# 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<br><br>Assistive Hearing Device? Yes No | **Eyes, visual acuity** Yes No | **Upper Respiratory** Yes No | **Lungs** **Yes No** | **Cardiovascular** Yes No<br><br>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 Health Science program at Kirkwood Community College.***

*Healthcare Practitioner's signature _____Print last name:_____*

*Clinic / Office Name and Location _____*

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