



# Santa Barbara City College

Santa Barbara Community College District

721 Cliff Drive □ Santa Barbara, Calif. 93109-2394 □ (805) 965-0581 / FAX (805) 963-7222

## PHYSICAL SCREENING

Name: \_\_\_\_\_ K # \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ b/m

**\* \*Have Medical history form filled out completely and available for physician's review.\* \***

### Physical Examination

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#### Head:

Eyes: R20 \_\_\_\_\_ L20 \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_

Respiratory Impairment: \_\_\_\_\_

Cardiovascular abnormalities: \_\_\_\_\_

Genitalia: \_\_\_\_\_

Hernia: \_\_\_\_\_

Non-Paired Organs: \_\_\_\_\_

#### Musculo-skeletal Evaluation (list abnormalities/restrictions)

Neck-Spine: \_\_\_\_\_

Shoulder Girdle: \_\_\_\_\_

Upper Extremity: \_\_\_\_\_

Trunk: \_\_\_\_\_

Ribs: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Hip-Thigh-Knee: \_\_\_\_\_

Ham/Quad: \_\_\_\_\_

Ligament Instability: \_\_\_\_\_

Joint effusion, crepitus: \_\_\_\_\_

Calf-Ankle-Foot: \_\_\_\_\_

Achilles, Anterior Compartment: \_\_\_\_\_

Ligament Instability: \_\_\_\_\_

Joint effusion, crepitus: \_\_\_\_\_

Foot and arches: \_\_\_\_\_

Comments and Recommendations: \_\_\_\_\_

I hereby certify that, \_\_\_\_\_ was examined by me on the above date. At that time no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in any sport, except \_\_\_\_\_ (if none, state none)

Examining Physician: \_\_\_\_\_ Date: \_\_\_\_\_

NAME: \_\_\_\_\_  
LAST \_\_\_\_\_  
FIRST \_\_\_\_\_  
SPORT \_\_\_\_\_  
MW

# Flexibility and Stability Exam

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<b><u>Standing:</u></b>	<b><u>Pass</u></b>	<b><u>Fail</u></b>	<b><u>Comments</u></b>
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- |                          |       |       |  |
|--------------------------|-------|-------|--|
| • Posture                | _____ | _____ |  |
| • Lumbar Forward Flexion | _____ | _____ |  |
| • Squat                  | _____ | _____ |  |

<b><u>Sitting:</u></b>	<b><u>Pass</u></b>	<b><u>Fail</u></b>	<b><u>Comments</u></b>
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- |                                |       |       |  |
|--------------------------------|-------|-------|--|
| • Posture                      | _____ | _____ |  |
| • Neck ROM                     | _____ | _____ |  |
| • Empty Can                    | _____ | _____ |  |
| • Internal Rotation (Strength) | _____ | _____ |  |
| • External Rotation (Strength) | _____ | _____ |  |
| • Piriformis Test (ROM)        | _____ | _____ |  |

<b><u>Supine:</u></b>	<b><u>Pass</u></b>	<b><u>Fail</u></b>	<b><u>Comments</u></b>
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- |                           |       |       |  |
|---------------------------|-------|-------|--|
| • Internal Rotation (ROM) | _____ | _____ |  |
| • External Rotation(ROM)  | _____ | _____ |  |
| • Thomas Test             | _____ | _____ |  |
| • Straight Leg Raise      | _____ | _____ |  |

<b><u>Prone:</u></b>	<b><u>Pass</u></b>	<b><u>Fail</u></b>	<b><u>Comments</u></b>
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- |                         |       |       |  |
|-------------------------|-------|-------|--|
| • Internal Hip Rotation | _____ | _____ |  |
| • External Hip Rotation | _____ | _____ |  |

<b><u>Side lying:</u></b>	<b><u>Pass</u></b>	<b><u>Fail</u></b>	<b><u>Comments</u></b>
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- |                       |       |       |  |
|-----------------------|-------|-------|--|
| • Glut Strength       | _____ | _____ |  |
| • Piriformis Strength | _____ | _____ |  |

Overall Comments/Concerns: \_\_\_\_\_

Performed by: \_\_\_\_\_



4. ABDOMEN

	Y	N
A. Ulcer of the stomach		
B. Diarrhea, chronic or recurrent		
C. Jaundice		
D. Tumor, growth, cyst, caancer		
E. Hernia (rupture)		
F. Hemorrhoids (piles) or rectal bleeding		
G. Frequent or painful urination		
H. Kidney stones or blood in urine		
I. Sugar or albumin in urine		
J. Abdominal pain		
K. Appendectomy		
L. Bladder infection		
M. Prostate trouble		
N. Other		

5. BONE AND JOINT

A. Neck (nerve, bones, disc)		
B. Backache		
C. Back (nerves, bones, disc)		
D. Worn neck\back brace or support		
E. Shoulder dislocation		
F. Elbow sprain, disloc, fx		
G. Wrist, Hand, Finger injury		
H. Hip and/or groin		
I. "Trick knee", loose, locked,...		
J. Knee ligament sprain - loose		
K. Kne cartilage - click, lock		
L. Tendonitis of knee		
M. Kneecap sublux, grinding		
N. Chronic, repetitive shin splints		
O. Frequent, severe sprained ankles		
P. Foot, Toe, Arch injuries		
Q. Other bone/joint disability\deformity		
Δ. Muscle strain - "pulls" (loc,sev,recoccur)		
S. Vericose veins		
T. Paralysis (including poliomyelitis)		
U. Advised surgery for any of the above		
V. Surgery completed (type,date,status)		
W. Have pin, screw, plate (loc, status)		
X. Wear specialized protective equip - type		

6. NERVOUS SYSTEM

A. Convulsions or Epilepsy		
B. Difficulty in going to sleep		
C. Excessive mood swings		
D. Psychiatric treatment		
E. Difficulty in concentrating		
F. Loss of memory or amnesia		
G. Illness due in part to nervousness		
H. Excessive sleepiness		

7. CHRONIC DISEASES

A. Diabetes		
B. Recurrent boils		
C. Recent\sudden gain or loss of weight		
D. Chronic skin disease		
E. Rheumatic fever		
F. Other		

8. INFECTIOUS DISEASES

	Y	N
A. Infectious hepatitis		
B. Infectious mononucleosus		
C. Malaria		
D. Venereal disease		
E. Rubella		
F. Measles		
G. Other		

9. DO YOU TAKE ANY MEDICATION SUCH AS:

A. Insulin		
B. Thyroid		
C. Dilantin		
D. Phenobarbital		
E. Digitalis		
F. Allergy injections		
G. Liver		
H. Iron		
I. Penicillin		
J. Tranquilizers		
K. Asthma medication -type		
L. Other		

10. PREVENTATIVE IMMUNIZATION

A. Had all required "shots" as a child		
B. Have measles protection -current		
C. Last tetanus booster date		
D. Other		

11. HAS ANY BLOOD RELATIVE HAD THE FOLLOWING

A. Apoplexy(stroke)		
B. High blood pressure, heart disease		
C. Nervous breakdown		
D. Kidney troubles		
E. Asthma, Hives, Eczema or Hay fever		
F. Migraine headaches		
G. Epilepsy		
H. Tuberculosis(or other chronic lung disease)		
I. Cancer		
J. Ulcer (stomach or duodenum)		
K. Other		

12. ADDITIONAL MEDICAL HISTORY

A. Had any serious illness or injury not listed previously		
B. Been hospitalized in the past 3 years		
C. Allergic to any medication -list		
D. Allergy to insect bite, sting, food, substance		
E. Require any special medication/procedure		

I certify to the best of my knowledge the information on this form is complete and accurate.

X

Signature

Date

Santa Barbara City College · Sport M/F\_\_\_\_\_

### Verification of Other Insurance

I. My Name: \_\_\_\_\_ Local Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address \_\_\_\_\_ Insurance Phone# \_\_\_\_\_  
Yes \_\_\_ I am covered by my own policy

II. Spouse's Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_  
Yes \_\_\_ I am covered by this Policy No \_\_\_ I am not covered by this Policy

III. Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Home Phone# \_\_\_\_\_  
Father's Employer: \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_  
Yes \_\_\_ I am covered by this Policy No \_\_\_ I am not covered by this Policy

IV. Mother's Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone# \_\_\_\_\_  
Mother's Employer: \_\_\_\_\_ Work Phone# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_  
Yes \_\_\_ I am covered by this Policy No \_\_\_ I am not covered by this Policy

V. I hereby certify that the foregoing answers I have designated to the stated questions are true, complete and correct to the best of my knowledge.

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This sheet will be placed in your team medical kit. Please fill it out completely  
Address needs to be local!

If you have no insurance write SBCC in the insurance blank and nothing in the policy holders blank.

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SANTA BARBARA CITY COLLEGE  
EMERGENCY INFORMATION CARD

NAME: \_\_\_\_\_ K# \_\_\_\_\_ SPORT M/W \_\_\_\_\_  
ADDRESS:(LOCAL) \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ HOME# \_\_\_\_\_ ROOMMATES \_\_\_\_\_

EMERGENCY NOTIFICATION

NAME: \_\_\_\_\_ RELATION \_\_\_\_\_ PHONE#( ) \_\_\_\_\_  
NAME: \_\_\_\_\_ RELATION \_\_\_\_\_ PHONE#( ) \_\_\_\_\_

MEDICAL INSURANCE COMPANY \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_

INSURANCE COMPANY PHONE# \_\_\_\_\_

LIST OF MEDICATION YOU'RE TAKING CURRENTLY \_\_\_\_\_  
LIST ANY SPECIAL MEDICAL NEEDS OR PROBLEMS \_\_\_\_\_  
LIST OF MEDICATION /ENVIRONMENT ALLERGIES \_\_\_\_\_

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