**Manhattan Christian College**

Athletic Department

Pre­participation Physical Examination

Date of Exam / /

Name \_Date of Birth \_/ /

Height:

Weight:

Blood Pressure: / (\_ / \_) Pulse: Regular/Irregular

Vision: R 20/

L 20/

Corrected: Y or N Pupils: Equal

Unequal

|  |  |  |
| --- | --- | --- |
|  | **NORMAL** | **ABNORMAL FINDINGS** |
|  **M EDICAL** |  |  |
| Appearance |  |  |
| Eyes/Ears/Nose/Throat |  |  |
| Lymph Nodes |  |  |
| Heart (supine & standing) |  |  |
| Pulse |  |  |
| Lungs |  |  |
| Abdomen |  |  |
| Genitalia (males only) |  |  |
| Skin |  |  |
|  **M USCULO SKELETAL** |  |  |
| Neck/Back |  |  |
| Shoulder/Arm |  |  |
| Elbow/Forearm |  |  |
| Wrist/Hand |  |  |
| Hip/Thigh |  |  |
| Knee |  |  |
| Leg/Ankle/Foot |  |  |
| Other |  |  |

**CLEARANCE: Cleared**

**Cleared with restrictions**

**Not Cleared**

**COMMENTS:\_**

Physician’s Signature:

Date: / /

**MANHATTAN CHRISTIAN COLLEGE**

1415 Anderson Avenue – Manhattan, KS 66502

**ATHLETIC INSURANCE INFORMATION**

Name Sport(s)

Parent’s Name(s)

Home Address

City State Zip

Are you covered under medical insurance provided by you, your parents, or an employer?

 Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Name of Insurance Company

Address of Insurance Company

City State Zip

Policy #

I understand that when making a claim for medical benefits, I will first send the claim to my personal or family insurer. Any balance unpaid will then be sent to the company that insures the MCC athletic program. Benefits will be paid to the extent stated in the policy. Any unpaid claims are the responsibility of the athlete.

Signature Date / /