WALKER HEALTH CENTER
PRE-PARTICIPATION SPORTS PHYSICAL EXAMINATION

Mary Walker Health Center, Bldg. #10
State University of New York at Oswego, Oswego, NY 13126
Fax# 315-312-5409 Phone# 315-312-4100 whealth@oswego.edu

Instructions to the student athlete:
Please have your health care provider complete **ALL** questions and physical exam.
Return to Walker Health Center along with your Health Record and Immunization Form via fax, email or mail. Call with 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 Walker Health Center and SUNY Oswego Athletics to share medical information as it relates to athletic participation. ______
Signature of Athlete/Date

1. Prior limitations on participation in sports? i.e. illness, injuries, surgery ______
   Date(s) of limitation ______ Date of return to play ______
2. Presently under a health provider's care? ______
3. Current medications: ______
4. Last Tetanus booster date: ______ Are you pregnant?______
5. Previous concussion or loss of consciousness? (Explain) ______
   How many, Date(s) ______
6. Previous history of fainting or near fainting? ______ Exertional chest pain or discomfort, SOB? ______
7. Allergies (medications, hives, asthma) ______
8. Loss of paired organ function (eye, kidney, testicle)? ______
9. History of heat related illness? ______ Personal History (PH) of excessive fatigability? ______
10. PH of cardiomyopathy, hypertension, heart murmur, arrhythmia or long QT syndrome? ______
    Echocardiogram Date ______ Result ______
11. Family History (FH) of premature death (sudden or otherwise)? ______
12. FH of significant disability from cardiovascular disease (under age 50)? ______
13. FH of Marfan's syndrome or aortic aneurysm ______ FH of heart disease, hypertension of surviving relatives? ______

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** ______

RESTRICTIONS/LIMITATIONS ______