MONTEREY PENINSULA COLLEGE
Date_____
ATHLETIC PREPARTICIPATION HEALTH SCREENING

Name_____Date of Birth_____
Phone_____Sex_____Sport_____
_____
Address/City/State/
Zip_____
____
Emergency Contact
Name_____
____
Relationship_____Phone_____
_____
Address/City/State/
Zip_____
____
Name of Family
Physician_____
_____

MEDICAL HISTORY
Record of Illness: Place a check next to any condition that you have/have had within the past FIVE years.
____Concussion
If Yes, how many?
_____
If Yes, when was the most recent?
_____
____Allergies (If Yes, specify)_____
___
____Appendicitis_____
_____
____Asthma_____
_____
____Convulsions_____
_____
____Diabetes_____
_____
____Epilepsy_____
_____

____Heart Disease_____

_____

____Hernia_____

_____

____Kidney/ Bladder_____

_____

____Tonsilitis_____

_____

____Surgery (type/ date)_____

_____

Record of Symptoms: Place a check next to any condition that you have/have had.

____Difficulty hearing
____Nose Bleeds
____Headaches
____Blackouts
____Painful menstrual cramps
____Shortness of breath
____Chest pain
____High blood pressure
____Fainting spells

If you have checked any condition above, please explain in detail:

_____
_____
_____

Eyes: Place a check next to the following that apply to you

____Wear glasses
____Contact lenses ____Hard____Soft
____Wear glasses/contact lenses when competing ____Glasses _____Contact lenses

Are you currently taking any medications at this time? (Circle) Y N If yes, please list all drugs or medications and daily usage/dosage.

_____
_____

Check if you have ever injured any of the following and if you had surgery for the injury:

____Face or Head
____Neck or Back
____Chest or Abdomen
____Shoulder
____Arm
____Wrist or Hand
____Leg
____Knee
____Ankle or Foot

If yes to any of the above, please give brief explanation and date of onset.

_____
_____
_____

**********STOP**********
****

THE FOLLOWING WILL BE COMPLETED BY THE PHYSICIAN

HEALTH SCREENING

_____Height
_____Weight
_____Blood Pressure
_____Pulse
_____Respiratory
_____Cardiovascular

_____Left Vision,
_____Right Vision
_____Ears
_____Nose
_____Throat
_____Hernia

Shoulder:
_____ROM_____
_____
_____Strength_____
_____
_____Ligament
Laxity_____
____
Knee:
_____ROM_____
_____
_____Strength_____
_____
_____Ligament
Laxity_____
____
Ankle:
_____ROM_____
_____
_____Strength_____
_____
_____Ligament
Laxity_____
____
Other:
_____ROM_____
_____

_____Strength_____
_____
_____Ligament
Laxity_____
____

COMMENTS AND RECOMMENDATIONS

I hereby certify that _____ was examined by me on _____. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport except _____ (if none, state so.)

Signature of examining physician (MUST BE MD or DO)_____