Cornell College Athletics
Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Date of Exam _____

Name_____ Date of Birth _____
Last First MI

Follow-Up Questions on More Sensitive Issues	**Yes**	**No**
1. Do you feel stressed out or under a lot of pressure?	☐	☐
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	☐	☐
3. Do you have a person in your life you trust and can openly share concerns?	☐	☐
4. Have you been getting regular/normal amounts of sleep daily?	☐	☐
5. Do you feel safe?	☐	☐
6. Have you ever taken medicine(s) without a doctor's prescription?	☐	☐
7. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	☐	☐

Notes:_____

Height: _____ Weight :_____ Pulse :_____ BP: _____/_____

Vision: R 20/_____ L 20/_____ Corrected : Yes No Pupils: Equal _____ Unequal _____

Are there any abnormalities of the following systems?		
	No	**Yes, please describe**
Eyes		
Head, ENT		
Cardiovascular		
Respiratory		
Breast		
Gastrointestinal		
Genitourinary		
Hernia		
Skin		
Metabolic/Endocrine		
Neuropsychiatric		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional: Duck walk, single leg hop		

Signature of Physician_____, MD or DO or PA or NP Date:_____

PHYSICIANS: PLEASE MAKE SURE YOU SIGN CLEARENCE FORM AS WELL

Adapted from the 2004 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine

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CLEARANCE FORM

Name_____ Birthdate_____ Assigned sex at birth (circle one) Male Female

Gender Identity (circle one) M F N T

☐ Cleared without restrictions

☐ Cleared, with recommendation for further evaluation or treatment for:_____

_____

_____

☐ Not cleared for: ☐ All Sports ☐ Certain Sports:_____ Reason:_____

Recommendations:_____

_____

EMERGENCY INFORMATION

Allergies_____

Medications _____

Other information_____

1st Year & Transfers: Sickle Cell Status: Positive _____ Negative _____

IMMUNIZATIONS (eg, tetanus/dipthera/pertussis; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

☐ Up to date ☐ Not up to date Specify_____

Name of Physician (print/type):_____ Date:_____

Address:_____ Phone:_____

Signature of Physician_____, MD or DO or PA or NP

I hereby authorize the Ebersole Student Health Center to release any information related to my athletic participation to the Cornell College's Sports Medicine Department. And for Cornell College's Sports Medicine Department to release any medical information to Ebersole Student Health Center or to Cornell College's Insurance Company claims administration services.

Athlete Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Questions can be directed to:

Courtney Zierten, MPH, ATC, LAT - czierten@cornellcollege.edu - 319-895-4573

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