**Pacific Lutheran University Health Center Club Sports Pre-Participation Physical Review and Medical History**

**2017-2018 Academic Year**

Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLU ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list all of the prescription and over-the counter medicines and supplements (herbal and nutritional) that you are currently taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any allergies? Yes No If yes, please identify specific allergies below:

Medicines Pollen Food Stinging insects

1. Explain all “Yes” answers below
2. In the last year, has a healthcare provider ever denied or restricted your participation in sports for any reason? Yes No
3. Do you have any new or ongoing medical conditions? If so, please identify them below:

  Asthma Anemia Diabetes Infections Other- please, provide details below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Since last season, have you had any injuries which caused you to lose time from your sport or classes? Yes No

If yes, please explain:

1. Do you have a bone, muscle, or joint injury that bothers you? Yes No
2. Have you had a head injury or concussion in the last year? Yes No
3. Do you worry about your weight? Yes No
4. Have you ever had an eating disorder? Yes No
5. Do you have any concerns that you would like to discuss with the healthcare provider?

**Attestation and Consent**

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

Signature of athlete \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian (if under age 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ As a student and/or parent or legal guardian, I consent to a comprehensive medical examination, electrocardiography, and laboratory testing as required for athletic participation. I also consent to any charges incurred for sickle cell trait screening in the event the above if the student elects to undergo this test. There are no charges for the medical examination.