

**University of Wisconsin – La Crosse  
Intercollegiate Athletics  
Physical Examination Form**

**PLEASE TYPE OR PRINT LEGIBLY:**

Name \_\_\_\_\_ Sport(s) \_\_\_\_\_

I.D. # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

Parent's Name \_\_\_\_\_ Parent's Phone \_\_\_\_\_

Parent's Address \_\_\_\_\_

Student-athlete's Permanent Address \_\_\_\_\_  
(If different from parent's)

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

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**Personal Health Information**

**Please list the dates for these vaccinations:**

MMR 1 \_\_\_\_\_ Polio primary series completed \_\_\_\_\_ TB Test \_\_\_\_\_  
MMR 2 \_\_\_\_\_ Hep B series completed \_\_\_\_\_ Last Tetanus Booster \_\_\_\_\_

**List any medications you are currently taking including birth control and over the counter:**

\_\_\_\_\_

**List any allergies:** \_\_\_\_\_

**Check and record date of any illness/condition you have or had in the last 5 years:**

Arthritis _____	Frost Bite _____	Heat Illness _____
Asthma _____	Hay Fever _____	Surgery _____
Concussions _____	Mononeucleosis _____	Hospitalization _____
Diabetes _____	Heart Problems _____	Tuberculosis _____
Epilepsy _____	Rheumatic Fever _____	

**Explain any current illness and/or medical limitations:** \_\_\_\_\_

\_\_\_\_\_

**Do any of the following apply to you?:**

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| Y N High Blood Pressure               | Y N Seizures                          |
| Y N Use of Orthotics                  | Y N Migraines                         |
| Y N Scoliosis                         | Y N Asthma                            |
| Y N Heart Problems                    | Y N Hearing Aid                       |
| Y N Wear Contacts/glasses             | Y N Other _____                       |
| Y N Unpaired Organ (i.e. 1 kidney)    | <b>Explain any YES answers:</b> _____ |
| Y N Passed out during sports          | _____                                 |
| Y N Family history of death before 50 | _____                                 |
| Y N Are your periods regular?         | _____                                 |

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**Physical Examination**  
(To be completed by a Physician)

Athlete's Name \_\_\_\_\_ Sport \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Heart Rate \_\_\_\_\_ Blood Pressure \_\_\_\_\_

	Normal	Comments and History of severe/chronic injury/illness
<b>Head</b>		
<b>EENT</b>		
<b>Neck</b>		
<b>Chest</b>		
<b>Abdominal</b>		
<b>Back</b>		
<b>Shoulder/Upper Arm</b>		
<b>Elbow</b>		
<b>Forearm/Wrist/Hand</b>		
<b>Hip/Thigh</b>		
<b>Knee</b>		
<b>Low Leg/Ankle/Foot</b>		

\_\_\_\_\_ **NO RESTRICTION** for collegiate athletic participation

OR

\_\_\_\_\_ **RESTRICTED PARTICIPATION** to \_\_\_\_\_

Physician's signature \_\_\_\_\_ DATE \_\_\_\_\_

Printed Physician's Name and Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**The athlete should return this to the address below before August 1<sup>st</sup> or as soon as possible !!!! You cannot begin team activities until be have this on file in the athletic training room.**

Head Athletic Trainer  
 144 Mitchell Hall  
 University of Wisconsin – La Crosse  
 La Crosse, WI 54601  
 Fax: 608-785-8674