



# Intercollegiate Athletics Pre-participation Examination

Must be returned to:

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4355 Lakeshore Drive  
Canandaigua, NY 14424

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

SS#/FLCC ID# \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

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

### Student intends to participate: (circle all that apply):

- 1) soccer 2) cross country 3) basketball 4) baseball 5) softball 6) lacrosse 7) woodsmen 8) track

## HEALTH HISTORY

### I. Current/Recent Health Problem (circle any that have occurred in the last 30 days))

- 1) fever 2) sore throat 3) U.R.I. 4) fatigue 5) mono 6) weight gain or loss (lbs.) 7) cough 8) musculoskeletal (Fx/sprain)

### II. Current Medications/Supplements (list all): \_\_\_\_\_ none

### III. Past Medical History/Within the last 12 months (circle all that apply) Staff: describe each problem circled including dates of incident

	YES	NO	COMMENT		YES	NO	COMMENT
Seizures	___	___		Heart problems	___	___	
Headaches/dizziness	___	___		High blood pressure	___	___	
Ear disease	___	___		Blood relatives who have died from heart problems before age of 50	___	___	
Glasses/contacts during play	___	___		Absent organs	___	___	
Skin problems	___	___		Allergies	___	___	
Back pain	___	___		Diabetes	___	___	
Medications	___	___		Bleeding problems	___	___	
Ever smoke cigarettes	___	___		Anemia	___	___	
Asthma	___	___		<u>Women only</u>			
Drink alcohol	___	___		Menstrual cramps	___	___	
Use street drugs	___	___		Date of last period	_____		

<u>Injuries</u>	YES	NO	DATE OF INJURY	TREATMENT
Concussion/head injury	___	___	_____	_____
Skull fracture	___	___	_____	_____
Neck injury	___	___	_____	_____
Loss of tooth	___	___	_____	_____
Back injury	___	___	_____	_____
Arm injury	___	___	_____	_____
Shoulder injury	___	___	_____	_____
Knee injury	___	___	_____	_____
Ankle injury	___	___	_____	_____

Student Signature: \_\_\_\_\_

### IV. Allergies

- 1) Drugs: \_\_\_\_\_ 4) Inhalants: \_\_\_\_\_  
 2) Foods: \_\_\_\_\_ 5) Pollens: \_\_\_\_\_  
 3) Contacts: \_\_\_\_\_ 6) Insects: \_\_\_\_\_

## EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Respiratory Rate \_\_\_\_\_ Pulse (resting) \_\_\_\_\_ BP (resting) \_\_\_\_\_

Vision	Corrective Lenses ( ) Y ( ) N	
	Right	Left
w/o correction	20/	20/
w/ correction	20/	20/

Urine Screen				
pH	Protien	Glucose	Ketones	Blood

# CLINICAL EXAMINATION

## BODY SYSTEMS

## NOTES:

SKIN:	Normal:	Furuncles:	Pyoderma:	Athletes foot:	Acne:	
	Herpes Simplex:	Warts:	Ringworm:	Jock Itch:		
EYES:	Normal:	Pupils:	E.O.M.			
EARS/NOSE/THROAT	Normal:	Other:				
LYMPH NODES:		Normal:	Other:			
HEART:	Normal:	Other:	Murmurs:	Rhythm:	Rate:	
	Size (percussed)					
LUNGS/THROAX	Normal:	Other:				
ABDOMEN:	Normal:	Other:				
GENITALIA:	Normal:	Other:				

## MUSCULOSKELETAL:

## NOTES:

JOINTS:	POSTURE/CONFIGURATION:	RANGE OF MOTION	STRENGTH	
BACK: CERVICAL SPINE: T/HORACIC SPINE LUMBOSACRAL:				
RIGHT SHOULDER:				
LEFT SHOULDER:				
RIGHT ELBOW:				
LEFT ELBOW:				
RIGHT WRIST:				
LEFT WRIST:				
RIGHT HAND:				
LEFT HAND				
RIGHT HIP:				
LEFT HIP:				
QUADRICEPS:				
HIP FLEXORS:				
HAM STRINGS:				
RIGHT KNEE:				
LEFT KNEE:				
RIGHT ANKLE:				
LEFT ANKLE:				
RIGHT FOOT:				
LEFT FOOT:				
GAIT:				

## SUMMARY OF FINDINGS AND DIAGNOSIS: No medical/Orthopedic contraindirations to athletics

- Restrictions: \_\_\_\_\_
- Other: \_\_\_\_\_

PHYSICIAN'S CERTIFICATION: I certify that I have examined this student on the basis of the examination and the medical information as presented to me. I have found no reason which would make it medically inadvisable for this student to participate in college life or to compete in athletic activities. Any exceptions are listed above.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PRINT PHYSICIAN'S NAME

\_\_\_\_\_  
PHYSICIAN'S ADDRESS

\_\_\_\_\_  
PHYSICIAN'S PHONE

\_\_\_\_\_  
DATE OF EXAM

Physical examination information will be kept in strict confidence and will not be released to anyone without your knowledge and consent. FLCC does not discriminate on the basis of race, color, creed, religion, national origin, sex, age, personal affiliation, disability, marital or veteran status in its educational programs, admissions, activities, or employment policies.

## MEDICAL INFORMATION RELEASE FORM

I hereby request and authorize Finger Lakes Community College Health Services to furnish pertinent information regarding my physical examination and immunization as it pertains to participating in the sports program to the Athletic Director, Athletic Trainer and Coaches.

A copy of my physical examination and other pertinent data related to my medical clearance will be on file at the Student Health Center at Finger Lakes Community College and with the attending physician.

\_\_\_\_\_  
student signature

\_\_\_\_\_  
date

\_\_\_\_\_  
social security number

\_\_\_\_\_  
parent or guardian

\_\_\_\_\_  
date

(if you are under age 18, this authorization must also be signed by a parent or guardian)

**Finger Lakes Community College Department of Athletics (Athletic Training)  
Pre-Participation Medical and Injury Questionnaire**

**\*\*This form must be completed in its entirety AND must be approved by a member of the FLCC Sports Medicine Team.\*\***

<b>Name:</b> _____	<b>Date:</b> _____ (must be within 3 months of entering the College)
<b>SSN # / FLCC ID #:</b> _____	<b>Date of Birth:</b> _____ <b>Age:</b> _____
<b>Home Address:</b> _____ _____ _____	<b>School Address:</b> _____ _____ _____
<b>Home Phone:</b> ( ) _____ - _____	<b>Cell Phone:</b> ( ) _____ - _____
<b>Emergency Contact Person:</b> _____	<b>Relationship:</b> _____
<b>Address:</b> _____ _____ _____	<b>Home Phone:</b> ( ) _____ - _____ <b>Work / Cell Phone:</b> ( ) _____ - _____

**MEDICAL INFORMATION RELEASE WAIVER**

I, \_\_\_\_\_, while participating in an intercollegiate athletic program at Finger Lakes Community College, give my consent for the certified athletic trainer, team physician, sports medicine staff, and the Finger Lakes Community College Student Health Services to provide me with any appropriate health care. I permit any health care provider that I might see, due to an injury or illness, to share any and all relevant information with the certified athletic trainer, team physician, sports medicine staff, Student Health Services, team coaches and my parent / guardian, when appropriate. This information is **ONLY** to be used in order to properly inform the above mentioned individuals about my condition and capabilities while I am participating as a student athlete at Finger Lakes Community College. Authorization provided by this form shall be considered valid for the **duration of my intercollegiate career** at Finger Lakes Community College.

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

**Informed Consent / Risk Management Statement**

I understand that injuries can, and do, occur as a result of athletic participation and I understand that these injuries can occur both at practices and during competition. These injuries can result in, but are not limited to, temporary or permanent disability, paralysis, or even death to my opponent or myself. These injuries may occur with or without any intent to violate any rules of the specific sport / event. All such injuries can not be prevented.

I understand that behaviors including, but not limited to, modifying protective equipment, not participating in an appropriate conditioning program, and ignoring the medical advice of the sports medicine team can increase my risk of injury.

By **signing** this form I acknowledge that I understand the risks that are involved in athletic participation in athletics at Finger Lakes Community College.

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

**HELMET WARNING (Lacrosse, Baseball, Softball)**

**DO NOT** use your helmet to butt, ram, or spear an opposing player; **DO NOT** use your helmet as a weapon. This is in violation of the rules of the sport and can result in severe head, brain, or spine (including neck) injuries, paralysis, or death to both you and your opponent. There is a risk that these injuries may occur as a result of accidental contact without the intent to butt, ram, or spear another player. No helmet can prevent all head and neck injuries that a player might receive while participating in intercollegiate athletics. By **signing** this form I acknowledge that I understand the proper use of protective equipment, including helmets, and I understand the risks involved with the participation in intercollegiate athletics.

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

**Student-Athlete Medical History**

Please answer the following questions to the best of your ability. If you answer "Yes" to any of the following questions please explain, **in detail**, the injury or situation (including dates, treatments, hospitalizations, etc.) so that we can provide the best medical coverage possible.

1) Have you ever been diagnosed with any of the following illnesses or diseases?

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Asthma	( )	( )	High Blood Pressure	( )	( )	Low Blood Pressure	( )	( )
Eating Disorder	( )	( )	Frequent Headaches	( )	( )	Migraine Headaches	( )	( )
Nervous Stomach	( )	( )	Kidney Problems	( )	( )	Appendicitis	( )	( )
Anemia	( )	( )	Sickle Cell Trait	( )	( )	Ulcers / Internal Bleeding	( )	( )
Diabetes	( )	( )	Cancer	( )	( )	Seizures / Epilepsy	( )	( )
Heart Murmur	( )	( )	Hearing Problems	( )	( )	Liver Problems	( )	( )
Frequent Colds	( )	( )	Mononucleosis	( )	( )	Skin Infections	( )	( )
Fainting / LOC	( )	( )	Pneumonia	( )	( )	Blood Clotting Problems	( )	( )
Hernia	( )	( )	Hepatitis	( )	( )	Thyroid Disease	( )	( )

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_

2) Do you have a family history of any of the conditions listed in question #1? **YES** \_\_\_\_ **NO** \_\_\_\_

3) Has any immediate family member suffered sudden and/or unexplained death? **YES** \_\_\_\_ **NO** \_\_\_\_

4) Have you ever suffered from heart or circulatory system problems? **YES** \_\_\_\_ **NO** \_\_\_\_

5) Have you experienced chest pain / discomfort, fainting / dizziness or any unexplained shortness of breath during exercise? **YES** \_\_\_\_ **NO** \_\_\_\_

6) Have you ever experienced chest tightness, wheezing, or uncontrollable coughing during or immediately after activity while not having an illness? **YES** \_\_\_\_ **NO** \_\_\_\_

7) Have you ever suffered from a heat illness (heat cramps, heat exhaustion, heat stroke)? **YES** \_\_\_\_ **NO** \_\_\_\_

8) Please list any allergies / sensitivities that you have to medications.  
\_\_\_\_\_  
\_\_\_\_\_

9) Please list all medications / supplements that you are taking and please explain why you are taking them.  
\_\_\_\_\_  
\_\_\_\_\_

- 10) Have you ever suffered a head injury / concussion? **YES** \_\_\_\_ **NO** \_\_\_\_  
\*\*How many? \_\_\_\_\_ \*\*Dates: \_\_\_\_\_  
\*\*Did you lose consciousness with any of the concussions? **YES** \_\_\_\_ **NO** \_\_\_\_  
\*\*Were you hospitalized with any of these concussions? **YES** \_\_\_\_ **NO** \_\_\_\_  
\*\*How long were you held out of activity for each concussion? \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

- 11) Do you wear glasses or contacts? **YES** \_\_\_\_ **NO** \_\_\_\_

- 12) Do you have any missing or non-functional organs? **YES** \_\_\_\_ **NO** \_\_\_\_

- 13) Have you ever had a facial injury? **YES** \_\_\_\_ **NO** \_\_\_\_

- 14) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) in your neck or back? **YES** \_\_\_\_ **NO** \_\_\_\_

- 15) Have you ever had a neurological injury (pinched nerve / herniated disc / "burner" / "stinger) in your neck or back? **YES** \_\_\_\_ **NO** \_\_\_\_

- 16) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **shoulder or collar bone?** **YES** \_\_\_\_ **NO** \_\_\_\_

- 17) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **elbow, forearm, or wrist?** **YES** \_\_\_\_ **NO** \_\_\_\_

- 18) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **hand, thumb, or fingers?** **YES** \_\_\_\_ **NO** \_\_\_\_

- 19) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **chest, sternum, ribs, or torso?** **YES** \_\_\_\_ **NO** \_\_\_\_

20) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **hips, groin, femur, quadriceps, or hamstrings?** YES \_\_\_\_\_ NO \_\_\_\_\_

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21) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **knee?** YES \_\_\_\_\_ NO \_\_\_\_\_

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22) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **ankle, calf, or shin?** YES \_\_\_\_\_ NO \_\_\_\_\_

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23) Have you ever had a musculoskeletal injury (sprain / strain / fracture / dislocation) to your **foot or toes?** YES \_\_\_\_\_ NO \_\_\_\_\_

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***\*\*Please read the following statement and sign below!\*\****

**If you have any questions, DO NOT sign this form until you fully understand how you answered the previous questions!**

I certify that I have completed the preceding questionnaire with honest answers and to the best of my knowledge. I understand that I will be held liable for any omissions and falsehoods and I understand that dishonest answers can result in my disqualification from athletic participation at Finger Lakes Community College. I also understand that the certified athletic trainer, team physician, and Student Health Services have the right to ask for more information about any injury or condition that I have listed above.

Furthermore, I realize that any of these injuries and illnesses may inhibit me from participating until I have been cleared to return to athletic participation from the appropriate health care provider, as deemed by FLCC's athletic training / sports medicine staff and / or FLCC's Student Health Services.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent / Guardian Signature (if athlete is under age 18)**

\_\_\_\_\_  
**Date**

**GO LAKERS!**