lateral) within two years.

(Attach copy of CXR report) Date: \_\_\_\_\_ Result: \_\_\_\_\_

Urinalysis \_\_\_\_\_

Repeat Urinalysis \_\_\_\_\_

Audio \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_

Visual Acuity OD N \_\_\_\_\_ F \_\_\_\_\_ With or without glasses

OS N \_\_\_\_\_ F \_\_\_\_\_

OU N \_\_\_\_\_ F \_\_\_\_\_ Peripheral \_\_\_\_\_

**Note: ALL TESTING MUST BE DONE AT TIME OF PHYSICAL. ABNORMAL RESULTS MUST BE ADDRESSED.**

D. CLINICAL EVALUATION - (To be completed by physician) - Required of all students.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Head		Abdomen	
Skin		Hernia	
Eyes		Genitalia (Male)	
Nose		Cardiovascular	
Throat		Endocrine System	
Teeth		Lymphatic System	
Ears		Neurological	
Neck-Thyroid		Spine-Musculoskeletal	
Chest-Lungs		Lower Extremities	
Heart		Upper Extremities	
Breast			

Remarks: \_\_\_\_\_

E. CLEARANCE

CLEARED FOR PROGRAM  CLEARED AFTER COMPLETING EVALUATION / REHABILITATION FOR: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOT CLEARED FOR: \_\_\_\_\_  REASON: \_\_\_\_\_

RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_ License No. \_\_\_\_\_

Physician's Stamp \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_