



PHYSICAL EXAM CONFIDENTIAL

Return this form to:
Athletic Training Department
1000 West Court Street
Texas Lutheran University
Seguin, Texas 78155

PLEASE PRINT. FILL IN ALL SPACES

Full Name: _____ Sport: _____

Sex: M F Date of Birth: _____ Class: Fr So Jr Sr

Street Address: _____

City, State, Zip: _____ Home Phone: () _____

Mobile phone () _____ e-mail: _____

Medical History

Please answer all questions. Explain all "yes" answers in the space provided.

<p>YES NO Have you had a major medical illness since your last check up or sports physical? _____ _____</p> <p>YES NO Have you been hospitalized or had surgery in the last year? _____ _____</p> <p>YES NO Are you currently taking any prescription or non-prescription medication or using an inhaler? _____ _____</p> <p>YES NO Do you have any severe allergies to pollen, medicine, food, or stinging insects that require medical treatment? _____ _____</p> <p>YES NO Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm? _____ _____</p>	<p>Have you ever had any of the following?</p> <p>YES NO heart murmur _____</p> <p>YES NO high blood pressure _____</p> <p>YES NO high cholesterol _____</p> <p>YES NO other heart problems _____</p> <p>YES NO dizziness from exercise _____</p> <p>YES NO epilepsy or seizure _____</p> <p>YES NO severe headaches _____</p> <p>YES NO asthma _____</p> <p>YES NO diabetes _____</p> <p>YES NO anemia _____</p> <p>YES NO infectious mononucleosis _____</p> <p>YES NO hepatitis/liver problems _____</p> <p>YES NO kidney disease _____</p>
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Immunizations

Record the dates of your most recent immunizations for:

Tetanus _____ Chicken pox _____ Measles _____ Hepatitis B _____

Physicians Report

Athlete Name _____ Sex _____ Age _____
 Height _____ Weight _____ Pulse _____ Blood Pressure _____
 Vision: Right 20/ _____ Uncorrected / Corrected
 Vision: Left 20/ _____ Uncorrected / Corrected Wears: Contact Lenses / Glasses
 Tuberculin Skin Test Date _____ Results Positive / Negative

THE FOLLOWING INFORMATION MUST BE FILLED IN AND SIGNED BY A PHYSICIAN (MD)

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Neurological			
Ears/Nose/Throat			
Lymph			
Heart Auscultation in supine position			
Heart Auscultation in standing position			
Heart - lower extremity pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

On the basis of this examination and in the absence of medical reason for disqualification, I judge this individual able to participate in any physical activity he/she chooses including intercollegiate athletics.

Exceptions(if any): _____

This individual is not cleared for physical activity due to: _____

NAME (print) _____

DATE OF EXAM _____

SIGNATURE _____

PHONE # _____