

# Southwest Tech Golf

## Medical Evaluation Form – Part 1

*(To be completed by the student and submitted to the examining physician before he/she examines the student)*

NAME (Last):	First:	Middle:
SOCIAL SECURITY NUMBER:		DATE of BIRTH:
SPORT/s: <b>GOLF</b>		GENDER:

**PERSONAL HEALTH OF STUDENT:**

Circle Correct Reply

- |  |     |    |
|--|-----|----|
| 1. Has had injuries of accidents requiring medical attention .....                       | Yes | No |
| 2. Has had a surgical operation .....  | Yes | No |
| 3. Has been in a hospital .....  | Yes | No |
| 4. Has had sickness lasting longer than one week .....                                   | Yes | No |
| 5. Has dental braces or bridgework.....  | Yes | No |
| 6. Taking medication now or regularly.....   | Yes | No |
| 7. Has allergies or allergic to any medications .....                                    | Yes | No |
| 8. Has had seizures or convulsions .....   | Yes | No |
| 9. Has a condition now under a physician' s care.....                                    | Yes | No |
| 10. Any defect of hearing or eyesight? Wear glasses or contact lenses.....               | Yes | No |
| 11. Any reason this student should not take part in any sport?.....                      | Yes | No |
| 12. Ever had an injury to:   |     |    |
| Neck.....  | Yes | No |
| Back.....  | Yes | No |
| Shoulder.....  | Yes | No |
| Elbow.....   | Yes | No |
| Wrist .....  | Yes | No |
| Hand .....   | Yes | No |
| Knee.....  | Yes | No |
| Ankle .....  | Yes | No |
| Foot.....  | Yes | No |
| 13. Do you have or have you ever had:  |     |    |
| Diabetes .....   | Yes | No |
| Epilepsy .....   | Yes | No |
| Heart Murmur .....   | Yes | No |
| Hepatitis.....   | Yes | No |
| Mononucleosis.....   | Yes | No |
| Rheumatic Fever.....   | Yes | No |
| Kidney Disease .....   | Yes | No |
| Arthritis.....   | Yes | No |
| High Blood Pressure .....  | Yes | No |
| Abnormal bleeding .....  | Yes | No |
| Heat exhaustion/heat stroke .....  | Yes | No |
| Concussion.....  | Yes | No |
| 14. Has had complete poliomyelities immunization (Salk) or vaccine by mouth (Sabin)..... | Yes | No |
| 15. Has had tetanus toxoid and booster inoculation within past 3 years .....             | Yes | No |

**If you answered YES to any question, explain with names and dates:**

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# Southwest Tech Golf

## Medical Evaluation Form - Part 2

*(To be completed by Physician)*

<b>NAME (Last):</b>	<b>First:</b>	<b>Middle:</b>
<b>SOCIAL SECURITY NUMBER:</b>		<b>DATE OF BIRTH:</b>
<b>SPORT/s:</b>		<b>SEX:</b>

Significant past illness or injury \_\_\_\_\_

\_\_\_\_\_ Height      \_\_\_\_\_ Weight      \_\_\_\_\_ Blood Pressure      \_\_\_\_\_ Pulse Rate

Visual Acuity: R \_\_\_\_/\_\_\_\_; L \_\_\_\_/\_\_\_\_      Hearing R \_\_\_\_/\_\_\_\_; L \_\_\_\_/\_\_\_\_

Laboratory: Urinalysis: Protein \_\_\_\_\_ Sugar \_\_\_\_\_ Other \_\_\_\_\_

Physician's Examination: (Check abnormal findings and explain below)

_____ Eyes	_____ Ears	_____ Nose (deformities)	_____ Oropharynx
_____ Teeth	_____ Respiratory	_____ Breasts	_____ Abdomen
_____ Spine	_____ Cardiovascular	_____ Genitalia and anus	_____ Skin
_____ Neuromuscular		_____ Extremities (special attention knees, ankles)	

Physician's explanation of abnormal findings: \_\_\_\_\_

I have on this date personally examined this person, reviewed the history and other data recorded on both sides of this form and find this person physically able to compete in supervised College Golf:

\_\_\_\_\_, M.D. \_\_\_\_\_  
 Physician's Signature      Physician's Address

\_\_\_\_\_, M.D. \_\_\_\_\_  
 Physician's Name Typed      Date of Examination      Physician's Phone Number