Student Athlete Information and Instructions

PHYSICALS

All student athletes who are planning on attending Hutchinson Community College are required to have a current physical and paperwork on file with the Sports Medicine Department before participating in any practice or games associated with the school.

You may obtain a physical anytime ***after May 30th***.

You will need to download (print off) all forms that are located on ***SportsWare Homelink*** page.

Complete Page 1: "REPORT OF MEDICAL HISTORY" yourself
Page 2: PHYSICANS' CERTIFICATION FOR ATHLETES" needs to be taken with you to a licensed M.D., D.O., P.A., or A.R.N.P. for your physical examination.
Read and complete the rest of the forms.

Once all forms are completed send them along with copies of any test results from your exam to:

Hutchinson Community College
Sports Medicine Department
1300 N Plum
Hutchinson, Ks 67501
(620) 665-3553

If you are unable to complete the above information, we will assist in scheduling a time for you when you arrive on campus.

CHECK LIST

Report of Medical History (page 1)
Completed by student athlete — Completed_____

Physicians Certificate (page 2)
Completed by Physician — Completed_____

Copies of results of tests/studies, x-rays,
Post-op notes, etc. Included with forms — Completed_____

Athletic Department Policy form — Completed_____

Insurance Coverage and Regulations form — Completed_____

Release of Health Information form — Completed_____

Risk of Acknowledgement & Consent to
Participation form — Completed_____

HUTCHINSON COMMUNITY COLLEGE SPORTS MEDICINE
REPORT OF MEDICAL HISTORY

NAME ____________________ (LAST / FIRST / MIDDLE) DOB ___/___/___ SEX ___ SS# ___-___-___

PERMANENT (HOME) ADDRESS ____________________ SPORT ________

CITY ____________ STATE _____ ZIP ________ PHONE ___-___-____

LOCAL (COLLEGE) ADDRESS (IF KNOWN) ____________________ APT/RM # ________

CITY ____________ ZIP ________ PHONE # (RM or CELL) ___-___-____

PARENT/GUARDIAN INFORMATION ____________________ (NAME) PHONE ___-___-____

EMPLOYER ____________________ PARENT BUSINESS PHONE ___-___-____

FAMILY HISTORY

	AGE	STATE OF HEALTH (GOOD,FAIR,POOR)	If in poor health what medical condition(s)	Age of death	Cause of death
FATHER					
MOTHER					
Immediate family member who's health Isn't good.					

PERSONAL HISTORY	YES	NO
Tooth or gum trouble? (excluding cavities)		
Ear, nose, or throat trouble? (if yes specify)		
Do you wear glasses?		
Do you wear soft contacts?		
Do you have asthma?		
Allergic to any of the following:		
Penicillin		
Sulfa		
Serum		
Bee Sting		
Other drugs or foods (please list)		
Head injury or unconsciousness		
Dizzy spells		
Heart Condition (if yes, explain in detail)		
High Blood Pressure		
Kidney Disease		
Kidney Injury		
Diabetes		
Hernia (if yes, when)		
Surgery (if yes complete information below)		
Bone/Joint disease or injury (if yes complete information below)		

Describe surgeries and/or bone and joint injuries here. Be specific as to date, side and location etc.

PERSONAL HIST. CONTINUED	YES	NO
Epilepsy		
Emotional Disturbance		
Year of last tetanus shot if known:		
Are you currently taking medication(s)		
If yes, list medications		
Excessive fatigability		
Light headedness/Fainting		
Excessive/progressive shortness of breath or Chest pain/discomfort with exertion		
Women Only:		
Regular menstrual cycle		

REMARKS AND/OR ADDITIONAL INFORMATION

Student Signature　　　　Date

HUTCHINSON COMMUNITY COLLEGE SPORTS MEDICINE

1300 North Plum
Phone 620-665-3553 Hutchinson, KS 67501 Fax 620-728-8121

PHYSICIAN'S CERTIFICATE FOR ATHLETES

NAME____ AGE______ SEX_____ Sport______________
Last First Middle

HEIGHT____'_____" WEIGHT_________LBS VISION– Corrected / Uncorrected R 20/_____ L 20/_____

BRACHIAL ARTERY BLOOD PRESSURE IN SITTING POSITION ________________ PULSE__________

HISTORY History from previous side reviewed with patient _________yes _________no

Further notes regarding history Loss or impairment of any paired organ _________no _________yes

____________________________ Is student under treatment for any

____________________________ physical or emotional condition _________no _________yes

Orthopaedic history

Body part -problem, recurrent pain	No	Yes	R/L	Ligament	Cartilage	Bone	Other Specify
Foot							
Ankle							
Knee							
Hand/Wrist							
Elbow							
Shoulder							
Spine/Back							
Other							

EXAM

	Normal	Abnormal Findings
Eyes / ENT		
Skin		
Respiratory		
Abdomen		
Neurological		
Genitalia/Hernia		
Ortho - Neck/Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
CV ausc supine and standing		
Bilat femoral artery pulse		
Rhythm		
Heart sounds / murmurs		

Additional remarks / follow up studies needed / reason unable to participate____________________

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____

Copies of all results from Tests/Studies utilized in completing the physical exam must accompany this form.

Your physical must be performed by a licensed MD, DO, or PA, ARNP that is affiliated with a licensed MD.

*This form must have a **PHYSICIAN'S SIGNATURE STAMP** below the Physician's signature line.*

I CERTIFY THAT ON THIS DATE I HAVE EXAMINED THIS STUDENT AND RECOMMEND HIM/HER AS PHYSICALLY ______ABLE_____UNABLE (see above for reason unable) TO PARTICATE FULLY IN INTERCOLLEGIATE ACTIVITIES.

SIGNED________________________________ DATE__________ ______________________________
(Signature) (printed physician's name)

Physician's License #______________ ______________________________________
City State Zip

Phone ________________________________