

JUDSON COLLEGE

STUDENT ATHLETE MEDICAL RECORD

Judson College student athlete's are required to complete a physical examination prior to the beginning of each academic year. This examination is done at the student's own expense.

Section one and two of this record should be completed prior to an examination by a physician. The physician should complete section three.

SECTION ONE:

Name _____

Birth date _____ Last _____ First _____ Middle _____
 Social Security No _____ - _____ - _____ Home Phone: _____

In emergency notify _____

Parent or guardian _____ Name _____ Phone Number _____

Family Physician _____ Name _____ Phone Number _____

Office Phone Number _____

Are you currently being treated for any medical condition? _____ Yes _____ No If yes, what? _____

Are you currently taking any medications? _____ Yes _____ No If yes, what? _____

Do you have allergies (i.e. medications, insects, foods)? _____ Yes _____ No If yes, what? _____

SECTION TWO: FAMILY AND MEDICAL HISTORY (COMPLETED BY STUDENT ATHLETE)

FAMILY HISTORY: Has any immediate relative suffered from the following diseases? If yes, please mark (X) and state the relationship to you.

| | | |
|-----------------------|--------------|----------------------|
| Heart disease _____ | Goiter _____ | Kidney Disease _____ |
| Tuberculosis _____ | AIDS _____ | Sickle Cell _____ |
| Mental Disorder _____ | Asthma _____ | Hay fever _____ |
| Diabetes _____ | Cancer _____ | Epilepsy _____ |

PERSONAL HISTORY: Mark an (X) on any of the following which apply now or in the past.

| Past | Now | Past | Now | Past | Now |
|-------|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

HISTORY OF DISEASES: Mark an (X) on any of the following that you have had.

| | | | |
|---------------------------------|-----------------------------------|----------------------------|--------------------------|
| _____ Chicken pox | _____ Smallpox | _____ Dysentery | _____ Thyroid problems |
| _____ Measles | _____ Whooping cough | _____ Diabetes | _____ Speech impaired |
| _____ Measles, German (rubella) | _____ Infantile Paralysis (polio) | _____ Epilepsy or seizures | _____ Emotional problems |
| _____ Mumps | _____ Diphtheria | _____ Stomach ulcer | _____ Tuberculosis |
| _____ Tonsillitis | _____ Pleurisy | _____ AIDS | _____ Eating disorder |
| _____ Rheumatic Fever | _____ Malaria | _____ Appendicitis | _____ Heart disease |
| _____ Scarlet Fever | _____ Asthma | _____ Other: _____ | |

Provide the nature and date of any surgeries or injuries: _____

Are you currently under treatment for any medical condition? _____ Yes _____ No
 If yes, what? _____

SECTION THREE: PHYSICIAN'S EXAMINATION

Date: _____

Height _____ Distant Vision
 Weight _____ R. 20/ Corr. to 20/
 L. 20/ Corr. to 20/
 B.P. _____
 Pulse _____

CHEST X-RAY
 (required if TB Skin Test results are positive
 or have been positive within past 12 months)
 Date _____ Results _____

REQUIRED LABORATORY WORK

Urinalysis: _____ Blood: _____
 Sp. Gr. _____ Hemoglobin _____ Gm.
 Alb. _____ Hematocrit _____
 Sug. _____ W.B.C. _____
 Micro _____ Diff. _____

| Region | Normal | Abnormal | Explanatory Note | Region | Normal | Abnormal | Explanatory Note |
|---------------------|--------|----------|------------------|-----------------------|--------|----------|------------------|
| EYES | | | | PELVIC (if necessary) | | | |
| Pupils | | | | Other | | | |
| EARS-Drums | | | | ANAL (if indicated) | | | |
| Canals | | | | Hemorrhoids | | | |
| Hearing | | | | Pilonidal Cyst | | | |
| NOSE & THROAT | | | | BACK-Posture | | | |
| Dental Repair | | | | EXTREMITIES | | | |
| Pharynx | | | | Upper extremities | | | |
| NECK-Cervical Nodes | | | | Hands | | | |
| Thyroid | | | | Lower extremities | | | |
| CHEST-Inspection | | | | Feet | | | |
| Pulmonary findings | | | | SKIN-condition | | | |
| Breasts | | | | Nails | | | |
| HEART-Size | | | | Hair | | | |
| Rhythm | | | | NERVOUS CONDITION | | | |
| Murmurs | | | | Tremor | | | |
| ABDOMEN | | | | Speech | | | |
| Tenderness | | | | Motor Paralysis | | | |
| Masses | | | | EMOTIONAL STABILITY | | | |
| Liver | | | | Psychiatric disorder | | | |
| Spleen | | | | | | | |
| Kidneys | | | | | | | |
| Hernia | | | | | | | |

Additional recommendations (medications, special diet, athletic brace or support or further explanations) _____

Physician's name and address:

Name: _____

Address: _____

City/State/Zip Code: _____

Physician Signature: _____