

**Lorain County Community College
Intercollegiate Sports Examination**

Name: _____ Age: _____ Birthdate: _____

Address: _____ City/State/Zip: _____

Phone: (____) _____ Student # _____ Sex: ___M ___F

I. HAVE YOU EVER HAD THE FOLLOWING?	YES	NO	DETAILS
1. Injury that kept you from playing sports for more than one day?			
2. Head injury of any kind?			
3. Loss of consciousness or fainting?			
4. Neck or back pain or injury?			
5. Broken bones or fractures?			
6. Problems with joints?			
7. Pulled muscles, ligaments or sprains?			
8. Hernia or rupture?			
9. An operation of any kind?			
II. DO YOU TAKE MEDICINES FOR ANY OF THE FOLLOWING?			
1. Asthma or allergies?			
2. Heart problems?			
3. Rheumatic Fever?			
4. High blood pressure?			
5. Diabetes?			
6. Epilepsy or Convulsions?			
7. Sickle Cell or other Anemia?			
III. ARE YOU ALLERGIC TO ANY MEDICINES?			
IV. HAS ANYONE IN YOUR FAMILY DIED OF A HEART ATTACK UNDER THE AGE OF 50?			

I certify that to the best of my knowledge the above information is true and accurate.

Date: _____

Signature: _____

**PARTICIPATION SPORTS
MEDICAL EXAMINATION**

SPORT: _____

Height _____ Weight _____ Blood Pressure _____/_____/_____ Pulse _____ Gross Vision R____ L____ Pupils R____ L____ Urinalysis _____



EXAMINATION	NL:	ABN:	COMMENTS:
1. Heart			
2. Lungs			
3. Skin			
4. Abdomen: Spleen Liver			
5. Hernia			
6. External Genitals			
7. Upper Extremities: ACJT's Symm ROM			
8. Spine: Neck Fwd. Bend Curve			
9. Lower Extremities: Gait I Hop Duck Symm ROM			

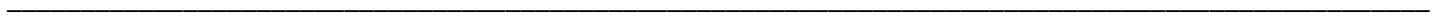
() Satisfactory Examination () Further Examination Regarding: _____



Cleared For: () Baseball () Basketball () Softball () Soccer () Volleyball () Golf

DATE: _____ PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S PHONE #: _____ PHYSICIAN'S ADDRESS: _____



PHYSICIAN'S NAME: _____

(please print)

