Sport(s): _____
_____

Lincoln College Health Services
300 Keokuk Street
Lincoln, IL 62656
Phone: (217) 735-7340
Fax: (217) 735-5214

LINCOLN COLLEGE ATHLETICS PRE-PARTICIPATION EXAMINATION

This page should be completed by the athlete or parent/guardian prior to examination

Full Name: _____ Birthdate: _____ Age: _____ Cell Phone: _____

Home Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Address: _____ City/State/Zip: _____

Emergency Contact Person: _____ Relationship: _____ Emergency Contact Phone: _____

Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking: _____

_____

Do you have any allergies? Yes___ No___ If yes, please identify: Medicine(s)_____ Food_____ Other_____

Circle the appropriate answers

General Questions

1. Has a doctor ever denied/restricted your participation in sports for any reason? Y / N
2. Do you have any ongoing medical conditions? Y / N
   If yes, please identify: Asthma__ Anemia__ Diabetes__ Infections__
   Other_____
3. Have you ever spent the night in the hospital? Y / N
4. Have you ever had surgery? Y / N

Personal Heart Health

5. Have you ever passed out or nearly passed out during or after exercise? Y / N
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise? Y / N
7. Does your heart ever race or skip beats (irregular beats) during exercise? Y / N
8. Has a doctor ever told you that you have any heart problems? Y / N
   If yes, please identify: High Blood Pressure__ Heart Murmur__ High Cholesterol__ Heart Infection__ Kawasaki Disease__
   Other_____
9. Has a doctor ever ordered a test for your heart (e.g., ECG/EKG, echocardiogram)? Y / N
10. Do you get lightheaded or feel short of breath during exercise? Y / N
11. Have you ever had an unexplained seizure? Y / N
12. Do you get more tired or short of breath more quickly than your friends during exercise? Y / N

Family Heart Health

13. Has any family member/relative died of heart problems or had an unexpected or unexplained sudden death before the age of 50 (including drowning, unexplained car accident or sudden infant death syndrome)? Y / N
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia? Y / N
15. Does anyone in your family have a heart problem, pacemaker or implanted defibrillator? Y / N
16. Has anyone in your family had any unexplained fainting, unexplained seizures or near drowning? Y / N

Bone & Joint Questions

17. Have you ever had any injury to a bone, muscle, ligament or tendon that caused you to miss a practice/game? Y / N
18. Have you ever had any broken/fractured bones or dislocated joints? Y/N
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches? Y / N
20. Have you ever had a stress fracture? Y / N
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)? Y / N
22. Do you regularly use a brace, orthotics or other assistive device? Y / N
23. Do you have a bone, muscle or joint injury that bothers you? Y / N
24. Do any of your joints become painful,swollen,feel warm or look red? Y/N
25. Do you have any history of juvenile arthritis or connective tissue disease? Y / N

Medical Questions

26. Do you cough, wheeze or have difficulty breathing during exercise? Y / N
27. Have you ever used an inhaler or taken asthma medicine? Y / N
28. Is there anyone in your family who has asthma? Y / N
29. Were you born without or are you missing a kidney, an eye, a testicle, your spleen or any other organ? Y / N
30. Do you have groin pain or a painful bulge/hernia in the groin area? Y / N
31. Have you had infectious mononucleosis (mono) within the last month? Y / N
32. Do you have any rashes, pressure sores or other skin problems? Y / N
33. Have you had a herpes or MRSA skin infection? Y / N
34. Have you ever had a head injury or concussion? Y / N
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache or memory problems? Y / N
36. Do you have a history of seizure disorder? Y / N
37. Do you have headaches with exercise? Y / N
38. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? Y / N
39. Have you ever been unable to move your arms or legs after being hit or falling? Y / N
40. Have you ever become ill while exercising in the heat? Y / N
41. Do you get frequent muscle cramps when exercising? Y / N
42. Do you or someone in your family have sickle cell trait or disease? Y / N
43. Have you ever had any problems with your eyes/vision? Y / N
44. Have you had any eye injuries? Y / N
45. Do you wear glasses or contact lenses? Y / N
46. Do you wear protective eyewear (goggles, face shield)? Y / N
47. Do you worry about your weight? Y / N
48. Are you trying to or has anyone recommended that you gain/lose weight? Y / N
49. Are you on a special diet or do you avoid certain food types? Y / N
50. Have you ever had an eating disorder? Y / N
51. Have you or any family member or relative been diagnosed with cancer? Y / N
52. Do you have any concerns that you would like to discuss with a doctor? Y / N

Females Only

53. When was your last menstrual period? _____

Explain "Y" answers here with correlating number:_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian if a minor _____ Date_____

Name (Last, First): _____

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This page is to be completed only by your evaluating medical provider

Height: ____ ft. ____ in. **Weight:** _____ lbs. **Gender:** M ___ F ___ **BP:** _____ / _____ **Pulse:** _____ **Vision:** R 20/____ L 20/____ (Corrected: Y / N)

Medical Examination	**Normal**	**Abnormal**
Appearance • Marfan Stigmata (kyphoscoliosis, high-arched palate, pectus excavatum Arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency		
Eyes / Ears / Nose / Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart [1] • Murmurs (auscultation standing, supine, + / - Valsalva • Location of point of maximal impulse (PMI)		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

[2] Consider GU exam if in private setting. Having third party present is recommended.

[3] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion. But be aware that each Lincoln College student-athlete will receive baseline ImPACT neurocognitive testing prior to any athletic participation.

Musculoskeletal Examination	**Normal**	**Abnormal**
Neck		
Back		
Shoulders / Upper Arms		
Elbows / Forearms		
Wrist / Hand / Fingers		
Hips / Thighs		
Knees		
Lower Legs / Ankles		
Feet / Toes		
Functional • Duck Walk, Single-Leg Hop		

On the basis of the examination on this day, I (select option below):

Select One	**Clearance Level**	**Explanation**
	Approve/clear this patient's participation in interscholastic athletic activity & sports for 395 days from this date *without any limitations*	
	Approve/clear this patient's participation in interscholastic athletic activity & sports for 395 days from this date *with the following limitations:*	
	Defer clearance for the following reason(s):	
	Disqualify this athlete from interscholastic athletic activity & sports for the following reason(s):	

Physician Signature: _____ Physician Name: _____ Exam Date: _____

Physician Assistant/Nurse Practitioner Signature: _____ PA/NP Name: _____ Exam Date: _____

Name of Practice: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Additional Comments:

Stamp of Practice Information (preferred)