

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

Student Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security#: \_\_\_\_\_  
 Bethel I.D.#(If known): \_\_\_\_\_ Male  Female   
 Sport: \_\_\_\_\_

**ATHLETE PLEASE COMPLETE  
 PRIOR TO PHYSICIAN'S EXAM**

- | <b>HISTORY</b>   | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 1. Have you ever fainted?<br>During exercise?<br>Have you had chest pain during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Family history of sudden death?<br>Before age 35? _____ Before age 50? _____<br>Cause _____<br>Family history of Marfan Syndrome?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a concussion, loss of consciousness, or head injury?<br>If yes, how many: _____ When: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had heat stroke or heat exhaustion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you wheeze or cough during or after exercise?<br>Do you have any history of Asthma?<br>Unexplained shortness of breath?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any allergies? (medications, bee sting <input type="checkbox"/><br>pollens, foods): _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you been ill in the last month?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you take any medication? (include vitamins and nonprescription drugs): _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. <b>Explain</b> any of the following:<br>Have you ever been hospitalized? If yes, explain.<br>_____<br>Have you ever had surgery? If yes, explain.<br>_____<br>Have you ever had a serious accident or injury? Explain.<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. If female, last menstrual period: _____<br>Age at onset of first period: _____<br>Usual cycle: Every _____ days.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. In last year, what was your:<br>Lowest weight? _____ Highest weight? _____<br>What do you think is your ideal weight? _____  |                          |                          |
| 12. Have you had an eating disorder (past or present?)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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           |                          |
| 14. Have you had any knee, ankle, or shoulder injuries?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are there any concerns you would like to discuss?<br>(Nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you use seat belts on a regular basis?  | <input type="checkbox"/> | <input type="checkbox"/> |

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.

**EXAMINATION**                      **DATE OF EXAM** \_\_\_\_\_

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

	<b>YES</b>	<b>NO</b>
HT _____ WT _____ Glasses: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision R _____ L _____ Contact Lenses: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anisocoria R _____ L _____ Eye Protection <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Standing BP \_\_\_\_\_ Sitting BP \_\_\_\_\_ Pulse \_\_\_\_\_

**MEDICAL EXAM**

	Normal	Abnormal	Comments
<b>HEENT</b>			
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 \_\_\_\_\_ 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	<input type="checkbox"/> <input type="checkbox"/>
Contact Sports	<input type="checkbox"/> <input type="checkbox"/>
Noncontact Sports	<input type="checkbox"/> <input type="checkbox"/>

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

Attending Physicians signature (MD or DO): \_\_\_\_\_

Print Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

's Signature: \_\_\_\_\_ Date \_\_\_\_\_

