



ATHLETICS
670 West Boylston Street
Worcester, MA 01606-2092
Phone: 508-854-4317
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PHYSICAL FORM

Sports Candidates Questionnaire

Part1- (to be completed by student, parents)

Name _____ Student ID # _____

Home Address _____ City _____ ST _____

Parent(s) Name(s) _____ Tel. # _____

Birthdate _____ HT _____ WT _____

[Circle all answer]

- | | | |
|--|--|---------------------|
| 1. Had injuries requiring medical attention.....YES NO | 5. Wears glasses.....YES NO | Contacts.....YES NO |
| 2. Had illness lasting more than a week.....YES NO | 6. Had surgical operation.....YES NO | |
| 3. Is under a physicians care now.....YES NO | 7. Has been hospitalized (except for tonsillectomy)..... YES NO | |
| 4. Takes medication now.....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)

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