

Year in College: 1 2 3 4

Name: _____ Date of Birth: _____ Sport(s): _____

Insurance Information: Please inform the athletic training staff as soon as possible if there are any changes in your insurance.

Parent/Guardian Name: _____

Parent/Guardian Address: _____

City: _____ State: _____ Zip: _____ Home Phone (): _____

Insurance Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policyholder: _____ Policy #: _____ Group #: _____ HMO or PPO

Does your insurance cover medical services outside of your state of residence? Yes No **Pre-Participation History**

When was your last physical examination? _____ Last tetanus booster shot? (must be within 10 years) _____

Are you under the care of a physician for any chronic medical condition(s)? Yes No

Have you ever:

- | | | | | | |
|---------------------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| passed out during exercise? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | had a wrist injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had chest pain during exercise? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | had a finger injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had a heart attack? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | had an elbow injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had a knee injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | had a hip injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had an ankle injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |
| had a shoulder injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

If yes, please give an explanation and date of occurrence: _____

Do you currently:

- | | | |
|---------------------------|------------------------------|-----------------------------|
| have high blood pressure? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| smoke cigarettes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| have back problems? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| use an inhaler? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| have joint pain? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| have diabetes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Have you:

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| had asthma or wheezing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| been dizzy during exercise? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had a head injury? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had a seizure? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| been told you have a heart murmur? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had your heart race or skipped beats? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| been hospitalized? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| had surgery? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, please give an explanation and date of occurrence: _____

Do you wear glasses or contacts? _____

Yes No

Are you missing one of any paired organ? (eye, kidney, testicle) _____

Yes No

If yes, please explain: _____

Has anyone in your family died from heart problems or died suddenly before age 55? Yes No

Are you presently taking any prescription medications? Yes No

If yes, please explain: _____

Are you allergic to any of the following:

- | | | | |
|-----------------------|------------------------------|-----------------------------|------------------------|
| Food | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, please explain |
| Medicine | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, please explain |
| Animal bites or sting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If yes, please explain |

I, the undersigned, declare to the best of my knowledge that the above questions have been answered truthfully and correctly.

Student-Athlete Signature _____ Date _____

Parent/Guardian (if student is under 18) _____ Date _____

Ashford University Physical Examination

Height _____ Weight _____

Vision R: _____ / _____ L: _____ / _____

Blood Pressure _____ Pulse _____

	Normal	Abnormal	Describe findings
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes (pupils), EN	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Maturity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine, Back	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulders, Upper	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____

Assessment

- Full Participation
- Participation contraindicated. Please give reasons _____

Examiner's Signature _____ Date _____

Examiner's Name (printed) _____

Ashford University Emergency Contact Form

Last Name _____ First Name _____ MI _____

Parents or Guardians

1) Last Name _____ First Name _____

Relationship _____ Home Phone () _____

Work Phone () _____

2) Last Name _____ First Name _____

Relationship _____ Home Phone () _____

Work Phone () _____

Other Emergency Contact

Last Name _____ First Name _____

Relationship _____ Home Phone () _____

Work Phone () _____