

# College of Mount Saint Vincent – Sports Medicine

All varsity athletic participants must have physician fill this form out completely to be eligible for play. Examination **must** be completed within 6 months prior to the **first** team practice of the year of participation.

**Please print or type** Name: \_\_\_\_\_ Male  Female  Date of Exam: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

**Varsity Sports Participating In:** \_\_\_\_\_ **Year** \_\_\_\_\_

**General Information**

BP: \_\_\_/\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Tetanus Booster Date: \_\_\_\_\_ Allergies: \_\_\_\_\_ Medications for Allergies: \_\_\_\_\_  
 Medications taken on a regular basis: \_\_\_\_\_ Reason: \_\_\_\_\_

**Medical History:** Please check any of the following that you have had. Attach a separate page to explain in further detail if necessary.

	Yes	No		Yes	No		Yes	No
1. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	8. Enlarged Spleen	<input type="checkbox"/>	<input type="checkbox"/>	15. Loss of Paired Organ	<input type="checkbox"/>	<input type="checkbox"/>
2. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	9. Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	16. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Collapsed Lung	<input type="checkbox"/>	<input type="checkbox"/>	10. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	17. Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>
4. Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	11. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	18. Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>
5. Glasses	<input type="checkbox"/>	<input type="checkbox"/>	12. High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
6. Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	13. Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>	20. Heat Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
7. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	14. Syncope/Near Syncope	<input type="checkbox"/>	<input type="checkbox"/>	21. Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>

**Sickle Cell Trait:**  
 Pos\_\_\_\_ Neg\_\_\_\_  
 (Provide appropriate documentation)

**Physician:** Please note any abnormalities found in your General Examination on the previous page:

**Cardiovascular Screening:**

<u>Have you ever had:</u>	Yes	No	<u>Explain</u>
1. Any prior occurrence of exertional chest pain, discomfort or syncope/near syncope?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Excessive, unexpected and unexplained shortness of breath or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Any past detection of Heart Murmur, or an increase in systemic blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Family history of premature death or significant disability from CV disease in any of your close relatives younger than 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Findings: \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

**Musculoskeletal/Orthopedic Evaluation:** Please note any joint laxity, tightness or abnormalities and include any previous surgery. Attach a separate page if necessary to explain any of the following.

Shoulders \_\_\_\_\_ Elbow \_\_\_\_\_ Hand \_\_\_\_\_  
 Wrist \_\_\_\_\_ Knee \_\_\_\_\_ Ankle \_\_\_\_\_  
 Back \_\_\_\_\_ Hips \_\_\_\_\_ Feet \_\_\_\_\_  
 Other abnormalities? \_\_\_\_\_

Are there any problems that need referral or follow-up? \_\_\_\_\_

**Recommendations for intercollegiate competition**

Limited   
 Unlimited  Explain: \_\_\_\_\_

\_\_\_\_\_ MD/DO/NP/PA \_\_\_\_\_  
**PHYSICIAN SIGNATURE and STAMP** **DATE**

**Student-Athlete Signature Required**

Understands that by signing this form that he or she gives permission to Mount Saint Vincent Sports Medicine to release information on this physical to Student Health Services at Mount Saint Vincent, should it be deemed necessary.

\_\_\_\_\_  
**STUDENT-ATHLETE SIGNATURE (Parent if under 18)** **DATE**

**Please send completed form to:  
Barima Yeboah,  
College Of Mount Saint Vincent  
6301 Riverdale Ave,  
Bronx NY 10471**

**Or**

**Fax to:  
Barima Yeboah  
(718) 405-3765**