



HEALTH / PHYSICAL FORM

College Connection Site(s) attending (please circle): West Chester Univ. Univ. of Massachusetts

This Form MUST complete and on file complete BEFORE APRIL 1ST for full participation

Last Name _____ First Name _____ DOB _____

Health Insurance Company: _____ Membership Number: _____

Emergency Contact: _____ Phone Number: _____

APPLICANT HAS HAD (dates MUST be provided) – ATTACH SEPARATLY IF DESIRED

DISEASE	VACCINATION	IMMUNIZATION
Measles	_____	_____
Hepatitis B (for children born after 1/1/92)	_____	_____
Mumps	_____	_____
Whooping Cough	_____	_____
Chicken Pox	_____	_____
Tetanus	_____	_____
Diphtheria	_____	_____
Polio	_____	_____
TB Test	_____	_____

PLEASE CHECK THE APPLICANTS FOLLOWING HEALTH PROBLEMS IN THE PAST OR PRESENT AND GIVE THE YEAR. Have you ever had, or now have, any of the following?

General	Yes	No	Briefly Explain
Asthma	_____	_____	_____
Tuberculosis	_____	_____	_____
Polio	_____	_____	_____
Diabetes	_____	_____	_____
Allergies	_____	_____	_____
Medications	_____	_____	_____
Food	_____	_____	_____
Bee Stings	_____	_____	_____
Fungus	_____	_____	_____
Herpes	_____	_____	_____
Staph (Boils)	_____	_____	_____
Cyst or Lumps	_____	_____	_____
Spleen Injury	_____	_____	_____
Contact Lenses	_____	_____	_____

Are you currently taking any medications, prescribed or otherwise? _____ Yes _____ No

If yes, please explain: _____

Neurological	Yes	No	Briefly Explain
Head Injury	_____	_____	_____
Concussion	_____	_____	_____
Nose Fracture	_____	_____	_____
Neck Injury	_____	_____	_____
Heat Problems	_____	_____	_____

Cardiopulmonary	Yes	No	Briefly Explain
Chest Pains	_____	_____	_____
Palpitations	_____	_____	_____
Shortness of Breath	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Murmur	_____	_____	_____
Fainting	_____	_____	_____

Orthopedic	Yes	No	Briefly Explain
Foot/Ankle	_____	_____	_____
Lower Leg/Knee	_____	_____	_____
Thigh/Hip/Groin	_____	_____	_____
Back/Ribs	_____	_____	_____
Neck/Shoulder	_____	_____	_____
Arm/Elbow/Wrist	_____	_____	_____
Hand/Fingers	_____	_____	_____
Other	_____	_____	_____

Please list any other pertinent medical history: _____

Attending Physician: _____
 Current Vitals:
 Height: _____ Weight: _____ Pulse: _____ B.P. _____

The above named individual has received a physical examination **on or AFTER June 20th 2009** for her general health and is cleared for activity in College Connection.

Physician Signature: _____ **Date:** _____
 Must be signed to be valid

Physician Address: _____

Physician Phone: _____

Participant: The responses to the questions on this form are correct to the best of my knowledge.

Participant's Signature: _____ **Date:** _____
 Must be signed to be valid

Parent/Guardian:

I understand and accept that risk of injury is possible while playing or practicing the sport of field hockey. I authorize the directors to act for me according to their best judgment in any emergency requiring medical attention.

Parent and/or Guardian's Signature: _____ **Date:** _____
 Must be signed to be valid