

**Attention Athletes:**

A pre-participation medical evaluation is required prior to sports participation. The Centenary College Health Office staff **MUST** perform this evaluation. It does not replace a complete physical examination performed by your personal health care provider. You will receive a mailing shortly from the Athletic trainer with schedules for the teams.

## PHYSICAL EXAMINATION

This form is to be completed, signed by a health care provider (the physical must be within 1 year) and returned to Health Service by **August 1<sup>st</sup> (Fall Semester), January 1<sup>st</sup> (Spring Semester), or June 1<sup>st</sup> (Summer Semester)**. This information is confidential and is only used by the Health Service professional staff in assuring the student's health and for addressing special needs during his/her college experience.

**A \$5 fee will be assessed if a form is returned late.**

\_\_\_\_\_  
Last Name First Name M.I. Social Security #

Male \_\_\_\_\_ Female \_\_\_\_\_ Birth date (month/date/year) \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Visual Acuity: R 20/ \_\_\_\_\_ Corrected - yes \_\_\_\_\_ no \_\_\_\_\_ Glasses - yes \_\_\_\_\_ no \_\_\_\_\_  
L 20/ \_\_\_\_\_ Corrected - yes \_\_\_\_\_ no \_\_\_\_\_ Contact Lenses - yes \_\_\_\_\_ no \_\_\_\_\_

History of drug allergy: \_\_\_\_\_

Allergies: \_\_\_\_\_

Are there any abnormalities of the following systems? Describe fully:

	Normal	Abnormal	Describe each abnormality
Eyes	_____	_____	_____
Head, ENT	_____	_____	_____
Respiratory	_____	_____	_____
Cardiovascular	_____	_____	_____
Lymphatic	_____	_____	_____
GI	_____	_____	_____
Hernia	_____	_____	_____
GU	_____	_____	_____
Musculoskeletal	_____	_____	_____
Metabolic/Endocrine	_____	_____	_____
Neurologic/Psychiatric	_____	_____	_____
Skin – Scars, tattoos, piercings	_____	_____	_____
Teeth, mouth	_____	_____	_____

Loss or seriously impaired function of any organ? Yes \_\_\_\_\_ No \_\_\_\_\_

History of emotional disorder? Yes \_\_\_\_\_ No \_\_\_\_\_ including: depression, suicide attempts, panic attacks, eating disorder, etc. If yes, please describe: \_\_\_\_\_

If yes, is student currently undergoing treatment and/or taking medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
List all medications taken regularly including dosages. \_\_\_\_\_

History of drug/alcohol/tobacco abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of hospitalization or any surgery? \_\_\_\_\_

Describe fully with dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is student cleared to participate in unrestricted rigorous competitive/noncompetitive sports events at Centenary College for the 2005 – 2006 academic year? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain any condition or handicap that will prevent or limit the student's full participation in activities at Centenary College (especially if an Equine major or athlete). \_\_\_\_\_  
\_\_\_\_\_

Is the student now under treatment for any existing medical problems of which the College should be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Examiner's signature: \_\_\_\_\_ Date \_\_\_\_\_  
Examiner's name (print) \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Stamp

**PLEASE RETURN TO:**

\_\_\_\_\_

Centenary College Health Service  
400 Jefferson Street  
Hackettstown, NJ 07840  
Phone (908) 852-1400, ext. 2206  
Fax (908) 979-4290

