### PHYSICAL EXAMINATION FORM

#### PHYSICIAN REMINDERS
1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dig?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcoholic beverages or any other drug?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>Pulse</th>
<th>Vision R 20'</th>
<th>L 20'</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Marfan stigmata (kyphoscoliosis, high-arched palate, pecus excavatum, arachnodactyly, arm span &gt; height, hypertelorism, myopia, RRP, aortic insufficiency)</td>
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<td></td>
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<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
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<tr>
<td>* Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Location of point of maximal impulse (PMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Simultaneous femoral and radial pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary males only*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* HSV, lesions suggestive of MRSA, tinea corporis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MUSCULOSKELETAL

| Neck                           |                                            |                   |
| Back                           |                                            |                   |
| Shoulder/arm                   |                                            |                   |
| Elbow/forearm                  |                                            |                   |
| Wrist/hand/fingers             |                                            |                   |
| Hip/leg                        |                                            |                   |
| Knee                          |                                            |                   |
| Leg/ankle                      |                                            |                   |
| Foot/toes                      |                                            |                   |
| Functional                     |                                            |                   |
| * Duck-walk, single leg hop   |                                            |                   |

*Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider Still exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for

- Not cleared
  - Pending further evaluation
  - For any sports
  - For certain sports

Reason

Recommendaions

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ____________________________ Date __________
Address ____________________________ Phone __________
Signature of physician ____________________________ MD or DO

**Preparticipation Physical Evaluation History Form**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

**Date of Exam:**

**Name:**

**Age:**

**Grade:**

**School:**

**Sport(s):**

**Medications and Allergies:** List all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

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Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

□ Medicines  □ Pollens  □ Food  □ Stinging Insects

---

**Explain "Yes" answers below. Circle questions you don’t know the answers to.**

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  Yes  No

2. Do you have any ongoing medical conditions? If so, please identify below:  □ Asthma  □ Anemia  □ Diabetes  □ Infections  □ Other:

3. Have you ever spent the night in the hospital?  Yes  No

4. Have you ever had surgery?  Yes  No

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out during or after exercise?  Yes  No

6. Have you ever had chest pain, tightness, or pressure in your chest during exercise?  Yes  No

7. Does your heart ever race or skip beats (irregular beats) during exercise?  Yes  No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   - High blood pressure  □
   - A heart murmur  □
   - High cholesterol  □
   - A heart infection  □
   - Kawasaki disease  □
   - Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/ECG, echocardiogram)  Yes  No

10. Do you get lightheaded or feel more short of breath than expected during exercise?  Yes  No

11. Have you ever had an unexplained seizure?  Yes  No

12. Do you get more tired or short of breath more quickly than your friends during exercise?  Yes  No

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)?  Yes  No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arteriovenous or venous cardiac malformations, long QT syndrome, short QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia?  Yes  No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  Yes  No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  Yes  No

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  Yes  No

18. Have you ever had any broken or fractured bones or dislocated joints?  Yes  No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  Yes  No

20. Have you ever had a stress fracture?  Yes  No

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)  Yes  No

22. Do you regularly use a brace, orthotics, or other assistive device?  Yes  No

23. Do you have a bone, muscle, or joint injury that bothers you?  Yes  No

24. Do any of your joints become painful, swollen, tired, or look red?  Yes  No

25. Have you ever had a history of juvenile arthritis or connective tissue disease?  Yes  No

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**MEDICAL QUESTIONS**

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  Yes  No

27. Have you ever used an inhaler or taken an asthma medicine?  Yes  No

28. Is there anyone in your family who has asthma?  Yes  No

29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ?  Yes  No

30. Do you have groin pain or a painful budge or hernia in the groin area?  Yes  No

31. Have you ever had infectious mononucleosis (mono) within the last year?  Yes  No

32. Do you have any rashes, pressure sores, or other skin problems?  Yes  No

33. Have you ever had a herpes or MRSA skin infection?  Yes  No

34. Have you ever had a head injury or concussion?  Yes  No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?  Yes  No

36. Do you have a history of seizure disorder?  Yes  No

37. Do you have headaches with exercise?  Yes  No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  Yes  No

39. Have you ever been unable to move your arms or legs after being hit or falling?  Yes  No

40. Have you ever become ill while exercising in the heat?  Yes  No

41. Do you get frequent muscle cramps when exercising?  Yes  No

42. Do you or someone in your family have sickle cell trait or disease?  Yes  No

43. Have you had any problems with your eyes or vision?  Yes  No

44. Have you had any eye injuries?  Yes  No

45. Do you wear glasses or contact lenses?  Yes  No

46. Do you wear protective eyewear, such as goggles or a face shield?  Yes  No

47. Do you worry about your weight?  Yes  No

48. Are you trying to or has anyone recommended that you gain or lose weight?  Yes  No

49. Are you on a special diet or do you avoid certain types of foods?  Yes  No

50. Have you ever had an eating disorder?  Yes  No

51. Do you have any concerns that you would like to discuss with a doctor?  Yes  No

**FEMALES ONLY**

52. Have you ever had a menstrual period?  Yes  No

53. How old were you when you had your first menstrual period?  Yes  No

54. How many periods have you had in the last 12 months?  Yes  No

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**Explain "yes" answers here**

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

**Signature of athlete:**

**Signature of parent/guardian:**

**Date:**

Rowan College at Gloucester County

Athlete Emergency Contact/ Health Insurance Information Form

This form must be completely filled out and returned to the Athletic Trainer before the commencement of the athletic season. This will ensure all insurance information is on file should an injury occur. Please provide all requested information. If you do not have your own insurance, please indicate that below with an N/A. Athletes will have school insurance to help cover medical costs associated with Athletic Related Injuries/Illnesses only. This will act as a secondary insurance except for cases where the athlete does not have personal insurance.

Name(Last)________________________(MI)_____________(First)_____________ Sport__________________________ DOB____/____/____

SSN_____________________________ E-mail Address_____________________________________________________

Home Address________________________________________________________________________________________

Home Phone Number________________________ Cell Phone Number________________________

Emergency Contacts

Father (or Guardian)                                                                   Mother (or Guardian)

Name_________________________________________________________ Name_________________________________________________________

Address________________________________________________________________________________________

Phone_________________ (Home)                                                                 Phone_________________ (Home)

____________________ (Cell)                                                                                     ______________________ (Cell)

____________________ (Work)                                                                                     ______________________ (Work)

Employer_________________________________________________________ Employer_________________________________________________________

(Name and Address)                                                                                               (Name and Address)

Do you wish to have someone else contacted in case of an emergency? ____________________________________________________________ ph#________________________

Health Insurance Name_________________________________________ Name of Policy Holder________________________

Insurance Address________________________________________________________________________________________

Ins. Phone # (for member services) ____________________________ Policy #________________________ Group #________

I hereby verify this information to be true & accurate, & Rowan College at Gloucester County & AIG insurance to inspect or secure copies of all pertinent medical information regarding current or previous injuries. A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize Gloucester County College or its insurance agent to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college.

Parent's Signature(if athlete is under 18)_________________________________________ Date:________________________________

Student's Signature:_________________________________________________________ Date:________________________________
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Student Athlete Name: ________________________________

Last ____________________________ First ____________________________ M.I. __________________

Date of Birth ____________________________ Social Security Number __________________

By signing this authorization, I authorize Rowan College at Gloucester County and their designated Licensed/Certified Athletic Trainer to act in the capacity of an approved medical provider to use and disclose the above persons’ health information to appropriate medical professionals, coaches, assistant coaches and other athletic staff as reasonable and necessary in order to further this individual’s injury care so that they may make decisions regarding their athletic ability and suitability to compete while participating as a student-athlete.

I understand that if the individual(s) to which this information is released are not health care providers, health plans or health care clearinghouses subject to the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rules, the health information disclosed pursuant to this authorization may be redisclosed by such individuals without obtaining my authorization.

I further understand that I have the right to revoke this authorization at any time and that the revocation must be in writing and directed to Gloucester County College. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization. This authorization will remain in effect until one calendar year past the date of my signature.

I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Participant Signature ____________________________ Date ________________

If signed by a Personal Representative, complete the following:

Name of Personal Representative (please print): ____________________________

Relationship to Participant or Nature of Authority: ____________________________

(e.g. Guardian, Parent, Power of Attorney)

Phone Number of where you can be contacted: ____________________________

Personal Representative Signature ____________________________ Date ________________

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