

Athletic Physical

(To be completed by the Healthcare Practitioner)

Name _____ DOB _____ KCC ID # _____ Program _____

Allergies (drug, latex, environmental, food): _____

HT _____ WT _____ BP _____ Pulse _____ Resp. _____ Temp. _____

Eye Exam (Snellen chart) Rt. _____ Lt. _____ Glasses / Contacts (Full eye exam is NOT necessary.)

Date of last Tetanus _____

Are there abnormalities of any of the following:

Head, ears, nose, throat Yes No Assistive Hearing Device? Yes No	Eyes, visual acuity Yes No	Upper Respiratory Yes No	Lungs Yes No	Cardiovascular Yes No BP: _____	Gastrointestinal/rectal Yes No
Hernia Yes No	Genitourinary/Pelvic Yes No	Musculoskeletal Yes No	Metabolic/endocrine Yes No	Neuro Yes No	Skin Yes No

Current or history of the following illnesses, if yes please comment:

- Rheumatic Fever _____
- Hepatitis _____
- Diabetes _____
- Kidney / Urinary condition _____
- Epilepsy / Seizures _____
- Seizure-free for 6 months? Yes / No Date of last seizure: _____
- Heart Disorder/Attack/Disease _____
- Have you ever experienced passing out, SOB, or irregular heartbeat during exercise? _____
- Tuberculosis / Asthma / other respiratory disorder or disease _____
- Varicosities _____
- Mental Illness / Condition (diagnosed) _____
- Abnormal Menstrual History _____
- Skeletal injury or condition _____
- Previous sports injuries? _____
- Substance abuse (tobacco, alcohol, recreational drugs, caffeine)? _____
- Other current medical condition: _____

Please list current prescription and frequent use over-the-counter medications: _____

Please list surgery types / years: _____

Do you have any recommendations, precautions, or limitations for this student in his/her participation in sports? Yes No
 If yes, please comment _____

Based on your findings, should this student be restricted from participating in sports? Yes No

VERIFICATION:

Your signature below indicates that this student is able to participate in the Athletics program at Kirkwood Community College.

Healthcare Practitioner's signature _____ Print last name: _____

Clinic / Office Name and Location _____

Date: ____/____/____ Telephone Number (____) _____