Florida National University®
SINCE 1982
OPENS DOORS TO THE FUTURE

Student-Athlete Information and Medical History (Returning Students)

(All information will be kept confidential)

Student-Athlete Information:

Name: ______________________________ Today's Date: ____________________

Sport(s): ______________________________ Birthdate: _____________ Age: _____

Year in School (circle): Fresh. Soph. Jun. Sen. Grad. Sex (circle): Male Female

Status (circle): US Citizen International Resident Asylum Other: __________________

Local Address: ________________________ City: ___________ State: ____ Zip: ______

E-mail: ____ Cell: _________________________

Marital Status: Single Married Divorced Widowed Separated

Spouse Name: _________________________________ Cell: _________________________

Guardian / Emergency Contact Information:

Name:
Relationship:
Address:
City:
State / Zip Code:
E-mail:
Cell:

Name:
Relationship:
Address:
City:
State / Zip Code:
E-mail:
Cell:

Personal Medical History:

Circle any area(s) below if you have you had any new problems since your last physical.

Head
Eyes
Ears / Nose / Throat
Mouth / Teeth
Skin
Heart
Lungs

Stomach
Abdomen
Ribs
Shoulder / Elbow / Arm
Wrist / Hand / Finger
Back
Hip

Knee
Ankle / Foot / Toes
Blood
Mental Health
Urination / Bowel Movement
Genitals and/or menstruation
Other:

Orthopedic Injuries / Surgeries (within the past two years):

Injury:	Date(s):	Comments:

Updated: April 2024

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I certify that all the above information is true and accurate to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in intercollegiate athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Student Signature: ____ Date: _____________

Parent Signature (if under 18): _______________________________ Date: _____________

Physical Examination Page 1 of 2

Name: ___________________________________ Today's Date: ___________________

Sport(s): _________________________________ Birthdate: ____________ Age: _____

Must be completed by M.D. or D.O. (No Exceptions)

Height: __________ Weight: _________ Body Composition: ____________________

Pulse: ___________ Blood Pressure: _____ / _____ (_____ / _____, _____ / _____)

Vision: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal Unequal

Musculoskeletal	Normal	Abnormal	Initial
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Posture			
Flexibility			
Strength			

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Physical Examination Page 2 of 2

Name: ___________________________________ Today's Date: ___________________

Sport(s): _________________________________ Birthdate: ____________ Age: _____

Medical	Normal	Abnormal	Initial
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Pulses			
Lungs			
Abdomen			
Genitalia (Males only)			
Skin			
Dental			

Must be completed by M.D. or D.O. (No Exceptions)

Circe: **Cleared** / **Not Cleared** Reason: _____________________________________

Recommendations / Restrictions / Limitations:

____

____

____

Name of the Physician (print/type): ____

Address: _______________________________________ Phone: _____________________

Physician Signature: ____

Medical Stamp Required →

Updated: April 2024