New Student Athlete ◯ Transfer Student Athlete ◯ Returning Student Athlete ◯

Mercer County Community College - Preseason Medical Evaluation

This annual form must be completed and returned before the student athlete will be permitted to practice or play. The NJCAA (Article V, Section 6) and MCCC policies state all student athletes pass a qualifying medical examination administered by a qualified health care professional. Further medical evaluation may be required for specific matters. All information is kept confidential and shared with authorized medical providers when necessary. (2015-2016)

Name:_____Sport_____Age_____ DOB_____

High School:_____ Today's Date_____

Check all that apply to your current or past medical history: EXPLAIN ALL YES RESPONSES on back of sheet

□ Absent organ	□ Seizure	□ Hepatitis	□ Physical handicap
□ Allergies	□ Depression	□ Hernia	□ Pneumonia
□ Anemia	□ Diabetes	□ High/Low blood pressure	□ Rheumatic Fever
□ Anxiety	□ Dizziness	□ Irritable bowel syndrome	□ Bone/Joint Injury
□ Arthritis	□ Eating Disorder	□ Kidney Disease	□ Sickle Cell Disease
□ Asthma	□ Epilepsy	□ Latex Senstivity	□ Tuberculosis
□ Cancer	□ Fainting Spells	□ Lung Disease	□ Ulcer
□ Chest Pain	□ Gastic Reflux	□ Malaria	□ Scoliosis
□ Chronic Cough	□ Heart Disease	□ Migraines	□ Marfan's Syndrome
□ Concussion	□ Heart murmur	□ Mononucleosis	□ Spinal Stenosis

Check YES or NO for the following personal history questions. If your answer is YES you MUST explain in space at end of line.

YES	NO		DATE
□	□	1. Have you had a medical illness in the past 12 months? (ex.mono, malari, MRSA)	_____
□	□	2. Have you been hospitalized overnight? When? For what?	_ _____
□	□	3. Have you had surgery for a medical condition or injury?	_____
□	□	4. Do you experience frequent headaches? (migraines)	_____
□	□	5. Do you have missing organs?	_____
□	□	6. Do any of your immediate family members have a history of heart disease?	_____
□	□	7. Have any of your family members died of heart disease before age 50?	_____
□	□	8. Do you ever experience shortness of breath during or after exercise?	_ _ _____
□	□	9. Do you experience wheezing during or after exercise	_____
□	□	10. Do you experience chest pain with or after exercise?	_____
□	□	11. Do you use an inhaler?	_____
□	□	12. Do you have a skin condition?	_____
□	□	13. Do you have hearing problems?	_____
□	□	14. Do you wear glasses or contacts while participating in sports?	_____
□	□	15. Are you currently taking over the counter medication?	_____
□	□	16. Are you currently taking prescription medication?	_____
□	□	17. Are you currently taking herbal or nutritional supplements?	_____
□	□	18. Are you allergic to any medications?	_____
□	□	19. Are you allergic to any foods? (nuts)	_____
□	□	20. Do you have any allergies not described above?	_____
□	□	21. Has your weight changed (±10 pounds) in the last year?	_____
□	□	22. Do you feel you need to gain or lose weight?	_____
□	□	23. Do you use any tobacco produces, smokeless or otherwise?	_____
□	□	24. Are you a diabetic?	_____

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□ □ 25. Do you feel stressed out? ________________________

□ □ 26. Have you been seriously injured while participating in athletics ________________________

□ □ 27. Have you suffered internal injuries, spleen, chest, other? ________________________

□ □ 28. Have you suffered ear, nose or throat injuries? ________________________

□ □ 29. Have you suffered bone or joint injury? Date and List ________________________

□ □ 30. Have you suffered muscle injury? Date and List ________________________

□ □ 31. How many concussions have you had? Date and List ________________________

□ □ 32. Did you loss consciousness with the concussion? How long ________________________

□ □ 33. Did you experience memory or concentration problems from concussion? ________________________

□ □ 34. How much time did you miss from play or practice due to concussion? ________________________

□ □ 35. Do you currently experience problems due to a past concussion? List ________________________

□ □ 36. Have you ever become ill from exercising in the heat? ________________________

□ □ 37. Have you received an X-ray, MRI or bone scan in the last 12 months? ________________________

□ □ 38. Do you wear ankle or knee braces to particiapte in sport? ________________________

□ □ 39. Have you ever been medically disqualified or restricted from sport? ________________________

□ □ 40. *Females Only*: Do you experience irregular menstrual cycles? ________________________

□ □ 41. *Females Only*: How many periods have you had in the last year? ________________________

□ □ 42. Do you know of any health reason why you should not participate in sport? ________________________

Student /Athlete Name: ________________________ ID number__________

Date: __________________________________

I hearby state to the best of my knowledge the answers provided are correct. I have not withheld any information important to my safety for play or practice in Intercollegiate Athletics.

Student Athlete Signature____

Emergency Contact Information:

Name _________________________ Relationship________________ Phone ___________

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Name:_____ DOB:_____Sport:_____

Information Requiring Medical Clearance

Height:_____ Weight:_____ BP:_____ Pulse:_____ Sex: □Male □ Female

General Screen	**Normal**	**Abnormal Findings**
Mouth/teeth		
Ears, Nose, Throat		
Lymph Nodes		
Skin		
Lungs		
Heart		
Abdomen		
Genitalia/Hernia		
Reflexes		
Musculoskeletal Screen (ROM-Strength)		
Neck		
Back/spine		
Shoulder		
Elbow		
Wrist		
Hands		
Hip		
Knees		
Ankles/Feet		
Reflexes		
Functional-Duck walk, Single leg hop		

Participation Status: □ Cleared for ALL athletic pursuits without restriction
□ Cleared after completing evaluation and or treatment for:_____
□ Not cleared for athletics

PHYSICIAN SIGNATURE_____Date_____