



Merced College Sports Medicine
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PREPARTICIPATION PHYSICAL EXAMINATION

Name _____ Age _____ Gender _____ Date of Birth ____/____/____

Address _____ Phone _____

Height _____ Weight _____ Personal Physician _____ Physician Phone _____

Medical History – This section must be completed before your examination. Include dates of any problems and explain all yes answers.

Are you currently under a doctor's care for any reason?	Yes	No	Have you ever been dizzy or passed out due to heat?	Yes	No
Have you ever been hospitalized?	Yes	No	Do you have trouble breathing before or after exercise?	Yes	No
Have you ever had surgery?	Yes	No	Have you had any problems with your eyes or vision?	Yes	No
Are you currently taking any medications or pills?	Yes	No	Do you wear glasses or contacts or protective eye wear?	Yes	No
Do you have any allergies (medicines, bee stings, etc.)?	Yes	No	Do you use any special equipment (splints, neck rolls, mouth guards, etc.)?	Yes	No
Have you ever been dizzy or fainted during or after exercise?	Yes	No	Has anyone in your family died of heart problems or sudden death before the age of 50?	Yes	No
Have you ever had chest pains during or after exercise?	Yes	No	Do you have only one working organ of usually paired organs (one eye, kidney, etc.)?	Yes	No
Have you ever had high blood pressure?	Yes	No	Have you ever sprained , broken, dislocated or had repeated swelling or pain of any bones or joints?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No	Have you ever had a stinger, burner or pinched nerve?	Yes	No
Have you ever had a racing heart or skipped heartbeats?	Yes	No	Have you had any medical problems or injuries (asthma, mono, diabetes, etc.)?	Yes	No
Have you ever had a head injury or concussion?	Yes	No	Have you had any medical problems or injuries since your last evaluation?	Yes	No
Have you ever been knocked unconscious?	Yes	No	Were there any special instructions or precautions given by the Medical Practitioner?	Yes	No
Have you ever had a seizure?	Yes	No	What was the date of your last tetanus shot?	Yes	No
Are any of the following currently bothering you? Hand__ Wrist__ Elbow__ Forearm__ Hip__ Thigh__ Knee__ Ankle__ Shin/Calf__ Foot__	Yes	No			

Explain all "Yes" answers and provide dates for each:

I/We hereby state that, to the best of my/our knowledge, the answers to the above questions are correct. I/We understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Signature of Student/Athlete _____ Date ____/____/____

Signature of Parent/Guardian (if athlete is under 18) _____ Date ____/____/____

	Blood Pressure	HEENT	Skin	Heart	Lungs	Abdomen	Flexibility/Strength
NORMAL							
ABNORMAL							

While this does not constitute a complete physical examination nor replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participation in interscholastic sports as of this date, except as indicated below:

- Cleared for sports without restrictions
- Cleared with the following restrictions: _____
- Cleared after completing evaluation/rehabilitation for: _____
- Not Cleared

At this athlete's screening exam the following is/are noted:

Condition/Sign/Symptoms with Simple Explanation/Recommendations

- Elevated (High) Blood Pressure. Maximum normal ____/____
- Heart Murmur: It is ____ "Functional" (normal) ____ Abnormal
- Asthma. ____ Use inhaler as prescribed and 30 minutes before exercise
- Allergic Reactions to Stings or Bites. ____ Epinephrine injector should be available at all times
- Diabetes. ____ Continue close monitoring with M.D.
- Scoliosis. ____ Continue close monitoring with M.D.
- Orthopedic Problem. ____ Should be cleared for play by M.D.
- Concussion. ____ Further evaluation required before athletic participation permitted.
- Other: _____

Physician Name _____ Physician's Signature _____ Date ____/____/____