2024-25 Physical Examination Record

Required for Student Athletes Only

THIS SIDE TO BE COMPLETED BY STUDENT OR STUDENT'S PARENT OR GUARDIAN.

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so.

The physical exam must take place **after June 1, 2024**, in order to remain valid throughout the 2024-25 athletic seasons.

○ Returning Athlete ○ New Athlete ○ Male ○ Female ○ Spring ○ Fall ○ Year 20 ______

Name ______________________________ **Soc. Sec. Number** ______________
First M. Last

Address ______________________________
Street City State ZIP

Date of Birth ______________ **Age** ______ **Cell Phone** ______________

Sport(s) ______________________________ **Student ID J#** ______________

IN AN EMERGENCY, CONTACT:

Name ______________________________ **Relationship** ______________

Address ______________________________
Street City State ZIP

Home Phone ______________ **Work Phone** ______________ **Cell Phone** ______________

Name and Address of Family Physician ______________________________

If student is not yet 19 years of age, this side must be completed by a parent or guardian before a physical examination can be given.

MEDICAL HISTORY

Yes	No	
○	○	Asthma
○	○	Diabetes
○	○	Mononucleosis
○	○	Hepatitis
○	○	Epilepsy
○	○	High Blood Pressure
○	○	Kidney Disease
○	○	Bleeding Disorder
○	○	Disordered Eating
○	○	Chronic Skin Disorders
○	○	Tuberculosis
○	○	Sickle Cell
○	○	Hernia
○	○	COVID

If yes, Illness Date ______

Yes	No	
○	○	COVID Vaccination
○	○	Others

Please explain any "yes" answers to the diseases noted above (dates/current condition/etc.):

____

____

Current medications:

____

____

Limitations/restrictions:

____

____

____

Food/medication/sting/bite or other known allergies:

____

____

ORTHOPEDIC HISTORY

General

Yes	No	
○	○	Sprains
○	○	Strains
○	○	Fractures
○	○	Subluxations
○	○	Ligament Injuries
○	○	Dislocations

Specific

Yes	No	
○	○	Skull
	○	Fracture
○	○	Concussions
	○	# ______
○	○	Face Injury
	○	Eye
	○	Ear
	○	Nose
○	○	Spine
	○	Neck
	○	Lower back

Yes	No	
○	○	Abdominal
○	○	Chest & Ribs
○	○	Foot
○	○	Ankle
○	○	Knee
○	○	Upper leg
○	○	Lower leg
○	○	Hip
○	○	Pelvis
○	○	Hand
○	○	Wrist
○	○	Forearm
○	○	Elbow
○	○	Upper arm
○	○	Shoulder

Description (body part/side/specific injury/date/current condition/etc.):

____

____

____

Surgical procedure (body part/side/date/current condition/etc.):

____

____

____

Any other current or severe injury not already listed?

____

____

This side was completed by ______________________________
PRINTED NAME **SIGNATURE** **DATE**

Please email the Concordia Nebraska physical form filled by your doctor to athletics@cune.edu.

ATHLETE NAME: ______________________ **SPORT:** ____________

Heart Health Questions About You

	Yes	No
1. Have you ever passed out or nearly passed out during exercise?	○	○
2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	○	○
3. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	○	○

Heart Health Questions About Your Family

	Yes	No
1. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	○	○
2. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right vetricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	○	○
3. Does anyone in your family have a heart problem, pacemaker, or implanted defibrilator?	○	○
4. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	○	○

If you answered yes to any questions above, please explain: ______________________

THIS SECTION TO BE COMPLETED BY A MEDICAL PROVIDER.

Eye Examination

Eye: RT ________ LT ________ Contacts ____ Glasses ____ Last Eye Exam ____________

Physical Examination

Weight ____________ Height ____________

BP ____ /____ T________ P________ O2 ______

Ears: Right __________ Left ____________

Nose ______________________

Throat ______________________

Neck ______________________

Heart ______________________

Thorax (deformity) ______________________

Lungs ______________________

Abdomen ______________________

____

Hernia ______________________

Upper/ Lower Extremities (range of motion, alignment, scars) ___

____

GU ______________________

Skin ______________________

Neurological Screening

	Yes	No
Cranial Nerves 2-12 grossly intact?	○	○

Patient Health Questionnaire

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Participation Status

- ○ Full participation
- ○ Limited participation (explain below)
- ○ No participation

Please indicate which sports (if any) this person should not participate in: ______________________

Comments: ______________________

Medical Provider who administered this examination (must be an MD, DO, PA-C, or APRN)

○ Medical Doctor ○ Doctor of Osteopathy ○ Physician Assistant ○ Advanced Practice Registered Nurse

Medical Provider Name (please print) ______________________

Medical Provider Address ______________________

Street City State ZIP

____

SIGNATURE OF MEDICAL PROVIDER **DATE**

Email completed forms to athletics@cune.edu