

Bristol Community College Athletic Department

Pre-Participation Physical Form

All students intending to participate on any one of Bristol Community College's intercollegiate athletic teams must first complete a pre-participation exam before their first practice.

Returning upper-class student-athletes will continue to have their pre-participation physicals completed on campus before their respective sports begin practicing. First year students and transfers are required by College Administration to have a complete physical examination and immunization record that is up to date by their family physician prior to beginning classes. **Incoming students interested in competing in athletics should also take the pre-participation form at that time to be completed by their family physician.** The physician must check with whether physical activities are limited or unlimited. If you have limited activity your physician must specify your limitations.

Please note that the athletic department's pre-participation physical form is different than the college's medical form and that for incoming student athletes **both must be filled out completely and cannot be interchanged.** Payment for the physical examination and immunization will be the responsibility of the parent/guardian and/or student.

Incomplete forms will be returned to the student athlete for completion. After the entire pre-participation physical form has been completed, please mail to: Bristol Community College, Athletic Department, 777 Elsbree Street, Fall River, MA 02720.

The athletic training staff will then review all pre-participation physical forms and any students with potential physical limitations to full involvement in intercollegiate athletics **may be withheld from participation** until proper clearance from the team orthopedic or other physician is received. All medical history information will remain confidential and will be considered as part of the student athlete's permanent health record with the Student Health Center.

Pre-Participation Physical Evaluation

History Form

Name _____ Sex _____ Age _____ Date of Birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____
 Personal Physician _____
In case of emergency, contact
 Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers below
 Circle questions you don't know the answers to.

- | | | | | | | | | | | | | | | | | | | |
|--|--|----------|-----------|----------|-----------|--------------|-----------|--------------|-------|------------|------------|-----|-------|------|-----------|-------|-----------|--|
| <p>1. Has a doctor ever denied or restricted your participation in sports for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like diabetes or asthma)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or non-prescription (over the counter) medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply)
 <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur
 <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection</p> <p>10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative died of heart problems or of sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis that caused you to miss a practice or a game? If yes, circle affected area below:</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td>Head</td><td>Neck</td><td>Shoulder</td><td>Upper arm</td><td>Elbow</td><td>Forearm</td><td>Hand/fingers</td><td>Chest</td> </tr> <tr> <td>Upper back</td><td>Lower back</td><td>Hip</td><td>Thigh</td><td>Knee</td><td>Calf/shin</td><td>Ankle</td><td>Foot/toes</td> </tr> </table> <p>18. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/fingers | Chest | Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | <p>24. Do you cough, wheeze, or have difficulty breathing during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you ever been hit in the head and been confused or lost you memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Do you have headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor you that someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you happy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommend you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Head | Neck | Shoulder | Upper arm | Elbow | Forearm | Hand/fingers | Chest | | | | | | | | | | | |
| Upper back | Lower back | Hip | Thigh | Knee | Calf/shin | Ankle | Foot/toes | | | | | | | | | | | |

FEMALES ONLY

47. Have you ever had a menstrual period? Yes No
48. How old were you when you first had your menstrual period? _____
49. How many periods have you had in the last 12 months? _____

Explain "yes" answers here: _____

Pre-Participation Physical Evaluation

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Signature of athlete _____ Signature of parent/guardian _____

Physical Examination Form
 Date _____

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ___/___(___/___ . ___/___)

Vision R/20 _____ L/20 _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat.			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Pre-Participation Physical Evaluation

Clearance Form

Name _____ Sex _____ Age _____ Date of Birth _____

- Cleared without restriction
- Cleared with recommendations for further evaluation or treatment for: _____

Not cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____
Address _____
Signature of Physician _____

Date of Physical Evaluation: _____

