# TITANS

## INTERCOLLEGIATE ATHLETIC HEALTH HISTORY

**SPORT:**_____

Is this your first contact with CCM Athletics? Yes_____ No_____

Name: _____
Last First Middle

Address: _____
Number Street City State Zip

Telephone Number:_____ Student I.D. Number:_____

Age:_____ Date of Birth:_____ Sex: M____ F____

Family Physician:_____ Telephone:_____Town:_____

Who may we contact in case
of an emergency? _____ Relationship:_____ Tel. #:_____

Do you have a family history of any hereditary diseases? Yes___ No___ Please identify disease and relationship: _____

_____

Have you ever had a SERIOUS illness, injury or surgery? Yes_____ No_____ If yes, please explain:_____

_____

Do you have any allergies? Yes_____ No_____ If yes, please list. *Include any allergies to medications:* _____

_____

Are you under the care of a physician at this time? Yes_____ No_____ If yes, please give details: _____

_____

Do you regularly take any medications? Yes_____ No_____ If yes, please list:_____

Have you ever had any form of head trauma/concussion?_____ Yes_____ No _____

If yes, please give details:_____

Height:_____ Weight: _____ Gain or loss in last year? _____ How many pounds: _____

Date of last Tetanus Booster? _____

Have you ever participated in intercollegiate sports at CCM? Yes_____ No_____

Have you ever participated in organized competitive sports elsewhere? Yes_____ No_____

If yes, where & when: _____

Have you had any injury or serious illness since your last Athletic Physical Exam? Yes____ No____

Details:_____

*If you are under the age of 18, it is necessary for your parent or guardian to sign below certifying that you have no restrictions with regard to your participation in physical activity and authorizing the college to provide emergency medical care as needed.*

_____
Your Signature Date Parent/Guardian Signature if under 18 years of age

**IMPORTANT:** This record must be signed and stamped prior to returning to the CCM Athletic Trainer. The form must be approved by the Athletic Trainer prior to any participation.

Physician, please complete reverse side.

Rev. 5/2022

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## INTERCOLLEGIATE ATHLETIC PHYSICAL EXAMINATION

Name:_____ Sport:_____

Height:_____ Weight:_____ Blood Pressure:_____/_____ Pulse: _____

Vision: R 20/___ L20/___ Corrective Lenses? Yes_____ No_____

Are there any abnormalities of the following systems?

| | YES | NO | COMMENTS |
|---|---|---|---|
| 1.) Eyes | | | |
| 2.) Head, Ears, Nose, Throat | | | |
| 3.) Respiratory | | | |
| 4.) Cardiovascular | | | |
| 5.) Gastrointestinal | | | |
| 6.) Hernia | | | |
| 7.) Genitourinary | | | |
| 8.) Musculoskeletal | | | |
| 9.) Metabolic/ Endocrine | | | |
| 10.) Neuropsychiatric | | | |
| 11.) Skin | | | |

Is there loss or serious Impairment of any organ? Yes_____No_____

Has student ever been treated for head trauma/concussion? Yes_____ No_____

Is this student medically eligible to participate in intercollegiate sports? Yes_____ No_____

Have you any general comments? _____

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: (please print)_____ Dr.'s Stamp_____