Student ID #:

WBU MEDICAL HISTORY FORM FOR ALL WBU ATHLETES

This medical h story form must be completed by each ath ete in order for the athlete to participate in NAIA athletics. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in an ath etic event.

NAME: _____ DATE OF BIRTH: _____ SEX: FEMALE/MALE

SPORT(S): _____

EXPLAIN ANY "YES" ANSWERS (use a separate sheet of paper if needed).

1. Have you ever had a medical illness or injury since your last check up or sports physical? Yes ___ No ___
2. Have you been hospitalized overnight in the past year? Yes ___ No ___
3. Have you had surgery in the past year? Yes ___ No ___
4. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or us ng an nhaler? Yes ___ No ___
5. Do you have any allergies? Please list: _____ Yes ___ No ___
   If yes, do you have an epi-pen? Yes ___ No ___
6. Have you ever passed out during or after exercise? Yes ___ No ___
7. Have you ever been dizzy during or after exercise? Yes ___ No ___
8. Have you ever had chest pain during or after exercise? Yes ___ No ___
9. Do you get tired more than your friends do during exercise? Yes ___ No ___
10. Have you ever had racing of your heart or skipped heartbeats? Yes ___ No ___
11. Have you had high blood pressure or high cholesterol? Yes ___ No ___
12. Have you ever been told you have a heart murmur? Yes ___ No ___
13. Has any family member or relative died of heart problems or of a sudden, unexpected death before age 50? Yes ___ No ___
14. Has any family member been diagnosed with an enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome or abnormal heart rhythm? Yes ___ No ___
15. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month? Yes ___ No ___
16. Has a physician ever denied or restricted your participation in sports for any heart problem? Yes ___ No ___
17. Do you have any current skin problems (itching, rashes, acne, warts, fungus or blisters)? Yes ___ No ___
18. Have you ever had a head injury or concussion? Yes ___ No ___
    If yes, when was your last concussion? _____
19. Have you ever been knocked out, become unconscious or lost your memory? Yes ___ No ___
    If yes, how many times? _____
20. Have you ever had a seizure? Yes ___ No ___
21. Do you have frequent or severe headaches? Yes ___ No ___
22. Have you ever had numbness or tingling in your arms, hand, legs or feet? Yes ___ No ___
23. Have you ever had a stinger, burner or a pinched nerve? Yes ___ No ___
24. Have you ever become ill from exercising in the heat? Yes ___ No ___
25. Have you ever had an unexpected shortness of breath with exercise? Yes ___ No ___
26. Do you cough, wheeze or have trouble breathing during or after exercise? Yes ___ No ___
27. Do you have asthma? Yes ___ No ___
    If yes, do you use an inhaler? Yes ___ No ___
28. Do you have seasonal allergies that require medical treatment? Yes ___ No ___
29. Have you had any problems with your eyes or vision? Yes ___ No ___
30. Are you missing any paired organs? Yes ___ No ___
31. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aids?) Yes ___ No ___
32. Have you ever had a sprain, strain or swelling after injury? Yes ___ No ___
33. Have you ever broken or fractured any bones or dislocated any joints? Yes ___ No ___

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34. Have you had any other problems with pain or swelling muscles, tendons, bones or joints? Yes ___ No ___
If yes, check below and explain (use a separate sheet of paper if necessary):

___ Head	___ Elbow	___ Hip
___ Neck	___ Forearm	___ Thigh
___ Back	___ Wrist	___ Knee
___ Chest	___ Hand	___ Shin/Calf
___ Shoulder	___ Finger	___ Ankle
___ Upper Arm	___ Foot	

_____
_____
_____

35. Do you have any pain or swelling from the past 12 months that has not been examined by a doctor? If yes, please explain in as much detail as possible. Yes ___ No ___
_____
_____
_____

36. Please list any and all surgeries that you have had (include date of surgery):
_____
_____
_____

37. Are you currently under a doctor's care? Yes ___ No ___
38. Have you been around anyone who has been diagnosed with COVID-19?
    a. If so, when? _____
39. Have you previously been diagnosed with COVID-19?
    a. If so, you must provide a return-to-play clearance from the physician that treated you.
40. Are you currently experiencing any of the of the following:
    a. Shortness of breath Yes___ No___
    b. Fever Yes___ No___
    c. Sore Throat Yes___ No___
    d. Unusual Fatigue Yes ___ No___
    e. New loss of taste or smell Yes___ No___

FEMALES ONLY:
41. When was your first menstrual period? _____
42. When was your most recent menstrual period? _____
43. How much time do you usually have from the start of one period to the start of the next? _____
44. How many periods have you had in the last 12 months? _____
45. What was the longest time between periods in the last year? _____

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

_____ _____
Student Signature (Parent/Guardian if minor) **Date**

_____
Printed Name

Student ID #:

WBU PHYSICAL EXAMINATON FORM FOR ALL ATHLETES

Name: _____ DOB: _____ FEMALE/MALE

Sports(s): _____

Physical Examination

Height: _____ Weight: _____ Pulse: _____ BP: _____

Vision: R 20/_____ L 20/_____ Corrected: Y/N _____ Pupils: Equal/Unequal

As a minimum requirement, this physical examination form must be completed prior to NAIA athletic participation.

Medical	Normal	Abnormal Findings	Initials*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in supine position			
Heart-Auscultation of the heart in standing position			
Heart-Lower Extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

The following information must be signed by either a physician, a physician assistant licensed by a State Board of Physician Assistant Examiners, or a registered nurse recognized as an Advanced Practice Nurse by the board for Nurse Examiners.

Signature of Physician: _____ Date: _____