



Cal Maritime Athletic Pre-participation Questionnaire

Name _____ Sport _____ Date _____

Age _____ Date of Birth _____ Year in school _____

Contact Phone Number _____

Explain all "Yes" answers below. Please complete both sides of this form.

1. Have you had a medical illness or injury since your last check up or sports physical?	Yes	No	22. Do you use any special protective equipment?	Yes	No
2. Do you have any ongoing illnesses (diabetes, asthma)?	Yes	No	23. Do you have any problems with your vision?	Yes	No
3. Have you ever been hospitalized overnight?	Yes	No	24. Do you wear glasses or contacts?	Yes	No
4. Have you ever had surgery?	Yes	No	25. Have you ever had a sprain, strain, or swelling after an injury?	Yes	No
5. Are you currently taking any medications?	Yes	No	26. Have you ever broken or fractured any bones, or dislocated any joints?	Yes	No
6. Do you have any allergies (seasonal, medicine, insects)?	Yes	No	27. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	Yes	No
7. Have you ever been dizzy during or after exercise?	Yes	No	If yes, please circle appropriate body part(s), and explain below.		
8. Have you ever had chest pain during or after exercise?	Yes	No	Head	Elbow	Hip
9. Have you ever had racing of your heart or skipped heartbeats?	Yes	No	Neck	Wrist	Thigh
10. Do you have high blood pressure or high cholesterol?	Yes	No	Back	Hand	Knee
11. Have you ever been told you have a heart murmur?	Yes	No	Chest	Finger	Shin / Calf
12. Has any family member died of heart problems or of sudden death before the age of 50?	Yes	No	Shoulder	Foot	Ankle
13. Have you had a severe viral infection (mononucleosis) within the last year?	Yes	No	28. Has a physician ever denied or restricted your participation in sports?	Yes	No
14. Do you have any current skin problems?	Yes	No	29. Do you know of or do you believe there is any health reason why you should not participate in the California Maritime Intercollegiate Athletic Program at this time?	Yes	No
15. Have you ever had a head injury or concussion?	Yes	No	Record the dates of your most recent immunizations for:		
16. Have you ever been knocked out?	Yes	No	Tetanus _____	Measles _____	
17. Do you have frequent headaches or migraines?	Yes	No	Hepatitis B _____	Chicken Pox _____	
18. Have you ever had a stinger, burner, or pinched nerve?	Yes	No	Females Only		
19. Have you ever had numbness, tingling, or loss of sensation in your arms, hands, legs, or feet?	Yes	No	When was your first menstrual period? _____		
20. Do you have asthma?	Yes	No	When was your most recent Menstrual period? _____		
21. Do you cough, wheeze, or have trouble breathing during or after exercise?	Yes	No	How much time do you usually have between periods? _____		
			How many periods did you have last year? _____		
			What was the longest time between periods? _____		

Explain all "Yes" answers here (use back of page if needed): _____

The undersigned, herewith:
A. Understands that I must refrain from the practice or play while ill or injured whether or nor receiving medical treatment until I am discharged from treatment or am given permission by the clinical practitioner to restart participation despite continuing treatment.
B. Understands that having passed the pre-participation exam does not necessarily mean that I am physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify me at said time of evaluation.
C. Certifies that the answers to the questions above are correct and true.

Athlete's Signature _____ Date _____
Legal Guardian signature (if under 18) _____

ATC Signature _____ **Physician Signature** _____ Date _____

CLEARED CLEARED, PENDING EVALUATION NOT CLEARED



Cal Maritime Athletic Pre-participation Physical Exam

Name _____	Sport _____	Date _____
Age _____	Date of Birth _____	Year in school _____
Contact Phone Number _____		
Ht _____	Wt _____	BP _____
HR _____	Vision (R) _____ (L) _____	

	NORMAL	ABNORMAL FINDINGS	INITIALS
Medical			
Appearance			
Eyes/Ears/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation / rehabilitation for: _____

Not Cleared for: _____

Recommendations: _____

Name of Physician (stamp) _____ **Date:** _____

Address _____ **Phone** _____

Signature of Physician _____