Preseason Medical Evaluation[4]

Health Questionnaire

This annual form must be completed and returned before the student athlete will be permitted to practice or play. The National Junior College Athletic Association (Article V, Section 9) and Mercer County Coummunity College policies recommend that all student athletes have a qualifying medical evaluation "health status" review. Further medical evaluation may be required for specific matters.

Name: _____ Sport: _____

Date of Birth: _____ School Year: _____

Have you previously passed a medical exam for sports participation for MCCC?	Y	N
If yes, when? _____		
Have you had any significant injury or illness since your last exam? If yes, when? _____	Y	N
Are you currently ill or injured? If yes, what? _____	Y	N
Have you been medically disqualified from any sport? If yes, when? _____	Y	N
Have you ever had any serious injury, operation, or illness? If yes, when? _____	Y	N
Have you ever had any injury requiring medical treatment (fracture, sprain, etc)?	Y	N
If yes, when? _____		
Do you wear knee or ankle braces to participate in sport?	Y	N
Have you ever had surgery? If yes, when? _____	Y	N
Have you ever been hospitalized overnight? If so, when? _____	Y	N
Have you ever been dizzy or passed out during or after exercise? If so, when? _____	Y	N
Have you ever experienced a headache from being hit or falling? _____	Y	N
Have you ever experienced nausea or dizziness from this hit/fall? When? _____	Y	N
Have you ever experienced concentration or memory problems from this hit/fall?	Y	N
Have you ever had a seizure? If yes, when? _____	Y	N
Do you have frequent or severe headaches?	Y	N
Have you ever had a pinched nerve? If so, when? _____	Y	N
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Y	N
Have you ever suffered from heat exhaustion or heat stroke? If yes, when? _____	Y	N
Have you had any family members with premature death due to heart problems?	Y	N
Do you currently take prescription medications? If yes, which ones? _____	Y	N
Do you have high blood pressure?	Y	N
Do you have a heart murmur?	Y	N
Do you use non-prescription medications, vitamins, or supplements?	Y	N
If so, which ones? _____	Y	N
Do you have asthma, allergies, or allergic reactions? If yes, what kind? _____	Y	N
Do you feel stressed out? If yes, why? _____	Y	N
Do you wear glasses or contact lenses? If so, which one? _____	Y	N
When was your last tetanus shot? Date: _____		

Females:

Any menstrual irregularities (skipped periods, PMS, pain)?	Y	N
How many periods have you had in the last year? _____		
What is the longest time between periods in the last year? _____		
Are you worried about any problems or conditions at this time? _____	Y	N
_____		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Athlete Signature: _____ **Today's Date:** _____

Health Checklist

Name:	Height:	Weight:
SID:	BP:	Pulse:

DOCTOR USE ONLY

General	Normal	Abnormal
EENT		
Mouth/Teeth		
Ears, Nose, Throat		
Thyroid		
Lymph Nodes		
Skin		
Lungs		
Heart		
Abdomen		
Extremities		
Genitalia/Hernia		
Reflexes		
Musculoskeletal	**Normal**	**Abnormal**
ROM - Strength, etc.		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back/Spine		
Knee		
Ankle		
Foot		
Neuromuscular	**Normal**	**Abnormal**
Recommendations		

Cleared for Participation Yes No

Dr. Name(printed): _____

Dr. Signature _____ **Date** _____