Hill College Sports Medicine

PREPARTICIPATION MEDICAL HISTORY FORM

Athletes MUST complete this form and take with them to physician when obtaining physical.

Name:_____ **Sport:** _____ **Date:**_____

General Health	Answer		Explanation of "YES" Answers including date
1. Have you had a medical illness or injury in the past year?	Yes	No	
2. Have you been hospitalized in the past year?	Yes	No	
3. Are you missing any paired organs?	Yes	No	
4. Are you currently under doctor's care?	Yes	No	
5. Are you currently taking any prescription or non-prescription (over the counter) medication or pills or using an inhaler?	Yes	No	
6. Do you have any allergies? (Pollen, medicine, food, insects)	Yes	No	
7. Do you have any current skin problems? (Itching, rashes, excessive acne, warts, fungus or blisters)	Yes	No	
8. Have you ever become ill from exercising in the heat? (Heat exhaustion, heat stroke)	Yes	No	
9. Have you ever had problems with your eyes or vision?	Yes	No	
10. Have you ever gotten unexpectedly short of breath with exercise?	Yes	No	
11. Do you have asthma?	Yes	No	
12. Do you have seasonal allergies requiring medical treatment?	Yes	No	
13. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position? (Knee brace, foot orthotics, retainer, hearing aide)	Yes	No	
14. Do you want to weigh less or more than you do now?	Yes	No	
15. Have you ever been diagnosed with or tested for sickle cell trait or cell disease?	Yes	No	
Neurovascular	**Answer**		**Explanation of "YES" Answers including date**
1. Have you ever had a head injury or concussion?	Yes	No	
If yes, how many times?			
If yes, when was last concussion? (Month and year)			
How severe was each concussion including symptoms experienced, treatment received, and time held out of athletics participation.			
2. Have you ever been knocked out, become unconscious, or lost your memory?	Yes	No	
3. Have you ever had a seizure?	Yes	No	
4. Do you have frequent or severe headaches?	Yes	No	
5. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	Yes	No	
6. Have you ever had a stinger, burner, or pinched nerve?	Yes	No	

Cardiovascular	Answer		Explanation of "YES" Answers including date
1. Have you ever been dizzy during or after exercise?	Yes	No	
2. Have you ever had prior testing for the heart ordered by a physician?	Yes	No	
3. Have you ever passed out/fainted during or after exercise?	Yes	No	
4. Have you ever had chest pain during or after exercise?	Yes	No	
5. Do you get tired more quickly than your teammates during exercise?	Yes	No	
6. Have you ever experienced racing of your heart or skipped heartbeats?	Yes	No	
7. Do you or have you ever had high blood pressure or cholesterol?	Yes	No	
8. Have you ever been told you have a heart murmur?	Yes	No	
9. Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	Yes	No	
10. Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy}, hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc.) Marfan's syndrome, or abnormal heart rhythm?	Yes	No	
11. Have you had a severe viral infection (myocarditis or mononucleosis) within the last month?	Yes	No	
12. Has a physician ever denied or restricted your participation in sports for any heart problems?	Yes	No	

Orthopedic	Answer		Explanation of "YES" Answers including date
1. Have you ever had a sprain, strain or swelling after injury?	Yes	No	
If yes, explain in further detail: body part injured, date of injury, extent of injury, if limited athletic participation and if participation was limited, for how long.			
2. Have you broken or fractured any bones or dislocated any joints?	Yes	No	

Females Only	Answer
1. When was you first menstrual period?	
2. When was your most recent menstrual period?	
3. How much time do you usually have from the start of one period to the start of another?	
4. How many periods have you had in the last year?	
5. What was the longest time between periods in the last year?	

Agree to the statements below by initialing in the blanks and sign and date.

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

_____I understand that the preparticipation medical history and physical forms are merely screening tools in determining overall health prior to athletic participation and not a complete medical physical and thus, not all medical conditions and illnesses may be observed.

_____I understand that failure to provide truthful answers to the above questions could cause complications to preexisting injuries, illnesses or conditions and Hill College will NOT be responsible for either preexisting injuries or complications that arise from preexisting injuries.

Student-Athlete Signature _____ Printed Name _____ Date _____

June 15, 2022

Hill College Athletics

Pre-Participation Student-Athlete COVID-19 Screening

To be completed prior to pre-participation physical and presented to healthcare practitioner for review during physical examination. Must be submitted at an attachment to your physical examination document.

_____ _____ _____ / _____ / _____

Name Last First Date of Birth (mm/dd/yyyy)

Complete the form to assess recent exposure/current infection of COVID-19 or other illness.

Are you currently symptom free from all illnesses? YES NO (circle one) (if no, list details including illness in space below)

In the past two weeks, have you experienced or are you currently experiencing any of the following:

Symptoms	YES	NO	LENGTH OF SYMPTOM (if yes)	EXPLANATION (has symptom resolved and, if so, when)
Fever				
Body Chills				
Extreme Level of fatigue				
Cough				
Pain/Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste				
Loss of Smell				
Charges to Vision / Eye Discharge				

QUESTIONS		
1 If you answered YES to any of the above questions, have you had a recent exposure (within past 7-10 days) to an individual who has tested positive for COVID-19?	YES	NO
2 Have you had a confirmed case of COVID-19? If yes, includes dates and outcomes (fully recovered/recovered with complications and what complications) below.	YES	NO
3 Prior, to your arrival at Hill College, have you been living in or visited an area with an increased/rising number of COVID-19 cases (i.e. hotspots)?	YES	NO
4 Have you received any vaccines for COVID-19? If so, includes dates of each vaccine below and attach a copy of vaccine card(s) in the attachments section in SportsWare.	YES	NO

Explanations: Please explain any yes questions above including dates and current health status.

Have you previously been or are you currently diagnosed with COVID-19? YES NO (circle one) Date of diagnosis (if yes): ____/____/____

If you answered YES, attach any paperwork from your physician regarding current health status and athletic participation status. **DO NOT** report to campus if you are currently diagnosed and/or under suspicion of contracting COVID-19. If you fall in this category, notify your coach immediately and you must be completely recovered including a 5-day quarantine from the onset of symptoms with medical documentation from your physician stating so prior to reporting to campus.

Please list any countries, states, cities you have traveled to/from or intent to travel to/from during the months of June, July and August and dates you were there below:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____ (add more to back, if applicable)

I understand the Novel Coronavirus, Covid-19, is an ongoing worldwide pandemic affecting everyone around the world and is constantly evolving. As so, I also understand, that recommendations will evolve, and today's recommendations may not be the same tomorrow. With this in mind, I understand that Hill College and the Hill College Athletics Department follow and utilize the recommendations and guidance of the Centers for Disease Control (CDC), the Health and Human Services (HHS), the Texas Department of health (TDH), and the National Junior College Athletic Association (NJCAA) in implementing a plan to reduce the possibility of infection and to contain potential positive instances of COVID-19 as well as all other forms of infectious disease, and so, I voluntarily choose to participate in the Hill College Athletics Programs and understand that there in not any way to fully prevent becoming infected with COVID-19 or any other infectious disease.

Student-Athlete Signature: _____ Date: _____

June 20, 2022

June 15, 2022

Hill College Sports Medicine

PREPARTICIPATION PHYSICAL EXAMINATION FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Sport: _____ Freshman / Sophomore (circle one)

ATHLETES PLEASE DO NOT WRITE BELOW THIS LINE FOR MEDICAL PERSONNEL ONLY

Height: ____ inches Weight: _____lbs. BP: __ / __ _ Pulse: _____bpm

Vision: (R) ___ / ___ (L) ___ / ___ (Both) ___ / ___ Corrected? Y / N

	NORMAL	ABNORMAL FINDINGS	ADDITIONAL COMMENTS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELET AL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Other			
RECOMMENDED TEST/NOT REQUIRED			
Electrocardiogram (ECG)			
Sickle Cell Trait			

Physician Please Circle Clearance Status and note and concerns on the comment line below

CLEARED **NOT CLEARED** **CLEARANCE PENDING** (comments below)

Comments _____

I have reviewed the student-athlete's COVID-19 screening form and they do not appear to have any concerns.

Physician's Printed Name: _____ **Physician's Signature:** _____

June 15, 2022