

Return all information to:
 Illinois Wesleyan University
 Athletic Training
 PO Box 2900
 Bloomington, IL 61702



Illinois Wesleyan University Athletic Training
 Ph. (309) 556-3601 Fax (309) 556-3484

This form is due:
August 1 for Fall Semester
December 1 for Spring Semester and/or May Term

Sex: Male Female

Last Name (Print) _____ First Name _____ Middle _____

Date of Birth _____ Social Security Number _____ E-Mail Address _____ Cell Phone Number _____

Home Address (Number and Street) _____ City or Town _____ State _____ Zip Code _____

Parent or Guardian _____ Cell Phone Number _____ Home Telephone _____

Alternative Emergency Contact – Name, Relationship _____ Cell Phone Number _____ Home Telephone _____

MEDICAL HISTORY TO BE COMPLETED BY STUDENT

Allergies to Drug(s)/Medication(s) No Yes (list) _____

Allergies to foods, nuts, insects, environmental No Yes (list) _____

Have you ever been diagnosed with any of the following: If Yes provide details below:

	Yes	No		Yes	No		Yes	No
Anemia (including sickle cell anemia)			Epilepsy or other seizure disorder			Inflammatory bowel, Crohn's		
Arthritis			Fracture/Dislocation			Kidney or bladder infection, stone		
Asthma			Guillain Barre			Migraine headache		
Bleeding disorder			Head injury			Pneumonia		
Cancer (incl. leukemia, Hodgkin's)			Heart murmur/Valve problem			Positive TB test/Tuberculosis		
Diabetes			High blood pressure			Psychiatric/Psychologist care		
Disordered eating (anorexia or bulimia)			Immunodeficiency disorder			Thyroid disorder		
Drug or alcohol dependency			Infectious mononucleosis			Serious accident or injury		

Women's Health				Men's Health			
Condition	Yes	No		Condition	Yes	No	
Removal of breast lump or cyst \breast cancer				Lump or mass in testicle			
Missed periods more than four months							
Excessive flow							

FAMILY MEDICAL HISTORY

Check each item	Yes	No	Relationship	Yes	No	Relationship
Father living				Heart disease		
Mother living				High blood pressure		
Alcoholism				Nervous or mental disorder		
Cancer				Thyroid disease		
Diabetes				Tuberculosis		

Have you consulted or been treated by clinics, healthcare provider(s), healer(s) or other practitioners within the past five years? (Other than routine checkups.) Yes No If Yes, provide details below.

Details _____

Attach additional sheet if necessary.

Signature of Student or Parent/Guardian (if under 18 years of age) _____ Date _____

This information is strictly for the use of the Athletic Training Department and will not be released to anyone without your knowledge and written consent.

Student-athletes are required to have the following exam completed no more than six (6) months prior to participation in IWU Athletics.

 Last Name (Print) First Name Middle Date of Birth Sport

HEALTH CARE PROVIDER EXAMINATION

Please correlate the student's medical history with your findings, and record below. All entries must be completed and in English.

Male Female Height _____ Weight _____

Blood Pressure _____ / _____ Pulse _____

Current Medications: _____

Enter "N.E." if not evaluated WNL ABN Give detail of abnormality

Head, Neck, Face and Scalp			
Nose and Sinus			
Mouth, Teeth, Gingiva and Throat			
Eyes			
Ears			
Lungs, Chest and Breast			
Heart			
Abdomen and Viscera (include hernia)			
Endocrine System			
Genito-Urinary System			
Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric			

Is this individual capable of normal physical activity? (athletics, physical education) Yes No

If no, give reasons and limitations/restrictions on comments line below.

- No disability Physical disability Emotional/psychiatric disability
 Learning disability History of Disordered Eating (anorexia/bulimia)

Comments: _____

I certify I have reviewed the history and immunization information and performed a physical exam on the above named patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.

 Date of Examination

 Health Care Provider's Signature

 Print Name of Health Care Provider

 Address

 Health Care Provider Telephone

 City State Zip Code