PHYSICAL FORM

Sports Candidates Questionnaire

Part1- (to be completed by student, parents)

Name_____ Student ID #_____

_____

Home Address_____City_____State ____

Student's Cellphone #_____ Birthdate: _____Height_____ Weight: ___

Parent(s) Name(s)_____ Parent's Cellphone # _____

[Circle all answer]

1. Had injuries requiring medical attention……..YES NO
2. Had illness lasting more than a week……YES NO
3.Is under a physicians care now……...YES NO
4. Takes medication now……...YES NO
5. Wears glasses……YES NO Contacts…….YES NO
6. Had surgical operation…….....YES NO
7.Has been hospitalized (except for tonsillectomy)……YES NO
8. Do you know of any reason this individual should not participate in sports?.....YES NO

Please explain any "YES" answers to the above questions:_____

_____

_____

The undersigned,

A. Understands the risks of participation in the above program and that he or she must refrain from practice or play while ill or injured and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
B. Understands that passing a physical examination does not necessarily mean that he or she is physically qualified to engaged in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
C. Certifies that the answers to the questions above are correct and true.

_____ _____

Student's signature Parent's signature (if under 18 years)

Part 2- (To be completed by student or parents)

This is to certify that the above named student is currently enrolled in an accident insurance program which includes coverage of participation in collegiate physical education and athletic programs. Massachusetts Mandatory Health Insurance Law requires all students (nine or more credits) to participate in the HCC plan or in a program with comparable coverage. Note comparable coverage requires a written waiver on a form provided by the college.

CHECK ONE: ◯ QCC Health Insurance Plan ◯ Waiver (your own Health Insurance)

Insurance Provider: _____ Primary Care Physician: _____

_____ _____

Student's signature Parent's signature (if under 18 years)

Part 3- Medical examination for Quinsigamond Community College
(to be completed by Physician/PA/NP)

This is to verify a thorough medical examination on the above named student on this date. In my opinion, said student is physically capable of handling the rigors required for varsity sports, and physical education, intramurals and other programs at Quinsigamond Community College.

_____ _____

Date Physician/Physician Assistant/Nurse Practioner Signature

_____

Address

_____

_____

_____

Phone Number

Part 4-

In my opinion the above named student is **NOT** physically capable of handling the rigors required for varsity sports physical education, intramurals and other programs at Quinsigamond Community College.

_____ _____

Date Physician/Physician Assistant/Nurse Practioner Signature

_____

Address

_____

_____

_____

Phone number