



**Lake Land College Athletic Physical Form**

5001 Lake Land Blvd.  
Mattoon, IL 61938

**This form must be completed and on file prior to the start of practice. Athletic Physicals are good for one year only....starting with the date completed. Please print!**

Date \_\_\_\_\_

**Sport:** Baseball \_\_\_\_\_ Men's Basketball \_\_\_\_\_ Women's Basketball \_\_\_\_\_ Volleyball \_\_\_\_\_  
Cheer/Dance \_\_\_\_\_ Men's Tennis \_\_\_\_\_ Softball \_\_\_\_\_

**Student Name:** \_\_\_\_\_  
Last First

**Student Address:** \_\_\_\_\_  
Street City State Zip Phone

**Parents:** \_\_\_\_\_  
Last First Phone (H) (W)

**Parents Address:** \_\_\_\_\_  
Street City State Zip

**S S N:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_ **Sex:** M \_\_\_\_ F \_\_\_\_

**Medical History:** (check ones that apply to you)

Ulcer/colitis \_\_\_\_\_ Diabetes \_\_\_\_\_ Back Problems \_\_\_\_\_ Cancer \_\_\_\_\_ Seizure Disorder \_\_\_\_\_

Hearing/Vision \_\_\_\_\_ Pneumonia/Lung Conditions \_\_\_\_\_ Heart disease \_\_\_\_\_ Migraines \_\_\_\_\_

Psychological \_\_\_\_\_ Other (please specify) \_\_\_\_\_

Family history of cardiac/heart problems resulting in death under the age of 50? Yes \_\_\_\_ No \_\_\_\_

**Injuries (including fractures)** \_\_\_\_\_

\_\_\_\_\_  
**Surgeries/Hospitalizations** \_\_\_\_\_

**List Medications: (include over-the-counter)** \_\_\_\_\_

**Signature of Student:** \_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_ SSN: \_\_\_\_\_

**NOTE:** This physical examination to be completed by physician.

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_

Allergies: \_\_\_\_\_ Vision \_\_\_\_\_ Glasses \_\_\_\_\_ Contact Lenses \_\_\_\_\_

	<u>Normal</u>	<u>Abnormal</u>	<u>As follows</u>
General	( )	( )	_____
Head, Eyes, Ears, Nose, Throat, Teeth	( )	( )	_____
Cardio-Pulmonary	( )	( )	_____
G.I. System	( )	( )	_____
Hernia	( )	( )	_____
G.U. System	( )	( )	_____
Musculo/Skeletal	( )	( )	_____
Neurological	( )	( )	_____

Other findings: \_\_\_\_\_  
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**Urinalysis:** Sugar \_\_\_\_\_ Albumin \_\_\_\_\_ Micro (if indicated) \_\_\_\_\_

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Please rate health:    Excellent    Good    Fair    Poor

Recommendations: \_\_\_\_\_

\_\_\_\_\_, M.D.  
Signature - Examining Physician

\_\_\_\_\_, M.D.  
Printed Name of Examining Physician

\_\_\_\_\_  
Physician Address

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) \_\_\_\_\_  
Telephone Number