The Sports Medicine Center
828 324-2800

Catawba Valley Community College
2550 Hwy 70 SE
Hickory, NC 28602
(828) 327-7000/4625

Pre-Participation Physical

Please Print Clearly

School/Group Name:____ Date:__________________

Student-Athlete's Name:____ Age:__________________

Street Address____Phone:________________________

City:____________________________________ State____________ Zip Code:_____________________

Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

Yes	No	Not Sure	
			1. Has anyone in the athlete's family ever died suddenly before the age of 50?
			2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			3. Does the athlete have asthma, hay fever, coughing spells, or wheezing during or after exercise?
			4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? If so, what was it and how long ago?
			5. Does the athlete have a history of concussion or ever been "knocked out"?
			6. Has the athlete ever suffered a heat-related illness, such as heat stroke?
			7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			8. Does the athlete currently take and medications?
			9. Is the athlete allergic to any medications or bee stings?
			10. Does the athlete have only one of any paired organ (eye, ears, kidneys, testicles, ovaries etc)?

I have reviewed and answered the above questions and give permission for my child to participate in

(please list sports)____

Parent/Guardian Signature:____ Date:__________________

Printed Parent/Guardian Name:____
Name:____Date of Birth____________________

Height:________________ Weight:_______________ Pulse_________________ BP:_______/_______(______/______)

Vision: R 20/_________________ L 20/_________________ Contacts/Glasses:_______________________________

Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
Medical		
Appearance		
ENT		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (Males Only)		
Skin		

Clearance

☐ Cleared

☐ Cleared after completing F/U with Primary or Rehabilitation:____

☐ Not Cleared for:______________________ Reason:____

Name of Physician or P.A.:____Date:____________________

Address:____Phone:___________________

Signature of Physician or P.A.:____Date:____________________

Parents/Guardians Please Read:

I hereby render authority to Carolina Orthopaedic Specialist Sports Medicine Staff permission to treat

___________________________________ in case of emergency during school sponsored events when I am not available.

Name of Parent/Guardian:____

Signature:____Date:_____________________