To the Student Athlete:
Please complete your part of the form before going to your physician for the examination. This completed form must be returned to the **Terry Campus** Athletic Department.

DELAWARE TECHNICAL COMMUNITY COLLEGE

PHYSICAL FORM

_____ /___/ /___/

Last Name (Print) First Name ID# Sex: Male Female

_____

Home Address (Number & Street) City or Town State Zip Code Date of Birth

_____

Name, Relationship, & Address of Next of Kin Home Telephone Number

_____

Next of Kin's Business Address Business Telephone

Personal History. Please answer **all** questions. Comment on all positive answers in space below or on additional sheet.

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Scarlet Fever	___	___	Head injury with unconsciousness	___	___	Back Problems	___	___
Measles	___	___	Hay Fever/Asthma	___	___	Tumor/Cancer/Cyst	___	___
German Measles	___	___	Tuberculosis	___	___	Jaundice	___	___
Mumps	___	___	Shortness of Breath	___	___	Stomach/Intestinal Trouble	___	___
Chicken Pox	___	___	Allergy:			Gallbladder Trouble or Gallstones	___	___
Malaria	___	___	Penicillin	___	___	Recurrent Diarrhea	___	___
Gum/Tooth Trouble	___	___	Sulfonamides	___	___	Rupture, Hernia	___	___
Sinusitis	___	___	Serum	___	___	Recent gain or loss of weight	___	___
Eye Trouble	___	___	Foods (which)	___	___	Dizziness/Fainting	___	___
Ear/Nose/Throat Trouble	___	___	Other	___	___	Weakness/Paralysis	___	___
Hepatitis	___	___	Pain/Pressure in chest	___	___	Venereal Disease	___	___
Surgery:			Chronic Cough	___	___	Albumin/Sugar in Urine	___	___
Appendectomy	___	___	Palpitations (Heart)	___	___	Frequent Urination	___	___
Tonsillectomy	___	___	High/Low Blood Pressure	___	___			
Hernia Repair	___	___	Rheumatic Fever or Heart Murmur	___	___			
Other	___	___						
Insomnia	___	___						
Frequent Anxiety	___	___	Disease or Injury of Joints	___	___	Females Only:		
Frequent Depression	___	___				Irregular Periods	___	___
Recurrent Headache	___	___	"Trick" Knee, Shoulder, etc.	___	___	Severe Cramps	___	___
Recurrent Colds	___	___				Excessive Flow	___	___

A. Has your physical activity been restricted during the past five years? Give reasons and durations. ___ ___

B. Have you had difficulty with school, studies, or teachers? (Give details) ___ ___

C. Have you received treatment or counseling for a nervous condition, personality or character disorder or emotional problem? (Give details.) ___ ___

D. Have you had any illness or injury or been hospitalized other than already noted? (Give details) ___ ___

E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?) ___ ___

F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons.) ___ ___

_____ _____

Student Athlete's Signature Date Delaware Tech Student Identification #

REPORT OF HEALTH EVALUATION

To the Examining Physician: Please review the attached Health History and complete this physical examination form. Please comment on all positive answers.

_____ /___/ /___/
Last Name First Name Middle Sex: Male Female

BP _____/_____ Height _____ feet _____ inches

Corrected Vision
Right 20/ Left 20/ Weight _____

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No		Yes	No
Head/Ears/Nose/Throat	___	___	Genitourinary	___	___
Respiratory	___	___	Musculoskeletal	___	___
Cardiovascular	___	___	Metabolic/Endocrine	___	___
Gastrointestinal	___	___	Neuropsychiatric	___	___
Hernia	___	___	Skin	___	___
Eyes	___	___	Lymph Nodes	___	___

Is there loss or seriously impaired function of any organ? ___ ___

Have you any general comments? _____
_____

Recommendations for physical activity: ___ Unlimited ___ Limited
Explain: _____
_____

Do you have any recommendations regarding the care of this student? ___ ___
Explain: _____
_____

Is the patient now under treatment for any medical or emotional condition? ___ ___

Physician's Signature: _____ Date:_____

Name & Address (Please Print) _____

_____

Return all information to:
Delaware Technical Community College
Athletic Department
100 Campus Drive
Dover, DE 19904
Office: (302) 857-1024
Fax: (302) 857-1806

ki/11/03/14/physical.frm/micrsoft