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 date.

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 AUGUST 1st.

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

Returning Athlete Questionnaire

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(Print) LAST NAME FIRST MI

______________________ ______________________ ______________________

SCHOOL ID # DATE OF BIRTH SPORT

____

HOME ADDRESS

____ (   )______________

CITY STATE ZIP HOME PHONE

____

CELL PHONE

EMERGENCY CONTACT

______________________________ ______________________________

PARENT/GUARDIAN'S FULL NAME RELATIONSHIP TO ATHLETE

______________________________ ______________________________

HOME PHONE CELL OR WORK PHONE

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**.)

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Name____ School ID__________________________

(All information provided on this form is confidential and will be available only to the Biola University Sports Medicine Staff)

WITHIN THE LAST 6 MONTHS:

1. Have you sprained or dislocated a joint? ❑ No ❑ Yes
2. Have you strained (pulled) a muscle? ❑ No ❑ Yes
3. Have you fractured a bone? ❑ No ❑ Yes
5. Have you had surgery to a bone or joint? ❑ No ❑ Yes
6. Have you had a head or neck injury? ❑ No ❑ Yes
7. Have you been knocked out or been unconscious? ❑ No ❑ Yes
8. Have you had a concussion? ❑ No ❑ Yes
9. Do you have frequent or repeated headaches? ❑ No ❑ Yes
10. Have you had unexplained muscle weakness? ❑ No ❑ Yes
11. Have you experienced pain/discomfort in the chest, neck, jaw or arms during or after sport participation? ❑ No ❑ Yes
12. Have you experienced dizziness or passed out during or after sport participation? ❑ No ❑ Yes
13. Have you experienced shortness of breath at rest or with mild exercise? ❑ No ❑ Yes
14. Have you experienced high or low blood pressure? ❑ No ❑ Yes
15. Have you noticed rapid heart palpitations or felt like your heart raced? ❑ No ❑ Yes
16. Have you been told you have a heart murmur, an irregular heartbeat, or any heart disease? ❑ No ❑ Yes
17. Has anyone in your family died suddenly due to heart related disease? ❑ No ❑ Yes
18. Have you experienced excessive coughing during or after sport participation? ❑ No ❑ Yes
19. Have you experienced breathing difficulties or been told you have asthma, bronchitis, or allergies? ❑ No ❑ Yes
20. Have you been advised that you should not participate in the sport(s) that you intend to participate? ❑ No ❑ Yes
21. Are you currently seeing a doctor for a medical problem? ❑ No ❑ Yes
22. Have you been diagnosed with a disease or been hospitalized overnight for a disease? ❑ No ❑ Yes
23. Have you had any general surgery or operation? ❑ No ❑ Yes
24. Are you currently taking any prescription medications? ❑ No ❑ Yes
25. Over the past six months, have you experienced any injury or disorder not covered above? ❑ No ❑ Yes

Please explain all YES answers: ____

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I hereby certify that all answers to the preceding questions are correct and true.

Signed:____ Date:______________________