

ATHLETIC PHYSICAL FORM

Lake Land College Athletics
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This form must be completed and on file prior to the start of practice including open gyms. Per NJCAA guidelines, athletic physicals are good for 13 months starting with the date completed. Please print.

Date: _____ Sport: Baseball Men's Basketball Cheer/Dance
 Softball Women's Basketball Volleyball

STUDENT INFORMATION:

LAST NAME	FIRST NAME	DOB
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SSN	AGE	GENDER	PHONE
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STUDENT'S ADDRESS

PARENT'S NAME	PHONE
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PARENT'S ADDRESS

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:	
Family history of cardiac/heart problems resulting in death under the age of 50? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Injuries (including fractures):		Surgeries/Hospitalizations:	
List prescription and over-the-counter medications:			

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

STUDENT'S SIGNATURE	DATE
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Name: _____ SSN: _____ Date: _____

PHYSICAL INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER):

EXAMINATION				
Age:	Weight:	Height:	B/P: /	Pulse:
Allergies:	Vision:	Glasses:	Contact Lenses:	

	NORMAL	ABNORMAL	COMMENTS
General			
Head, Eyes, Ears, Nose, Throat, Teeth			
Cardio-Pulmonary			
G.I. System			
Hernia			
G.U. System			
Musculo/Skeletal			
Neurological			
Other findings:			
Health rating: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Recommendations:			
ATHLETE CLEARED TO PARTICIPATE WITHOUT RESTRICTION: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Name of physician (print): _____

Address: _____ Phone: _____

Signature: _____ Date: _____