Attention Student-Athlete
Read this First

Pre-Participation Examination Guidelines

The Biola University Athletic Training Staff is constantly striving to render our student-athletes the best possible medical care available with a minimal amount of confusion. In order for this to be accomplished, we require certain information from you and your family physician that will assist us in the event that you become ill or injured while participating in an organized practice or an intercollegiate athletic contest.

1. Each student is required to obtain a completed physical examination (using **only** Biola University pre-participation exam) from a personal physician. **Exams must be performed by a licensed M.D., D.O., or PA/NP only.**

2. Each student must complete the medical clearance packet (physical, medical history, medical and insurance policy forms) and turn it in by the assigned dates.

3. Each form must be filled out completely or it will not be accepted. The athletic training room staff must accept all three forms before you are eligible to participate with your sport. Once you and your doctor have completed the forms please send them to Biola University.

Student-athlete may not participate/practice in athletics until these documents have been completed and accepted. All forms must be turned to the athletic training room by <u>AUGUST 1st</u>.

If you have any questions or concerns, please feel free to contact the athletic training staff. Your cooperation in this matter is greatly appreciated.

Sincerely,

The Athletic Training Staff

Biola University Athletics
Athletic Training
13800 Biola Ave
La Mirada, CA 90639

Biola University Athletic Department

Athletic Medical History

(To be completed by Student Athlete)

(Print) LAST NAME FIRST MI

SOCIAL SECURITY # SCHOOL ID # SPORT(S)

SEX: ❒Male ❒ Female (check one)

DATE OF BIRTH

HOME ADDRESS

CITY STATE ZIP ( ) HOME PHONE

LOCAL/ CELL PHONE

EMERGENCY CONTACT

PARENT/GUARDIAN'S FULL NAME RELATIONSHIP TO ATHLETE

HOME PHONE WORK OR CELL PHONE

GENERAL MEDICAL HISTORY (Please answer all questions completely.)

Allergies:

Penicillin ❑ No ❑ Yes

Sulfa Drugs ❑ No ❑ Yes

Other Drugs ______________________________

Foods ______________________________

Medications: List all regular medications. (Include prescription medicine, over the counter medicine, vitamins. If none, write NONE.)

ORTHOPEDIC HISTORY

Indicate as to whether or not you have sustained a significant injury (i.e., required medical attention) to the below listed body parts. If so, please indicate date(s) of injury and any associated surgery.

1. ❑ No ❑ Yes **Neck:**

cervical fracture	Date ______________
cervical sprain	Date ______________
cervical strain	Date ______________
"pinched nerve"	Date ______________
other (describe below)	Date ______________

____

2. ❑ No ❑ Yes **Shoulder:**

dislocation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
A/C separation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
rotator cuff	❑R	❑L	Date ______________	❑ Surgery	Date ______________
biceps tendinitis	❑R	❑L	Date ______________	❑ Surgery	Date ______________
clavicle fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

3. ❑ No ❑ Yes **Upper arm/Forearm: (please circle)**

fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
strain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

4. ❑ No ❑ Yes **Elbow:**

fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
hyperextension	❑R	❑L	Date ______________	❑ Surgery	Date ______________
sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
dislocation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
tendinitis	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

5. ❑ No ❑ Yes **Hand/Wrist: (please circle)**

fracture	❑R	❑L	Date ______________	❑Surgery	Date ______________
sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
carpal tunnel	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

6. ❑ No ❑ Yes **Chest/Ribs: (please circle)**

sternum fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
rib fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

7. ❑ No ❑ Yes

Back/lowback: (please circle)					
sciatica	❑R	❑L	Date ______________	❑ Surgery	Date ______________
lumboscacral strain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
sacroiliac sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
scoliosis	❑R	❑L	Date ______________	❑ Surgery	Date ______________
disc injury	❑R	❑L	Date ______________	❑ Surgery	Date ______________
spondylolosis	❑R	❑L	Date ______________	❑ Surgery	Date ______________
fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
kidney injury	❑R	❑L	Date ______________	❑ Surgery	Date ______________
surgery	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

8. ❑ No ❑ Yes

Hip/Pelvis (please circle)					
fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
dislocation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

9. ❑ No ❑ Yes

Thigh:					
fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
strain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
contusions	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

10. ❑ No ❑ Yes

Lower leg (shin/calf): (please circle)					
fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
stress fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
strain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
contusion	❑R	❑L	Date ______________	❑ Surgery	Date ______________
shin splints	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

11. ❑ No ❑ Yes

Knee:					
sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
medial	❑R	❑L	Date ______________	❑ Surgery	Date ______________
lateral	❑R	❑L	Date ______________	❑ Surgery	Date ______________
ant. cruciate	❑R	❑L	Date ______________	❑ Surgery	Date ______________
post. cruciate	❑R	❑L	Date ______________	❑ Surgery	Date ______________
meniscal tear	❑R	❑L	Date ______________	❑ Surgery	Date ______________
tendinitis	❑R	❑L	Date ______________	❑ Surgery	Date ______________
Osgood-Schlatter	❑R	❑L	Date ______________	❑ Surgery	Date ______________
chondromalacia	❑R	❑L	Date ______________	❑ Surgery	Date ______________
patella fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
patella dislocation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

Do you wear a brace for any of the above? ❑ No ❑ Yes
If yes, what type? ____

12. ❑ No ❑ Yes **Ankle:**

fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
dislocation	❑R	❑L	Date ______________	❑ Surgery	Date ______________
sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

13. ❑ No ❑ Yes **Foot:**

fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
stress fracture	❑R	❑L	Date ______________	❑ Surgery	Date ______________
arch sprain	❑R	❑L	Date ______________	❑ Surgery	Date ______________
other (describe)	❑R	❑L	Date ______________	❑ Surgery	Date ______________

____

14. ❑ No ❑ Yes Do you currently have any incompletely healed injury or condition which is receiving medical attention and/or giving you difficulty that should be reported? Please be specific.

Describe: ____
____

Please explain all YES answers:____
____
____

ILLNESSES/ DISEASES (check and complete appropriate answer.)

1. ❑ No ❑ Yes Do you experience frequent headaches?

2. ❑ No ❑ Yes Do you experience fainting spells?

3. ❑ No ❑ Yes Have you experienced an epileptic seizure or been informed by a physician that you might have epilepsy?

4. ❑ No ❑ Yes Have you experienced a head injury or concussion?
Date(s)____
Hospitalized? ❑ No ❑ Yes Date(s) ___________________________________

5. ❑ No ❑ Yes Do you experience frequent nose bleeds?

6. ❑ No ❑ Yes Do you have asthma?
❑ No ❑ Yes Have you been treated by a physician for an asthma attack?
If yes, what usually brings on an attack? ____
Is your condition controlled with medication? ❑ No ❑ Yes
If yes, give name of medication. ___________________________________

7. ❑ No ❑ Yes Do you suffer from frequent colds or flu?

8. ❑ No ❑ Yes Have you ever been treated by a physician for viral pneumonia? If yes, give date ________________

9. ❑ No ❑ Yes Have you ever been treated by a physician for infectious mononucleosis (mono)?
If yes, give date _______________________

10. ❑ No ❑ Yes Do you experience frequent ear infections?

11. ❑ No ❑ Yes Have you ever been treated by a physician for anemia? Date ___________________

12. ❑ No ❑ Yes Are you a diabetic? If yes, how is it regulated? ❑ Injections ________times/day
❑ Exercise
❑ Diet

13. ❑ No ❑ Yes Do you have any medically diagnosed blood disorders? (eg. Hemophilia, sickle cell)
Type ____

14. ❑ No ❑ Yes Have you ever been treated by a physician for hepatitis? Date __________________

15. ❑ No ❑ Yes Have you ever been treated by a physician for any kidney disorder? Date _________________
Describe ____

16. ❑ No ❑ Yes Have you ever been treated by a physician for heart problems, murmur or irregular rhythm, etc?
Type ___________________________________ Date ____________

17. ❑ No ❑ Yes Do you have high or low blood pressure?

18. ❑ No ❑ Yes Have you ever been treated by a physician for any form of cancer?
Type ___________________________________ Date ____________

19. ❑ No ❑ Yes Have you ever been treated by a physician for a hernia?
Type ___________________________________ Date ____________

20. ❑ No ❑ Yes Do you experience insomnia (difficulty in sleeping) frequently?

21. ❑ No ❑ Yes Have you ever been treated by a physician for tumors or cysts? Type ________________

22. ❑ No ❑ Yes Have you experienced recent weight loss or gain?
Which? _________________ How much? __________________

23. ❑ No ❑ Yes Have you ever been diagnosed with or been treated for an eating disorder?
If yes, explain ____

24. ❑ No ❑ Yes Have you ever suffered from heat illness? If yes, which of the following?
❑ heat illness ❑ heat cramps

25. ❑ No ❑ Yes Have you ever suffered the loss or serious impairment of a paired organ (eg., eye, kidney)?
Explain ____

26. ❑ No ❑ Yes Do you currently suffer from any illness or disease for which you are receiving medical attention that should be reported?
Comments ____

27. ❑ No ❑ Yes Do you experience frequent menstrual problems?
If yes: ❑ irregular periods ❑ excessive flow ❑ severe cramps

Eyes

1. ❑ No ❑ Yes Are you without vision in either eye? If yes, explain ________________________

2. ❑ No ❑ Yes Do you have any visual deficiencies? If yes, explain ________________________

3. ❑ No ❑ Yes Do you wear eye glasses? If yes, do you wear them during athletics? ❑ No ❑ Yes

4. ❑ No ❑ Yes Do you wear contact lenses? If yes, which kind? ❑ hard ❑ soft

Ears

1. ❑ No ❑ Yes Do you have any hearing impairment?

2. ❑ No ❑ Yes Do you wear a hearing aid?

3. ❑ No ❑ Yes Have you ever injured your ear? ❑ tympanic membrane (ear drum)
❑ outer ear (eg. cauliflower ear)
❑ other ______________________

Teeth

1. ❑ No ❑ Yes Do you have any missing, damaged, or diseased teeth?
Explain ____
Location ____

2. ❑ No ❑ Yes Do you wear any dental appliances? (dentures, plates, braces, crowns, etc.)
Explain ____
Location ____

Please explain all YES answers:____
____
____

This information is strictly for the use of the Athletic Department. The information furnished will be used as an aid in providing necessary health care while you are a student. It will not influence your situation at the University. This information will not be released without your knowledge and consent.

My signature below indicates that I have completely and truthfully answered the above questions.

Student Signature: ____ Date_____________________

Parent/Guardian: ____
(if student-athlete is under 18)

Parental permit for treatment of illness or accident to minor student-athletes of Biola University (those under 18 years of age).

I ❑ do ❑ do not give permission to the Athletic Department Medical Staff at Biola University to carry out such diagnostic and therapeutic procedures as may be necessary for my son/daughter. I also ❑ do ❑ do not permit such procedures to be carried out at and by one of the local hospitals in the event that my son/daughter has been referred or taken there for emergency care.

Signed: ____ Date _____________________
Relationship: ____