



HEALTH SERVICES

PRE-PARTICIPATION SPORTS PHYSICAL EXAMINATION

Mary Walker Building #10

State University of New York at Oswego, Oswego, NY 13126
Fax# 315-312-5409 Phone# 315-312-4100 whealth@oswego.edu

Physical must be completed within six months of the first official practice of the season.

Instructions to the student athlete:

Please have your health care provider complete ALL questions and physical exam.
Return to Health Services along with your Health Record and Immunization Form via fax, email, or mail. Call with any questions.

PLEASE COMPLETE ALL OF THE FOLLOWING: (Incomplete forms will be returned)

Name: _____ Date of Birth: _____ Sport: _____
ID #: _____ Cell Phone #: _____

[] CONSENT to share information. I give permission to Health Services and SUNY Oswego Athletics to share medical information as it relates to athletic participation.

Signature of Athlete/Date

- Prior limitations on participation in sports? (i.e., illness, injuries, surgery) _____
Date(s) of limitation: _____ Date of return to play: _____
 - Presently under a health provider's care? _____
 - Current medications: _____
 - Last Tetanus booster date: _____ Are you pregnant? _____
 - Previous concussion or loss of consciousness? (Explain) _____
How many, Date(s) _____
 - Previous history of fainting or near fainting? _____ Exertional chest pain or discomfort, SOB? _____
 - Allergies (medications, hives, asthma): _____
 - Loss of paired organ function (eye, kidney, testicle)? _____
 - History of heat related illness? _____ Personal History (PH) of excessive fatigability? _____
 - PH of cardiomyopathy, hypertension, heart murmur, arrhythmia or long QT syndrome? _____
Echocardiogram Date: _____ Result: _____
 - Family History (FH) of premature death (sudden or otherwise)? _____
 - FH of significant disability from cardiovascular disease (under age 50)? _____
 - FH of Marfan's syndrome or aortic aneurysm: _____ FH of heart disease, hypertension of surviving relatives? _____
 - Have you ever tested positive for Covid-19? _____ Please list dates: _____
- Exam: WT _____ BP _____ Radial pulses _____ Femoral pulses _____ VISION: R ___ L ___
 HEENT _____ HERNIA _____
 GLANDS _____ SKIN _____
 CHEST _____ GENITALS _____
 ABD _____ HEART (Standing Supine) _____
 NEURO _____
- MUSCULOSKELETAL: U/E _____ L/E _____ SPINE _____

Approved for sports participation at SUNY Oswego: _____
Signature of Examiner/Date

STAMP WITH ADDRESS AND PHONE NUMBER.

****Sickle Cell Trait Test Result:** _____
(Blood test result required of all athletes by NCAA guidelines as of August 1, 2022)

RESTRICTIONS/LIMITATIONS: _____