



# VANCE-GRANVILLE COMMUNITY COLLEGE

## STUDENT-ATHLETE

### SPORT PREPARTICIPATION HISTORY FORM - PART I

This is a screening examination for participation in sports. This must be completed in conjunction with the Physical Examination Form (Part II) at your appointment with your regular physician where important preventive health information can be covered.

**ATHLETE'S NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ATHLETE'S DIRECTIONS:** Please review all questions and answer them to the best of your knowledge.

**PHYSICIAN'S DIRECTIONS:** We recommend repeating the questions listed below and carefully reviewing details of any positive answers.

QUESTION	YES	NO	DON'T KNOW
Has anyone in the athlete's family died of heart problems or of sudden death before 50 years of age?			
Has anyone in the athlete's family died for no apparent reason?			
Has the athlete ever stopped exercising because of dizziness or passed out?			
Has a doctor ever told the athlete that he / she has high blood pressure, high cholesterol, a heart murmur, or a heart infection?			
Does the athlete have asthma (wheezing), hay fever, trouble breathing or coughing spells after exercise?			
Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?			
Has the athlete ever had a head injury or concussion (getting knocked out)?			
Has the athlete ever suffered a heat related illness (heat stroke, or heat exhaustion, severe cramps, etc.)?			
Does the athlete have anything he / she wants to talk to the doctor about?			
Does the athlete have a chronic illness (i.e., diabetes, kidney problems, etc.) or see a doctor regularly for any particular problem?			
Does the athlete presently take any medicine, pills, or supplements?			
Does the athlete have any allergies (medicine, bees or other stinging insects, latex, etc.)?			
Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?			
Does the athlete wear contacts or eyeglasses?			
Date of last tetanus booster: _____			
Has the athlete ever passed out or nearly passed out during or after exercise?			
Has the athlete ever had discomfort, pain, or pressure in his / her chest during exercise?			
Does the athlete's heart race or skip beats during exercise?			
Has a doctor ever ordered a test for the athlete's heart (e.g., electrocardiography (EKG), echocardiography (ECHO))?			
Does the athlete or anyone in the athlete's family have a heart problem?			
Does the athlete or anyone in the athlete's family have Marfan syndrome?			
Does the athlete currently use tobacco or caffeine?			

Does the athlete experience palpitations (abnormal heartbeat)?			
If yes, during exercise?			
Is there a gradual onset of palpitations on exertion?			
Do the palpitations gradually subside with rest?			
Do the palpitations suddenly subside with rest?			
Has the athlete ever been hospitalized or had surgery?			
Has the athlete had extreme fatigue associated with exercise (different from other athletes)?			
Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?			
Has the athlete ever had an eating disorder, or are there any concerns about the athlete's eating habits or weights?			
Does the athlete or his/her family members have sickle cell disease or the sickle cell trait?			

Elaborate on any positive answers:

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I certify and acknowledge I have answered and reviewed the questions above, and promise that all are true and accurate responses. By signing below, I recognize that (i) this sports participation screening is simply a general medical examination, required by Vance-Granville Community College and it cannot be expected to discover or uncover all possible (even life-threatening) abnormalities; and (ii) if the athlete or someone in his/her family has a history of heart problems or sudden death or disease, then the health care providers involved in his screening recommend that the athlete be seen prior to the athlete's participation in sports by the athlete's primary care doctor (family doctor or pediatrician) and/or cardiologist (heart doctor) or any other doctor suggested by the primary care doctor and/or cardiologist.

**Signature of Athlete:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**If the Athlete is a Minor:**

**Signature of Athlete's Parent/Legal Custodian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Emergency Contact for Athlete:**

**Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Name of Athlete's Current Primary Care Physician:** \_\_\_\_\_



# VANCE-GRAINVILLE COMMUNITY COLLEGE

## STUDENT-ATHLETE

### PHYSICAL EXAMINATION FORM - PART II

ATHLETE'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

1. BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ WT: \_\_\_\_\_ HT: \_\_\_\_\_ Vision (R): \_\_\_\_\_ (L): \_\_\_\_\_

2. CARDIOVASCULAR EXAM: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

Comments/Describe: \_\_\_\_\_

3. LUNGS EXAM: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

Comments/Describe: \_\_\_\_\_

4. MUSCULOSKELETAL EXAM - Record laxity, weakness, instability, decreased ROM- if abnormal

	NORMAL	ABNORMAL	COMMENTS
Lumbar Spine			
Knee			
Ankle			
Shoulder			
Other (i.e. neck, feet, scoliosis)			

5. OPTIONAL EXAM – should be done if history is positive.

	NORMAL	ABNORMAL	COMMENTS
ENT			
Heart			
Abdomen			
Genitalia			
Skin			
Lungs			
Kidneys			

\* ASSESSMENT: 5A. \_\_\_\_\_ No problems identified 5B. Other: \_\_\_\_\_

\* RECOMMENDATIONS: 6A. \_\_\_\_\_ Unlimited Sports Participation 6B. \_\_\_\_\_ Limited to specific sports 6C. Deferred until: \_\_\_\_\_

\* REEXAMINATION: 7A. \_\_\_\_\_ Yearly and after any injury that limits participation for greater than one week.

7B. \_\_\_\_\_ Other: \_\_\_\_\_

**\*REQUIRED ELEMENTS**

Additional Recommendations/Rehab Instructions (if applicable)

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I have reviewed the Student-Athlete Sport Participation History Form (Part I).  Yes  No

I certify that I have examined the above student and that such examination revealed ( Conditions  No Conditions) that would prevent this student from participating in intercollegiate sports.

If student not qualified, list reasons for disqualification: \_\_\_\_\_

(The following are considered disqualifying until medical releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with function loss, history of convulsions or concussions, absence or one kidney, eye, testicle or ovary, etc.)

Are you licensed to practice medicine in the United States:  Yes  No

**Signature of Physician/Extender:** \_\_\_\_\_, MD DO PA NP (please circle)

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**North Carolina License Number:** \_\_\_\_\_

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I certify that I have been provided with a copy of this Physical Examination form, and the results have been explained to me.

**Signature of Athlete:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Name of Athlete (Printed or Typed):** \_\_\_\_\_

**Address:** \_\_\_\_\_

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