

MADISON AREA TECHNICAL COLLEGE

Medical Evaluation Form

(To be completed by the student and submitted to the examining physician before he/she examines the student)

NAME (Last):	First:	Middle:
SOCIAL SECURITY NUMBER:		DATE of BIRTH:
SPORT/s:		GENDER:

PERSONAL HEALTH OF STUDENT:

Circle correct reply

1. Has had injuries of accidents requiring medical attention Yes No
2. Has had a surgical operation Yes No
3. Has been in a hospital Yes No
4. Has had sickness lasting longer than one week Yes No
5. Has dental braces or bridgework..... Yes No
6. Taking medication now or regularly Yes No
7. Has allergies or allergic to any medications Yes No
8. Has had seizures or convulsions Yes No
9. Has a condition now under a physician=s care..... Yes No
10. Any defect of hearing of eyesight? Wear glasses or contact lenses..... Yes No
11. Any reason this student should not take part in any sport?..... Yes No
12. Ever had an injury to:
 - Neck..... Yes No
 - Back..... Yes No
 - Shoulder..... Yes No
 - Elbow..... Yes No
 - Wrist..... Yes No
 - Hand..... Yes No
 - Knee..... Yes No
 - Ankle..... Yes No
 - Foot..... Yes No
13. Do you have or have you ever had:
 - Diabetes Yes No
 - Epilepsy Yes No
 - Heart Murmur Yes No
 - Hepatitis..... Yes No
 - Mononucleosis..... Yes No
 - Rheumatic Fever..... Yes No
 - Kidney Disease..... Yes No
 - Arthritis..... Yes No
 - High Blood Pressure..... Yes No
 - Abnormal bleeding..... Yes No
 - Heat exhaustion/heat stroke..... Yes No
 - Concussion..... Yes No
14. Has had complete poliomyelities immunization (Salk) or vaccine by mouth (Sabin)..... Yes No
15. Has had tetanus toxoid and booster inoculation within past 3 years Yes No

If AYES@ to any question, explain here with names and dates:

MADISON AREA TECHNICAL COLLEGE

Medical Evaluation Form - Part 2

(To be completed by Physician)

NAME (Last):	First:	Middle:
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SOCIAL SECURITY NUMBER:	DATE of BIRTH:
SPORT/s:	SEX:

Significant past illness or injury _____

_____ Height _____ Weight _____ Blood Pressure _____ Pulse Rate

Visual Acuity: R ____/____; L ____/____ Hearing R ____/____; L ____/____

Laboratory: Urinalysis: Protein _____ Sugar _____ Other _____

Physician=s Examination: (Check abnormal findings and explain below)

_____ Eyes _____ Ears _____ Nose (deformities) _____ Oropharynx
_____ Teeth _____ Respiratory _____ Breasts _____ Abdomen
_____ Spine _____ Genitalia and anus _____ Cardiovascular _____ Skin.....
_____ Neuromuscular _____ Extremities (special attention knees, ankles)

Physician=s explanation of abnormal findings: _____

I have on this date personally examined this person, reviewed the history and other data recorded on both sides of this form and find this person physically able to compete in supervised activities listed here NOT ~~CROSSED OUT~~:

Basketball Track Softball
Baseball Golf Volleyball
Cross Country Soccer Tennis Other _____

_____, M.D. _____
Physician=s Signature Physician=s Address

_____, M.D. _____
Physician=s Name Typed Date of Examination Physician=s Phone Number