



BACONE COLLEGE PREPARTICIPATION PHYSICAL

Returning Athlete Questionnaire

DATE: ____ / ____ / ____
Month Day Year

Athlete's Name: _____ Sports(s): _____
(Last) (First) (Middle) (Nickname)

Social Security No: ____ / ____ / ____ Date of Birth: ____ / ____ / ____ Age / Sex / Race
Month Day Year

Student No: ____ / ____ / ____ Classification: Fr. So. Jr. Sr. Red Shirt Sr.
(Different than Social Security No.)

Local Apartment, Address, Dormitory, etc. _____ E-Mail Address: _____
Local Phone: _____ Cell Phone: _____

EMERGENCY CONTACT:

NAME _____ Relationship: _____

Address: _____
(City) (State) (Zip)

Home Phone: (_____) _____ Business Phone: (_____) _____

Cell Phone (_____) _____ E-Mail: _____

PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS.

Have there been any changes in your FAMILY health history in the past year? (heart attack, stroke, etc.)	YES	NO
Has there been a significant change in YOUR health history in the past year? (asthma, diabetes, seizures, Sickle Cell, etc.)	YES	NO
Have you had any illness during the past month? (ex: cold, flu, sore throat, fever)	YES	NO
Have you had a serious injury/illness requiring physician care in the past year?	YES	NO
Have you had any surgeries in the past year?	YES	NO
Have you had a head injury or concussion in the past year? This includes athletic and non-athletic related injuries.	YES	NO
Have you had a neck/back injury within the past year?	YES	NO
Have you experienced a heat illness in the past year? (Heat exhaustion, heat stroke, fainting, etc.)	YES	NO
In the past year, have you experienced any of the following during or immediately after exercise: chest pain, irregular heartbeat, shortness of breath, fainting?	YES	NO
Have you been diagnosed with mononucleosis in the past year?	YES	NO
Have you lost/gained significant weight in the past year?	YES	NO
Are you currently under the care of a physician?	YES	NO
FEMALES ONLY: Have you had any significant changes in your menstrual cycle in the past year?	YES	NO
Are you currently taking any medications? *If YES, please list medications.	YES	NO
Do you feel healthy and ready to participate in this year's season? *If NO, please explain.	YES	NO

PLEASE EXPLAIN ANY "YES" ANSWERS IN THE SPACE BELOW.

I hereby certify that the answers provided are true and correct to the best of my knowledge.

Athletes Printed Name _____ Date _____

Athletes Signature _____

V. Acknowledgment of Shared Responsibility for Sports Safety

SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in sports requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of sports have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

Periodic analysis of injury patterns leads to refinements in the rules and other safety decisions. I realize that despite improvement in equipment standards, and how well rules are refined by athletic governing bodies, or enforced by officials, risks still exist that require my compliance and cooperation with any and all safety guidelines in order to minimize injury to myself, as well as other participants. "Compliance" means respect and cooperation on everyone's part for the intent and purpose of a rule or guideline.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating in athletics at Bacone College.

DATE: _____ SIGNATURE: _____

The undersigned, herewith,

- A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
- B. Understands that his/her having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics; but only that the examiner did not find a medical reason to disqualify him/her.
- C. Fully realizes that Bacone College cannot be held responsible for any previous medical condition(s) that he/she might have or any medical expense incurred due to any identified pre-existing medical condition and not directly attributable to any athletic participation at Bacone College.

(PLEASE PRINT) (First) (Middle) (Last)

ATHLETE'S SIGNATURE

DATE

WITNESS SIGNATURE

VI. Acceptance of Risk Statement

I, _____ understand the chance of sustaining a catastrophic sports injury is extremely remote, yet understand that serious injuries can and do occur to anyone. Participation in your sport could result in death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of your body, general health and well-being.

DATE: _____ ATHLETE'S SIGNATURE: _____

WITNESS SIGNATURE: _____

*****ONLY FEMALES ANSWER THIS SECTION*****

VII. Acknowledgment of Personal Responsibility to Withdraw from Sports Participation Due to Pregnancy

I, _____ hereby understand that once I become pregnant it is my responsibility to notify the Head, Associate, or Assistant Athletic Trainer and remove myself from all practices, conditioning, and competitions.

I totally understand that my participation in varsity athletics at BACONE COLLEGE is voided upon becoming pregnant.

DATE: _____ ATHLETE'S SIGNATURE: _____

WITNESS SIGNATURE: _____



BACONE COLLEGE WARRIOR ATHLETICS

Health Insurance Information

By filling out this sheet, I _____ understand that Bacone College does not hold medical insurance on me. I understand that Bacone College is not responsible for payment of any form of treatment for athletic injuries or any other reason. I understand that all medical bills are my responsibility and I must hold my own personal health insurance which will be used in case of an injury or illness.

Athlete's Name _____ M/F
Last First MI (circle)

Athlete's Home Address _____
City State Zip

Phone Number _____
Athlete's SSN _____ Athlete's DOB _____
Emergency Contact Name _____ Relation _____
Contact Phone Number _____

COMPLETE INSURANCE INFORMATION

Name of Insurance Company _____
Address _____
City State Zip

Phone Number _____
Policy Holder Name _____
Last First MI

Policy Holder's Address _____
City State Zip

Policy Number _____ Group Number _____
Policy Holder's SSN _____
Policy Holder's DOB _____

Athlete's Signature _____ Date _____
Sport _____

Parent/Guardian Signature (if minor) _____

***ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.**

THE REMAINDER OF THIS FORM IS TO BE COMPLETED BY A PHYSICIAN.

HEIGHT: _____ NECK GIRTH: _____ CHEST _____ BICEPS: R) _____ BICEPS L) _____
 WEIGHT: _____ NECK LENGTH: _____ ABDOMEN: _____ CALF: R) _____ CALF L) _____
 BODY COMPOSITION: _____ % _____ THIGH: R) _____ L) _____
Formula (Above Medial Knee Joint) 4" 7" 4" 7"

NECK: ROM: Normal, Restricted _____
 History of Injury: _____
 Physician Comments: _____

SHOULDER: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Physician Comments: _____
 Deltoid Strength R) Good () Weak () Supraspinatus R) Good () Weak ()
 L) Good () Weak () L) Good () Weak ()
 Internal Rotation R) Good () Weak () External Rotation R) Good () Weak ()
 L) Good () Weak () L) Good () Weak ()

ELBOW: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Physician Comments: _____

WRIST: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Physician Comments: _____

HANDS & FINGERS: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Deformities: _____
 Physician Comments: _____

SPINE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Posture: () Normal () Scoliosis () Kyphosis () Lordosis
 Physician Comments: _____

HIP: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____
 Psoas Muscle: R): Tight, Flexible Rectus Femoris: R): Tight, Flexible
 L): Tight, Flexible L): Tight, Flexible
 Hamstring: R): Tight, Flexible _____(degrees) Hip Flexor Strength: R): Strong, Weak
 L): Tight, Flexible _____(degrees) L): Strong, Weak
 Physicians Comments: _____

KNEE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____
 History of Injury: _____

	Right	Left	Comments		Right	Left	Comments
Bowleg (Genu Varum)				Plica			
Knock Knee (Genu Valgum)				Q Angle			
Back Knee (Genu Recurvatum)				Abduction Stress (30°)			
Hyperextension Lift				Abduction Stress (0°)			
Patella Lateral				Adduction Stress (30°)			
Patella High (Alta)				Adduction Stress (0°)			
Patella Low (Baja)				Lachman Test			
Patella Hypermobility				McMurray's Test			
Anterior Drawer (ER)				Jerk/Pivot Shift			
(N)				VMO Dysplasia			
(IR)				Posterior Drawer			

Physician Comments: _____

ANKLE: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

	Right	Left	Comments		Right	Left	Comments
Dorsiflexion (with knee fully extended)				Anterior Drawer Test			
Jump Test				Inversion Stress Test			
				Eversion Stress Test			

Physician Comments: _____

FEET & TOES: ROM: R) Normal, Restricted _____; L) Normal, Restricted _____

History of Injury: _____

ARCH: R): NORMAL, HIGH, LOW **REARFOOT:** R): NEUTRAL, PRONATED, SUPINATED

L): NORMAL, HIGH, LOW L): NEUTRAL, PRONATED, SUPINATED

Physicians Comments: _____

VISUAL ACUITY: L) _____ R) _____ **DOMINANCE:** EYE _____ HAND _____

HEARING:	(Left ear - Blue headphone)				(Right ear - Red headphone)				
	500	1000	2000	4000	500	1000	2000	4000	
Left					Right				

URINALYSIS:	Glucose	Bilirubin	Ketone	SG	Blood	Ph	Protein	Urobilinogen	Nitrate	Leukocytes

GENERAL MEDICAL:

BLOOD PRESSURE: _____

PULSE: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEAD			RESPIRATORY		
EYES			HEART		
EAR, NOSE, THROAT			ABDOMEN		
NECK			URINARY		
SKIN			OTHER		

Physicians Comments: _____

DENTAL:

OVERALL PHYSICAL EXAMINATION RESULTS:

RESULTS	CHECK ONE	COMMENTS
PASSED WITHOUT LIMITATIONS		
PASSED PENDING THE FOLLOWING:		
FAILED DUE TO THE FOLLOWING:		

At this date, I can find no physical abnormality that would deter this student from fully participating in all of the sports listed below, except the ones that are circled: Badminton, Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Rodeo, Soccer, Softball, Swimming, Tennis, Track & Field, Volleyball, Weight Training, Wrestling

Physician's Signature: _____ Date: _____