Gender: M ___ F ___ Sport: ______________________

RIVERSIDE COMMUNITY COLLEGE DISTRICT
ATHLETIC PRE-PARTICIPATION PHYSICAL SCREENING

Name: ____ Age: _____ Date of Birth: _________________ Student ID: _________________

Address: ____ Phone: ________________________

Complete this form, including signature, before the time of your examination.

1. Are you currently under a doctor's care of any kind?..................... Y N
2. Have you ever been hospitalized?.. Y N
3. Have you ever had surgery?.. Y N
4. Are you currently taking any medications or pills?......................... Y N
5. Do you have any allergies (medications, bee stings, etc.)?.............. Y N
6. Have you ever been dizzy or passed out during or after exercise?.... Y N
7. Have you ever had chest pain during or after exercise?.................. Y N
8. Have you ever had high blood pressure?.................................... Y N
9. Have you ever been told that you have a heart murmur?................ Y N
10. Have you ever had a racing of your heart or skipped heartbeats?..... Y N
11. Have you ever had a head injury?... Y N
12. Have you ever been knocked out or unconscious?........................ Y N
13. Have you ever had a seizure?... Y N
14. Have you ever had a stinger, burner or pinched nerve?.................. Y N
15. Have you ever been dizzy or passed out from the heat?................. Y N
16. Do you have trouble breathing or do you cough during or after exercise?........ Y N
17. Do you have any skin problems (itching, rashes, etc.)?.................. Y N
18. Have you had any problems with your eyes or vision?................... Y N
19. Do you wear glasses, contacts or protective eye wear?.................. Y N
20. Do you use any special equipment (splints, neck rolls, etc)?............ Y N
21. Has anyone in your family died of heart problems or sudden death before age 50?... Y N
22. Do you have only one working organ of usually paired organs (eye, kidney, etc.)?.. Y N
23. Have you ever sprained, broken, dislocated or had repeated swelling or pain of any bones or joints?......... .... Y N
    - ☐ Head ☐ Neck ☐ Chest ☐ Shoulder ☐ Back
    - ☐ Hand ☐ Thigh ☐ Elbow ☐ Forearm ☐ Hip
    - ☐ Thigh ☐ Knee ☐ Ankle ☐ Shin/Calf ☐ Foot
24. Are any of these currently bothering you? .... Y N
25. Have you had any other medical problems (asthma, mono, diabetes, etc.)?... Y N
26. Have you had any other medical problems or injuries since your last evaluation?.. Y N
27. Any special instructions or precautions?..................................... Y N
28. When was your last Tetanus shot? ____________________
29. Women Only:
    Date of first menstrual period: ____/____/________
    When was your last menstrual period? ____/____/_______
    What was the longest time between your cycles during the past year?

Explain all "Yes" answers by questions number and indicate dates for each item (include any special instructions): ______________________________________
____
____

I/we hereby state that, to the best of my knowledge, the answers to the questions are correct. I/we understand that by performing this examination, the undersigned physician does not assume responsibility for the medical care of this individual.

Signature of Athlete ____ Date: ___________________________________

Signature of Parent/ Guardian if under 18: ____ Date: ___________________________________

PHYSICIAN USE ONLY

Blood Pressure:			Ht:___________ Wt:__________	
	Normal	Abnormal	Findings	Initials
HEENT				
Skin				
Heart				
Lungs				
Abdomen				
Orthopedic				
Flexibility/Strength				

While this does not constitute a complete physical examination or replace the need for periodic health evaluations by a family physician, this individual appears to be physically capable of participating in interscholastic sports as of this date, except as indicated below.

- ☐ Cleared for sports without restriction
- ☐ Cleared with the following restriction____
- ☐ Cleared after completing evaluation/rehabilitation for ______________________________
- ☐ Not Cleared

Physician Stamp

Recommendations: ____

Physician Name ____________________________________Physician Signature ________________________________ M.D / D.O. Date ____________________________
Please Print

Consent to Treat and Disclosure of Information

ATHLETE NAME: ____

I hereby authorize and give consent to the Riverside City College (RCC) Athletic Training Services and RCC Health and Wellness Services, or any licensed physicians, to perform or administer any reasonably necessary medical or surgical treatment. I also authorize and consent to receive treatment during on-field or sideline examination with understanding this could occur in the presence of parents, coaches, and spectators. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections and minor medical procedures. I authorize RCC Athletic Training Services to provide RCC Health and Wellness Services any information requested concerning my health and athletic status.

In the event major surgery is necessary, RCC Athletic Training Services, RCC Health and Wellness Services or licensed physicians are not excused from attempting to contact my parent(s)/legal guardian by phone or mail before relying upon this authorization. This authorization does not entitle a licensed physician to render any medical or surgical treatment without my personal consent, unless I am unable to give consent.

Authorization and consent is hereby granted by the undersigned to Riverside City College, including its Athletic Training staff, health care professionals, and consultants, to obtain and release health information and records for treatment, payment, and operations purposes, including for the purpose of processing insurance claims. I understand and agree that information, including information about my injury/condition, may be disclosed to staff and personnel of Riverside City College Department of Athletics in relation to my participation in any physical activity. This Consent to Treat and Disclosure of Information is a required condition for participation in the athletics program and shall remain valid until revoked by me in writing.

______________________	______________________	______	______________________
Signature of Student-Athlete	Birthdate (mm/dd/yy)	Age	Date (mm/dd/yy)

______________________	______________________	______________________
Name of Parent/Legal Guardian (PRINT)	Signature of Parent/Guardian	Date (mm/dd/yy)