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_____
Last First Middle

Birth date_____ Social Security No. _____-_____-_____ Home Phone:_____

In emergency notify _____
Name Phone Number

Parent or guardian_____
Name Phone Number

Family Physician_____
Name 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_____
___Tuberculosis_____
___Mental Disorder_____
___Diabetes_____
____Goiter_____
____AIDS_____
____Asthma_____
_ _Cancer_____
___KidneyDisease_____
___Sickle Cell_____
_ _Hay fever_____
___Epilepsy_____

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

Past	Now		Past	Now		Past	Now	
____	____	Frequent upper respiratory infections or colds	____	_ _	Spitting Blood	____	____	Indigestion/heartburn
_ _ _	_	Eye, ear, nose or throat	____	____	Night sweats	____	_ _	Joint trouble/injuries
_ _ _	_	Heart palpitations	____	____	Insomnia	____	____	Frequent urination
_ _ _	_	Fainting or dizzy spells	____	_ _	Convulsions/seizures	____	____	Shortness of breath
____	____	Frequent Headaches	_ _ _	_	Nervousness/anxiety	____	_ _	Other:

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:
Sp. Gr._____
Alb._____
Sug._____
Micro _____

Blood:
Hemoglobin____Gm.
Hematocrit _____
W.B.C._____
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: _____