Staff Team Physicians: Carle
John Flannell, MS, LAT, ATC, PES
Carle Orthopedics and Sports Medicine
Athletic Training Supervisor
2300 S. First St.
Champaign, IL 61820

LACROSSE

Sex: Male☐ Female☐

Last Name (Print) First Name Middle

Date of Birth Social Security Number E-Mail Address Cell Phone Number

Home Address (Number and Street) City or Town State Zip Code

Parent or Guardian Cell Phone Number Home Telephone

Alternative Emergency Contact – Name, Relationship Cell Phone Number Home Telephone

MEDICAL HISTORY TO BE COMPLETED BY STUDENT

Allergies to Drug(s)/Medication(s) ☐No ☐Yes (list)_____

Allergies to foods, nuts, insects, environmental ☐No ☐Yes (list) _____

Have you ever been diagnosed with any of the following: If Yes provide details below:

	Yes	No		Yes	No		Yes	No
Anemia (including sickle cell anemia)			Epilepsy or other seizure disorder			Inflammatory bowel, Crohn's		
Arthritis			Fracture/Dislocation			Kidney or bladder infection, stone		
Asthma			Guillain Barre			Migraine headache		
Bleeding disorder			Head injury			Pneumonia		
Cancer (incl. leukemia, Hodgkin's)			Heart murmur/Valve problem			Positive TB test/Tuberculosis		
Diabetes			High blood pressure			Psychiatric/Psychologist care		
Disordered eating (anorexia or bulimia)			Immunodeficiency disorder			Thyroid disorder		
Drug or alcohol dependency			Infectious mononucleosis			Serious accident or injury		

Women's Health			**Men's Health**		
Condition	Yes	No	Condition	Yes	No
Removal of breast lump or cyst \breast cancer			Lump or mass in testicle		
Missed periods more than four months					
Excessive flow					

FAMILY MEDICAL HISTORY

Check each item	Yes	No	Relationship		Yes	No	Relationship
Father living				Heart disease			
Mother living				High blood pressure			
Alcoholism				Nervous or mental disorder			
Cancer				Thyroid disease			
Diabetes				Tuberculosis			

Have you consulted or been treated by clinics, healthcare provider(s), healer(s) or other practitioners within the past five years? (Other than routine checkups.) ☐Yes ☐No If Yes, provide details below.

Details_____

Attach additional sheet if necessary.

Signature of Student or Parent/Guardian (if under 18 years of age) Date

This information is strictly for the use of the Athletic Training Department and will not be released to anyone without your knowledge and written consent.

Last Name (Print) First Name Middle Date of Birth Sport

HEALTH CARE PROVIDER EXAMINATION

Please correlate the student's medical history with your findings, and record below. All entries must be completed and in English.

☐ Male ☐ Female Height_____ Weight_____

Blood Pressure_____/_____ Pulse_____

Current Medications: _____

Enter "N.E." if not evaluated	WNL	ABN	Give detail of abnormality
Head, Neck, Face and Scalp			
Nose and Sinus			
Mouth, Teeth, Gingiva and Throat			
Eyes			
Ears			
Lungs, Chest and Breast			
Heart			
Abdomen and Viscera (include hernia)			
Endocrine System			
Genito-Urinary System			
Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric			
Is this individual capable of normal physical activity? (athletics, physical education) ☐ Yes ☐ No If no, give reasons and limitations/restrictions on comments line below.			

☐ No disability ☐ Physical disability ☐ Emotional/psychiatric disability
☐ Learning disability ☐ History of Disordered Eating (anorexia/bulimia)

Comments: _____

_____

_____

I certify I have reviewed the history and immunization information and performed a physical exam on the above named patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.

_____ _____
Date of Examination Health Care Provider's Signature

_____ _____
Print Name of Health Care Provider Address

_____ _____
Health Care Provider Telephone City State Zip Code