SCHENECTADY COUNTY COMMUNITY COLLEGE
Athletic Health Information Report

Upon completion, this form should be returned promptly to the Athletic Director, Schenectady County Community College, 78 Washington Avenue, Schenectady, New York 12305.

- *THIS SIDE TO BE COMPLETED BY APPLICANT* - -- -

NAME _____ **SOCIAL SECURITY NO.** _____
LOCAL ADDRESS _____ **DATE OF BIRTH** _____ _____
LOCAL PHONE _____ **SPORT** _____ _____
PARENT/GUARDIAN _____ **FAMILY PHYSICIAN** _____ _____
ADDRESS _____ **ADDRESS** _____ _____
TELEPHONE _____ **TELEPHONE** _____ _____
EMERGENCY NAME & NUMBER _____

PERSONAL HISTORY

If you ever had or now have any of the following, check yes or no.

	YES	NO		YES	NO
Measles	[ ]	[ ]	Skin Infections	[ ]	[ ]
German Measles	[ ]	[ ]	Neck, head or back injury	[ ]	[ ]
Mumps	[ ]	[ ]	Joint injury or surgery	[ ]	[ ]
Chicken Pox	[ ]	[ ]	Fractured or broken bones	[ ]	[ ]
Scarlet Fever	[ ]	[ ]	Trick or locked knee	[ ]	[ ]
Whooping Cough	[ ]	[ ]	Pain or pressure in chest	[ ]	[ ]
Rheumatic Fever	[ ]	[ ]	Palpitations or pounding in chest	[ ]	[ ]
Frequent Colds	[ ]	[ ]	Any heart problems	[ ]	[ ]
Frequent Sore Throats	[ ]	[ ]	Chronic cough	[ ]	[ ]
Eye Trouble	[ ]	[ ]	Difficulty breathing	[ ]	[ ]
Wear Glasses/Contact Lenses	[ ]	[ ]	Collapsed lung	[ ]	[ ]
Ear Trouble	[ ]	[ ]	Other lung problems	[ ]	[ ]
Bronchitis or Pneumonia	[ ]	[ ]	Blood in urine	[ ]	[ ]
Infectious Hepatitis	[ ]	[ ]	Sugar or albumin in urine	[ ]	[ ]
Infectious Mononucleosis	[ ]	[ ]	Kidney problems	[ ]	[ ]
Tuberculosis or Contact w/Tuberculosis	[ ]	[ ]	Loss or absence of any of the following:		
Asthma	[ ]	[ ]	Eye	[ ]	[ ]
Hay Fever	[ ]	[ ]	Lung	[ ]	[ ]
Color Blind	[ ]	[ ]	Kidney	[ ]	[ ]
Epilepsy	[ ]	[ ]	Testicle	[ ]	[ ]
Diabete	[ ]	[ ]			

Give details of those checked YES. (If necessary, use additional sheet) _____
_____
_____

Are you under the care of a physician? Yes [ ] No [ ] Have you every been hospitalized? Yes [ ] No [ ]

If yes, indicate where and for what reason _____

IMPORTANT - DO YOU HAVE ALLERGIES TO DRUGS OR MEDICATIONS? Yes [ ] No [ ]
DO YOU HAVE ALLERGIES TO SUBSTANCES OTHER THAN MEDICATION? Yes [ ] No [ ]
If yes, note the drug(s), medication(s) or other substances to which you are allergic: _____
_____

Are you presently taking medications? Yes [ ] No [ ]
If so, state what medications and for what condition. _____
_____

CONFIDENTIAL INFORMATION **PHYSICAL EXAMINATION**

(*This side to be completed by examining physician)*

Height _____ **Build** _____ **Blood Pressure** _____

Weight _____ **Pulse** _____ **Hearing: right** _____
left _____

Vision: right 20/ _____ **Corrected to 20/** _____ **by contacts** _____

left 20/ _____ **Corrected to 20/** _____ **by glasses** _____

CLINICAL EVALUATION

ABNORMALITY	NORMAL	ABNORMAL	GIVE DETAILS OF EACH AND IDENTIFY BY NO.
1. Head, Neck, Fact and Scalp	[ ]	[ ]	_____
2. Nose and Sinuses	[ ]	[ ]	_____
3. Throat	[ ]	[ ]	_____
4. Oral Cavity	[ ]	[ ]	_____
5. Ears (perforation of drum, etc.)	[ ]	[ ]	_____
6. Eyes (lids, conjunctiva, color blindness, etc.)	[ ]	[ ]	_____
7. Pupils and ocular motion	[ ]	[ ]	_____
8. Lungs, chest and breasts	[ ]	[ ]	_____
9. Heart (include estimate of cardiac function)	[ ]	[ ]	_____
10. Vascular system (varicosities, etc.)	[ ]	[ ]	_____
11. Abdomen and viscers (include Hernia/other disorders)	[ ]	[ ]	_____
12. Ano-rectal (pilonidal cyst)	[ ]	[ ]	_____
13. Endocrine system	[ ]	[ ]	_____
14. G-U system	[ ]	[ ]	_____
15. Upper extremities strength/movement: ankles, knees, hips	[ ]	[ ]	_____
16. Feet	[ ]	[ ]	_____
17. Lower extremities strength/movement: wrists, elbows, shoulders	[ ]	[ ]	_____
18. Spine, other musculo-skeletal	[ ]	[ ]	_____
19. Skin and lymphatic	[ ]	[ ]	_____
20. Neurologic	[ ]	[ ]	_____
21. Psychiatric	[ ]	[ ]	_____

IS THIS STUDENT PHYSICALLY ABLE TO PARTICIPATE IN UNLIMITED PHYSICAL ACTIVITY AND/OR OTHER SPORTS IN THE INTERCOLLEGIATE ATHLETIC PROGRAM? Yes [ ] No [ ]

If no, please cite reasons.

_____

Summary and additional comments.

_____

_____

_____ _____

Type or Print Name of Examining Physician **Signature of Examining Physician**

Address _____ **Registration No.** _____

_____ **Date** _____

Phone _____

ALL THESE REQUIREMENTS MUST BE MET BEFORE ENROLLMENT AND/OR PRACTICE SESSIONS.