To: Knox College Athletes

Find below the Pre-Season Physical Form. Please have this filled out by your physician and return directly to the address below or when you come back to campus present to a member of the Athletic Training Staff. We will accept physicals that have been performed by Physicians (MD or DO) or Physician Assistants only. Please present us with any documentation or supporting information for any abnormal findings during the physical.

If you are currently under the care of a physician for a particular injury or illness please provide us with any documentation that would assist us in continuing your care. Letters, notes, and/or treatment plans from the physician and/or therapist would be greatly appreciated. Please try to provide operative notes and/or x-ray/MRI reports and films as applicable for our physicians to review as needed.

Please do not hesitate to contact us if you have any questions or concerns.

Scott Sunderland MS ATC
Knox College
Box #226
2 E. South Street
Galesburg, IL 61401

(309)341-7378

Sincerely,

Scott Sunderland MS, ATC
Head Certified Athletic Trainer
KNOX COLLEGE STUDENT ATHLETE PHYSICAL FORM

This exam is not covered through
the Knox College Health Services.

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

A. Personal Data:

Name ____________________________
Home Address ________________________ 
Campus Box# ________________________
Campus Phone ________________________
Cell Phone ________________________

Home Telephone ________________________ 
Campus Phone ________________________

Notify in Case of Emergency:

Name ____________________________
Address ____________________________
D.O.B. ____________________________
Social Sec. # __-__-
Year in School ________________________
Sports ____________________________

B. Previous Health History:

1. Please list any pre-existing medical conditions (i.e., asthma, anemia, diabetes, epilepsy):

________________________________________

2. Please list any significant illnesses in the last two years (i.e., mononucleosis, hepatitis, flu):

________________________________________

3. Has there been any loss of bodily organs (i.e., kidney, appendix)? If so, please list:

________________________________________

4. Is there any history of head injury and/or concussion? If so, please provide dates, nature of injury and treatment:

________________________________________

5. Please list any known drug, food, and/or insect bite allergies:

________________________________________

6. Please list any medication taken on a regular basis, amount taken and the purpose for taking the medication:

________________________________________

7. Please list any pre-existing orthopedic conditions and describe the nature of the injury, any appliances worn and any rehabilitation currently being undertaken:

________________________________________

8. Do you ever have abnormal shortness of breath during physical activity?

________________________________________

9. Please list and explain any known family history of diabetes, high blood pressure, heart trouble, epilepsy, etc.

________________________________________

10. Please list any dental injuries, work performed and/or any special appliances worn:

________________________________________

11. Do you wear contacts? _____________

Do you wear glasses? _____________

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

A. Vital Statistics:  
Height_______ inches  
Weight_______ lb.  
Blood Pressure_______ mmHg  
Pulse_______ beats/min.

B. Head and Neck:  
1. ears
2. oropharynx
3. eyes
4. thyroid

Normal  Abnormal

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

*Describe any abnormal findings:

K. Laboratory data: (This section not required for athletic participation.)
1. urinalysis:  glucose _____ protein _____ specific grav ________
2. CBC (if indicated clinically):  HgB _____ WBC _____

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:__________________________________