

**Rhode Island College**  
**ADMISSION AND PREPARTICIPATION PHYSICAL**  
**Required for Athletes, Nursing Majors, and Residential Students**  
*Student must complete this side prior to physical examination.*

Name \_\_\_\_\_

Age \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex \_\_\_\_\_

**Medical History**

- |                                                                                                                                                                                                     | Yes   | No    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|
| 1. Do you have any allergies? ( <i>Drugs, Food, Insect Stings, etc.</i> )<br><i>If yes, list:</i> _____<br>If yes, Do you carry an Epi-pen? _____<br>If yes, Do you wear Medic-Alert jewelry? _____ | _____ | _____ |
| 2. Are you currently taking any drugs or medications including steroids or protein supplements?<br>( <i>Daily or occasionally</i> )<br><i>List:</i> _____                                           | _____ | _____ |
| 3. Are you presently being treated for any condition by a health care professional?<br><i>Explain:</i> _____                                                                                        | _____ | _____ |
| 4. Have you ever been advised by a provider not to participate in any sport/activity?<br><i>If yes, explain:</i> _____                                                                              | _____ | _____ |
| 5. Do you use any protective equipment/devices while playing sports?<br><i>If yes, explain:</i> _____                                                                                               | _____ | _____ |
| 6. Do you, or do any <b>immediate</b> family members (parents, sisters, brothers or grandparents), have any chronic conditions, disorders or diseases?                                              |       |       |

- |                                 |                              |                                                      |                           |              |
|---------------------------------|------------------------------|------------------------------------------------------|---------------------------|--------------|
| _____ Asthma                    | _____ Bleeding Disorders     | _____ Diabetes                                       | _____ Epilepsy (Seizures) | _____ Cancer |
| _____ Hepatitis (Liver Disease) | _____ Hypertension (High BP) | _____ Sickle Cell Anemia                             | _____ Mental Illness      | _____ Other  |
| _____ Mononucleosis Yr. _____   | _____ Heart Disease          | _____ Handicap or congenital disease(describe) _____ |                           |              |

**Please check where applicable** if you have or have had any of the following:

	Yes	No		Yes	No
Head injury, concussion, or been unconscious			Eye injury or retinal detachment		
Headaches more than once a week			Wear glasses or contact lenses		
Lack of feeling or numbness in any body part			Nose bleeds for no reason		
Heat exhaustion or heat stroke			False teeth, caps or braces		
Difficulty running 1/2 mile without stopping			Rash or skin problem		
Chest pain, dizziness or passing out during exercise			Missing or malfunction of any body part (eg. kidney, eye, ear, testicle)		
Coughing, wheezing or gasping for breath with exercise or cold weather			Bruising easily or taking a long time to stop bleeding when cut		
Smoke cigarettes or chew tobacco			Neck, spine or low back injury or pain		
Heart problem, murmur or arrhythmia			Lump(s) in arm pit or groin		
Family member with a heart attack or sudden death under age 50			Black or bloody bowel movements (stools)		
Loss or gain of more than 10 lbs. in last year			Kidney disease or dark, brown or bloody urine		
Special diet for medical reasons			Diarrhea more than once a week		
<i>Females: Date of last period:</i>			<i>Disabling cramps with menstrual periods</i>		
<i>Absent or irregular monthly periods</i>					

**Within the last five years, have you been hospitalized (for medical or surgical reasons) or sustained an injury that did not allow you to participate in regular activities for more than a week?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide the following information:

INJURY OR MEDICAL PROBLEM	YEAR	RESOLVED	
		YES	NO

I hereby state that I have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge:

STUDENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PARENT/ GUARDIAN SIGNATURE \_\_\_\_\_  
(IF STUDENT UNDER 18)

DATE \_\_\_\_\_

Provider's Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_