Grand View University Athletics
1200 Grandview Avenue
Des Moines, Iowa 50316-1599
515-263-6050
Fax: 515-263-2882

Athletic Medical History & Physical Form

Fill out completely and RETURN TO THE ATHLETICS OFFICE prior to participation.

Part A – To be completed by the Athlete

Name _____
Last First MI

DOB _____ Sport _____ Gender ❑ Female ❑ Male

Home Address _____
Street

_____
City State Zip

Student Cell Number _____ Year in School ❑ Fr ❑ So ❑ Jr ❑ Sr

Medical History

Yes	No	Have you ever?
❑	❑	Been hospitalized
❑	❑	Had surgery
❑	❑	Been dizzy during or after exercise
❑	❑	Had chest pain during or after exercise
❑	❑	Had high blood pressure
❑	❑	Been told you that you have a heart murmur
❑	❑	Had racing of the heart or skipped heartbeats
❑	❑	Had a head injury
❑	❑	Been knocked out or unconscious
❑	❑	Had a seizure, 'fit', or epilepsy
❑	❑	Had a stinger, burner or pinched nerve
❑	❑	Had heat cramps, heat illness or muscle cramps
❑	❑	Had problems with your eyes or vision
❑	❑	Sprained, strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints
❑	❑	Had any other medical problems (infectious mononucleosis, diabetes, anemia, etc.)
❑	❑	Had a medical problem or injury since your last evaluation

Yes	No	Are you?
❑	❑	Presently under a doctor's care
❑	❑	Taking any medication or pills
❑	❑	Missing an eye, kidney or testicle
		Do you?
❑	❑	Have any allergies (medicine, bees, etc.)
❑	❑	Skin problems (itching, rash, acne)
❑	❑	Trouble breathing or cough during or after exercise
❑	❑	Use any special equipment (pads, braces, eye guard, etc.)
❑	❑	Wear glasses or contacts
		Has anyone in your family?
❑	❑	Died of heart problems or sudden death before the age of 50
❑	❑	Had Marfan's syndrome

When was?

Your last tetanus shot? _____

Females only First menstrual period? _____

Last menstrual period? _____

Longest time between your periods last year? _____

Please explain any **YES** answers _____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

_____
Signature of Athlete Date

Have Part B on next page completed and signed by physician before returning to Grand View Athletic Department.

Athlete Name _____

Part B – To be completed by the Physician

Height _____ Weight _____

Blood Pressure _____ Pulse _____

Uncorrected Vision: Right eye _____ Left eye _____

Corrected Vision: Right eye _____ Left eye _____

Physical Examination		Comments
1. Eyes	❑ Ok	_____
2. Ears	❑ Ok	_____
3. Nose	❑ Ok	_____
4. Throat	❑ Ok	_____
5. Skin	❑ Ok	_____
6. Heart	❑ Ok	_____
7. Lungs	❑ Ok	_____
8. Abdomen	❑ Ok	_____
9. Extremities	❑ Ok	_____
10. Spine	❑ Ok	_____

Status

❑ Cleared for full activity ❑ Cleared, with restrictions ❑ Not cleared for activity

Comments, restrictions, other medical concerns: (i.e., asthma, diabetes, meds, allergies, etc.)

_____

_____

_____

_____

_____

Physician's Name (print)

_____

Physician's Signature Date

Return completed form to Grand View Athletic Department prior to participation.