NORTH IDAHO COLLEGE
REPEAT SPORTS SCREENING EXAMINATION

PLEASE PRINT LEGIBLY:

SPORT | STUDENT ID NUMBER | DATE OF EXAM

LAST NAME | FIRST NAME | MI | DATE OF BIRTH

LOCAL ADDRESS | PHONE NUMBER | E-mail address

PARENT OR PERSON TO NOTIFY IN CASE OF AN EMERGENCY (ADDRESS AND PHONE NUMBER)

Over the past year, have you had any of the following?

	Yes	No		Yes	No
Asthma	____	____	Tennis Elbow	____	____
Mononucleosis	____	____	Hyperextended elbow	____	____
Heart Trouble	____	____	Low Back Pain	____	____
Neck Injury	____	____	Knee Injury	____	____
Pinched Nerve	____	____	Patellar Tendonitis	____	____
Shoulder Injury	____	____	Shin Splints	____	____
Concussion	____	____	Foot Problems	____	____
Heat Illness	____	____	ITB Syndrome	____	____

If you marked YES to any of the above please explain:_____

_____

Are you currently taking any medications?____ If yes, list type and purpose:_____

_____

Were you hospitalized over the past year?____ If yes, for what?_____

_____

Have you had any recent (within the last 1-2 months) illness or injury?____ If yes, please describe:_____

_____

Have you had any injuries or illness since your previous exam?____ If yes, please describe:_____

_____

Have you had any other changes in your medical history since your last exam?____ If yes, please describe:_____

_____

_____ _____

Student signature | Date

revised 4/05

_____ _____
Student Name Date of Birth

Height_____ Weight_____ Blood Pressure_____ Pulse:_____

	Normal	**Abnormal Findings**
Heart	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Hernia(males)	_____	_____

Comments:_____

_____

_____

_____

Disposition:

_____ 1) Unrestricted activity in all sports except:

_____ 2) No participation until ____/___/____; and/or:

_____ 3) Conditional participation, limited to:

_____ 4) No participation in any sport, or specific sports:

_____
Date Health Care Provider Signature Phone

_____
Printed Name of Health Care Provider