PHYSICIAN'S CERTIFICATION of PARTICIPANT'S HEALTH

*In order to participate in a **sports-related program**, the Physician of a Minor or Counselor in the Program must complete this form. The completed form must be returned to the Program Director. If a physical examination occurred within the last six months, then a copy of the results may be attached. Otherwise a physical examination must be conducted by a licensed healthcare practitioner within six months prior to the program. A physical examination is also required if the individual is currently under medical care, takes prescribed medication, requires a medically prescribed diet, has had an injury or illness during the last six months that limited activity foe a week or more, has ever lost consciousness during physical activity, or has suffered concussion from a head injury.*

Participant's Name: _____ Last 4 digits of SSN: _____

Note to Licensed Healthcare Practitioner: The person listed above will be participating in a program at The Citadel that may involve strenuous athletic outdoor activities, where the temperature may reach 95°F. Please review the healthcare history with this person for any interim changes. Please explain any abnormal evaluations. Thank you.

1. GENERAL HEALTH

Height: _____	Weight: _____	Blood Pressure: _____
Eyes: _____	Glasses/Contacts: _____	Hearing: _____
Teeth: _____	Braces: _____	Skin: _____
Heart: _____	Nose: _____	Throat: _____
Lungs: _____	Abdomen: _____	Hernia: _____
Posture (Spine): _____	Extremities: _____	Genitalia: _____

Allergies to Medications: _____

Other Allergies (Please specify type and severity): _____

_____

2. MEDICAL HISTORY

Does the individual have chronic medical problems, emotional difficulties, or behavioral issues of which you are aware? **[Check one.]** ☐ YES ☐ NO

If Yes, please describe the condition and list prescribed medications and dosing instructions.

_____

_____

_____

Recommendations and/or restrictions (e.g., diet, swimming, etc.):

_____

_____

_____

3. ACKNOWLEDGEMENT

I certify the veracity of the above information.

Printed Name of Examining Physician: _____
Address: _____
City, State, Zip: _____
Work Phone: _____ **Date:** _____

Signature of Examining Physician: _____