

HILLSBOROUGH COMMUNITY COLLEGE

HEALTH / MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Pages 1 and 2 are to be completed by the student-athlete, **prior** to getting a physical examination. Please fill in all items. Confer with parents or family physician for accurate health/medical information.

NAME: _____
First **Middle** **Last**

H.C.C. I.D. # (or SOCIAL SECURITY #) _____

CURRENT ADDRESS: _____
Street or PO Box

City **State** **Zip**

HOME PHONE #: _____ **CELL PHONE #:** _____

DATE OF BIRTH: _____
Month/ Day/ Year

BIRTH PLACE: _____
City **State** **Country**

HOME TOWN: _____
City **State** **Country**

EMAIL ADDRESS: _____

NEXT OF KIN: _____
Parent, guardian, spouse or other relative

ADDRESS: _____
Street or PO Box **City** **State** **ZIP**

PHONE # (Home): _____ **PHONE # (Business):** _____

Person to notify in the case of emergency (if different than above):

Name **PHONE #:** _____

(Please continue on to the next page)

FAMILY PHYSICIAN: _____

ADDRESS: _____
Street City State ZIP

BUSINESS PHONE #: _____

HEALTH/MEDICAL HISTORY

1. Do you wear eyeglasses or contact lenses? (Circle one or both)
2. Do you have asthma? Yes _____ No _____
Do you have an inhaler/puffer? Yes _____ No _____
Where do you keep it? _____
3. Please describe and give dates regarding: Operations, injuries or major illnesses:

4. Allergies: Aspirin _____ Codeine _____ Sulfa _____ Penicillin _____
Acetaminophen _____ Insect Bites/Stings _____ Food _____
Other: _____
5. Has medical care been required over the past two years? Yes _____ No _____
If Yes, for what? _____

6. List medications or drugs you are currently taking:

(Please continue on to the next page)

