Hill College Sports Medicine

PREPARTICIPATION MEDICAL HISTORY FORM

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

Name: _____ **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 weight 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	

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 exam.
To be submitted to Athletic Department as attachment to physical exam document.

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

Please complete this form to assess your potential exposure / possession of COVID-19 and other illness.

Are you currently free from all illnesses? Yes NO (circle one)

Prior to today, have you experienced or are you currently experiencing any of the following:

Symptom	YES	NO	LENGTH OF SYMPTOME (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				
Changes to Vision / Eye Discharge				

QUESTIONS	YES	NO
1. If you answered YES to any of the above questions, did you experience a suspected exposure to COVID-19 2-14 days prior		
2. Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		
3. Have you had any direct contact with someone what has a suspected or lab confirmed case of COVID-19?		
4. Prior to today, have you self-quarantined due to suspected symptoms or exposure of COVID-19?		
5. Prior to today, have you been living in, or have you visited an area reporting an increased number of COVID-19 cases (i.e. hotspots)?		

Explanations: Please explain any yes question above including how and when including dates and your current 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 all paperwork confirming diagnosis and date of recovery or current status. **DO NOT** report to campus if you are currently diagnosed and under suspicion of contracting COVID-19. If you fall under this category, you must be completely recovered with medical documentation stating so prior to reporting to campus.

Please list any countries/states/cities you have traveled to since March 15th, 2020 and dates you were there:

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

I understand the Novel Coronavirus, COVID-19, is a new worldwide pandemic affecting everyone around the world and is constantly evolving. As so, I also understand, that recommendations will evolve, and that 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 Athletics Association (NJCAA) in implementing a plan to reduce the possibility of infection 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 is not any way to fully prevent becoming infected with COVID-19 or any other infectious disease.

Student-Athlete Signature: _____ Date: _____

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			
Lumph 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)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Other			
RECOMMENDED TEST/NOT REQUIRED			
Electrocardiogram (ECG)			
Sickle Cell Trait			

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: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____