SPORTS QUALIFYING MEDICAL EVALUATION
BETHEL UNIVERSITY HEALTH SERVICE
3900 Bethel Drive, St. Paul, MN 55112

Student Name: ______________________ Social Security#: ______________________
Address: ______________________ Bethel I.D.#(If known):______________________ Male ☐ Female ☐
Date of Birth: ______________ Age: ________ Sport:______________________

ATHLETE PLEASE COMPLETE PRIOR TO PHYSICIAN'S EXAM

HISTORY	YES	NO
1. Have you ever fainted?	☐	☐
During exercise?	☐	☐
Have you had chest pain during exercise?	☐	☐
2. Family history of sudden death?	☐	☐
Before age 35?_______ Before age 50?_________		
Cause ______________________		
Family history of Marfan Syndrome?	☐	☐
3. Have you ever had a concussion, loss of consciousness, or head injury?	☐	☐
If yes, how many: ________ When: ____________		
4. Have you ever had heat stroke or heat exhaustion?	☐	☐
5. Do you wheeze or cough during or after exercise?	☐	☐
Do you have any history of Asthma?	☐	☐
Unexplained shortness of breath?	☐	☐
6. Do you have any allergies? (medications, bee sting pollens, foods): ______________	☐	☐
7. Have you been ill in the last month?	☐	☐
8. Do you take any medication? (include vitamins and nonprescription drugs): ______________	☐	☐
9. **Explain** any of the following:		
Have you ever been hospitalized? If yes, explain. ______________	☐	☐
Have you ever had surgery? If yes, explain. ______________	☐	☐
Have you ever had a serious accident or injury? Explain. ______________	☐	☐
10. If female, last menstrual period: ______________	☐	☐
Age at onset of first period: ______________		
Usual cycle: Every _______ days.		

11. In last year, what was your:
Lowest weight?__________ Highest weight?_____________
What do you think is your ideal weight? _________________

	YES	NO
12. Have you had an eating disorder (past or present?)	☐	☐

13. Circle any of the following you have had:

Abnormal bleeding/bruising	Anemia
Broken bones/Stress fracture	Diabetes
Dislocation(shoulder, etc.)	Hearing impairment
Heart murmur/palpitations/arrhythmias	Hepatitis/jaundice
Other heart anomalies	Loss of eye sight
High blood pressure	Scoliosis
Rheumatic fever	Sickle-cell disease
Seizures	Undescended testicle
Single organs (kidney, eye, testicle, etc.)	Blood in Urine

	YES	NO
14. Have you had any knee, ankle, or shoulder injuries?	☐	☐
15. Are there any concerns you would like to discuss? (Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other)	☐	☐
16. Do you use seat belts on a regular basis?	☐	☐

I do not know of any existing physical condition or additional health reason that would preclude my participation in sports. I certify that the answers to the above questions are true and accurate.

Athlete's Signature: ______________________ Date ____________

EXAMINATION **DATE OF EXAM**______________________

TO BE COMPLETED BY PHYSICIAN (within 6 months prior to participation)

				YES	NO
HT ______	WT______		Glasses:	☐	☐
Vision	R _________	L _______	Contact Lenses:	☐	☐
Anisocoria	R _________	L _______	Eye Protection	☐	☐

Standing BP _________ Sitting BP_________ Pulse____________

MEDICAL EXAM

	Normal	Abnormal	Comments
HEENT			
Fundoscopic Exam	______	______	______________
Ears	______	______	______________
Mouth	______	______	______________
Throat	______	______	______________
Dental	______	______	______________
Thyroid	______	______	______________
Nodes	______	______	______________
Lungs	______	______	______________
Cardiac	______	______	______________
Including precordial auscultation (supine & standing) and femoral artery pulses.			
Abdomen	______	______	______________
Genitalia	______	______	______________
Hernia	______	______	______________
Skin	______	______	______________
Neuro	______	______	______________

Labs: UA:______________________
Hgb: ______________________

MUSCULOSKELETAL

	Normal	Abnormal		Normal	Abnormal
Neck	______	______	Quad/Hamstring	______	______
Shoulder	______	______	Ankle/Feet	______	______
Elbow	______	______	Back/Spine	______	______
Hands	______	______	Toe/Heel Walk	______	______
Wrist	______	______	Duck Walk	______	______

Comments:____
____

* Hepatitis B Vaccine recommended_____________

I have reviewed the medical history and herewith certify that ____________________ (name) has been evaluated in the following areas as indicated below to be physically fit to participate in school interscholastic activities.

Medical History	Y/N
Medical Exam	Normal/Abnormal
Musculoskeletal	Normal/Abnormal

	Cleared for	Not Cleared for
Collision Sports	☐	☐
Contact Sports	☐	☐
Noncontact Sports	☐	☐

Due to: (if not cleared)______________________________
Modifications or exceptions:______________________________
How long have you been patient's physician? ______________________

Attending Physicians signature (MD, DO, PA or RNP): ______________________

Print Name: ______________________________

Address: ______________________________ Phone #:_______________
____

STATEMENT REGARDING ATHLETIC PHYSICALS

As a prospective athlete for Bethel University, you will be required to have a complete physical exam by a physician of your choice before you participate in any athletic activities.

The staff of Bethel University Health Service works hard to maintain strict confidentiality. However, in order for you to perform safely as an athlete, the Athletic Department requests knowledge of certain information. This includes information concerning current medications, allergies (ex. bee stings), need for corrective lenses, and history of any medical condition or injury that may need to be monitored during your participation in sports. This information will be released to the Athletic Department.

It is because of our strong concern for confidentiality that we want you to be aware of this procedure prior to your physical. Our aim is to help you to safely participate in the Bethel University athletic program.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

______________________________ ____________

Signature Date

For Bethel Health Service Use Only:

Athletic Clearances					
Date	Sport	Date	Sport	Date	Sport