KNOX COLLEGE STUDENT ATHLETE PHYSICAL FORM

This exam is not to be billed through the Knox College Health Plan.

PART I (To be filled out by student prior to seeing physician)

A. Personal Data:

Name ___________________________  Student ID# (Returns Only) __________
Home Address _____________________  Campus Box __________
                                      __________
Home Telephone ____________________  Cell Phone _______________________
Campus Address ____________________

Notify in Case of Emergency:

Name ___________________________  Social Sec. # __-__-____
Address __________________________  D.O.B. ______/____/____
Telephone ________________________  Year in School ________________
Relationship ______________________  Sports ______________________

B. Previous Health History:

1. Previous operations, if any (include year of operation):

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

2. Previous serious illnesses requiring hospitalization or more than two physician visits including any heat
   and/or lung related illness including asthma (include nature of illness and year):

____________________________________________________________________

____________________________________________________________________

3. Previous bone or joint injuries (fractures, dislocations, cartilage or ligament injuries):

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

4. Previous head injury and/or concussion (please include date, time out of activity, and care received):_______

____________________________________________________________________

____________________________________________________________________

5. MEDICATIONS you take on a regular basis, if any (include dosage of each):

____________________________________________________________________

____________________________________________________________________

6. Allergies, if any:

____________________________________________________________________

____________________________________________________________________

7. Is there a personal history of diabetes, epilepsy, heart trouble, color blindness?  YES _______  NO _______

If answer is yes, please explain below:

____________________________________________________________________

____________________________________________________________________

8. Do you know your Sickle Cell Trait Status?  YES _______  NO _______  (If yes please forward results from
   physician to the Knox College Athletic Training Office)

   SCTrait (+) _______  SCTrait (-) _______.

(OVER)
PART II  Physical Examinations (To be filled out by the attending physician)

A. Vital Statistics:  
- Height_________ inches  
- Weight________ lbs  
- Blood Pressure _______/______mmHg

- Pulse________ beats/min.  
- Vision:  R 20/______ L 20/______

Flexibility:  
- Hamstring  R_____ L_____  
- Gastroc R_____ L_____  
- Hip (Thomas)  R + / - L + / -

B. Head and Neck:  
- Normal  
- Abnormal
  - 1. ears__________________________
  - 2. oropharynx______________________
  - 3. eyes__________________________
  - 4. thyroid_________________________

C. Chest__________________________

D. Heart and Peripheral Vessels__________________________

E. Abdomen (include hernia examination)__________________________

F. Genitalis__________________________

G. Skin (include exam for tinea eruris and tinea pedis)__________________________

H. Lymphatics__________________________

I. Neurologic
  - 1. gait__________________________
  - 2. reflexes__________________________

J. Muskuloskeletal (pay special attention to previously injured or operated areas)

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*Describe any abnormal findings:__________________________________________

__________________________

K. Laboratory data:

1. urinalysis:  glucose _____ protein _____ specific grav ________
2. CBC (if indicated clinically):  HgB _____ WBC _____
3. Sickle Cell Trait:  SCTrait (+) ______  SCTrait (-) ______

(Please attach results of sickle cell traits)

This is to certify that the above named individual is______ is not______ physically able to participate in collegiate athletics for the year 20______.

Restrictions if any:__________________________________________

__________________________

Name and Address of Physician:  SIGNATURE OF PHYSICIAN:  
__________________________________________  ______________________________________

DATE:__________________________________________

Updated 4.10.2012