BABSON

PRE-PARTICIPATION EXAMINATION

Revised 4/2023

THIS FORM IS TO BE TO BE COMPLETED BY FIRST-YEARS, TRANSFERS, JUNIORS AND ATHLETES WHO DID NOT PARTICIPATE IN BABSON COLLEGE ATHLETICS.
THIS FORM IS BROUGHT TO PHYSICIAN'S OFFICE AND REVIEWED WITH THE ATHLETE.
ONCE COMPLETED PLEASE UPLOAD THE ENTIRE 6 PAGE DOCUMENT 6 TO YOUR
ON-LINE STUDENT HEALTH PORTAL

THIS IS THE ONLY FORM THAT WILL BE ACCEPTED ***This information is provided to both Health Services and Sports Medicine***

Name (Please Print) _____ Date of Birth _____ Sport(s) _____

Home Address (Street or P.O. Box) _____ City _____ State _____ Zip Code _____

Date _____

Athlete/Guardian: Please review all questions and answer them to the best of your ability.

Physician: Please review with the athlete details of any positive answers and sign off that this was done.

❒ Yes ❒ No ❒ Don't Know Has a doctor ever denied or restricted your participation in sports for any reason?

❒ Yes ❒ No ❒ Don't Know Have you ever had Chest pain/discomfort/tightness/pressure related to exertion or during exercise.

❒ Yes ❒ No ❒ Don't Know Has the athlete ever passed out or nearly passed out during or after exercise?

❒ Yes ❒ No ❒ Don't Know Do you get more tired or short of breath more quickly than your friends during exercise?

❒ Yes ❒ No ❒ Don't Know Do you get lightheaded or feel more short of breath than expected during exercise?

❒ Yes ❒ No ❒ Don't Know Does your heart ever race or skip a beat (irregular beats) during exercise?

❒ Yes ❒ No ❒ Don't Know Has a doctor ever told you that you have any heart problems?
If so check those that apply:

High Blood pressure	Heart Murmur	High Cholesterol
Heart Infection	Kawasaki Disease	Other_____

❒ Yes ❒ No ❒ Don't Know Has a doctor ever ordered a test for your heart? (For example, EC/EKG, echocardiogram)

❒ Yes ❒ No ❒ Don't Know Have you ever had an unexpected seizure?

❒ Yes ❒ No ❒ Don't Know Has anyone in your family had an unexpected fainting, unexplained seizures or near drowning?

❒ Yes ❒ No ❒ Don't Know Has any one in your family have any of the following? If so check which apply:

Hypertrophic heart	Cardiomyopathy	Marfan syndrome,
Arrhythmogenic Right	Ventricular Cardiomyopathy	Long QT syndrome
Short QT syndrome	Brugada syndrome	
Catecholaminergic	Polymorphic Ventricular Tachycardia	

❒ Yes ❒ No ❒ Don't Know Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?

❒ Yes ❒ No ❒ Don't Know Have you ever broken a bone, had to wear a cast, or had an injury to any joint?

❒ Yes ❒ No ❒ Don't Know Does you have a history of a concussion?

❒ Yes ❒ No ❒ Don't Know Have you ever suffered a heat-related illness (heat stroke)?

❒ Yes ❒ No ❒ Don't Know Do you have a chronic illness or see a physician regularly for any particular problem?

❒ Yes ❒ No ❒ Don't Know Do you take any prescribed medicine, herbs or nutritional supplements?

❒ Yes ❒ No ❒ Don't Know Are you allergic to any medications or bee stings?

❒ Yes ❒ No ❒ Don't Know Do you have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?

❒ Yes ❒ No ❒ Don't Know Have you ever been hospitalized overnight or had surgery?

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Last First M.I.

Athlete/Guardian: Please review all questions and answer them to the best of your ability.

Physician: : Please review with the athlete details of any positive answers and sign off that this was done.

❒ Yes	❒ No	❒ Don't Know	Do you lose weight regularly to meet the requirements for your sport?
❒ Yes	❒ No	❒ Don't Know	Do you have anything you would like to discuss with the physician?
❒ Yes	❒ No	❒ Don't Know	Do you have asthma?
❒ Yes	❒ No	❒ Don't Know	I often have trouble sleeping.
❒ Yes	❒ No	❒ Don't Know	I wish I had more energy most days of the week.
❒ Yes	❒ No	❒ Don't Know	I think about things over and over
❒ Yes	❒ No	❒ Don't Know	I feel anxious and nervous much of the time
❒ Yes	❒ No	❒ Don't Know	I often feel sad or depressed.
❒ Yes	❒ No	❒ Don't Know	I struggle with being confident
❒ Yes	❒ No	❒ Don't Know	I don't feel hopeful about the future
❒ Yes	❒ No	❒ Don't Know	I have a hard time managing my emotions (frustration, anger, impatience).
❒Yes	❒ No	❒ Don't Know	I have feelings of hurting myself or others.
❒Yes	❒ No	❒ Don't Know	I have tested positive for COVID-19 (swab, sputum, saliva test)
❒Yes	❒ No	❒ Don't Know	I have tested positive for COVID-19 antibodies (antibody, blood test)
❒Yes	❒ No	❒ Don't Know	I have been hospitalize for complications due to COVID-19.
❒Yes	❒ No	❒ Don't Know	I have been Vaccinated for COVID-19
❒Yes	❒ No	❒ Don't Know	I have received a Booster Vaccination for COVID-19.

This has been reviewed by the physician and the athlete and discussed all positive answers.

Student-Athlete's Signature _____ Date _____

Print Health Care Provider's Name _____ Title _____

Health Care Provider's Signature _____ Date _____

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Student's Name: _____ Date of Exam: _____
Last First M.I.

Physical Examination is *recommended for all students*
A Pre-Participation Exam is required no more than 6 months prior to participation in first Varsity Athletics activity per NCAA regulations.
The athlete assumes all costs related to the exam.

Sport(s): _____

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

This student has been accepted for admission to Babson College. This information is confidential and will not affect his/her enrollmentstatus.

Weight_____Height_____BP_____Pulse_____Hearing: Right_____Left _____

Vision: without glasses Right_____Left_____with glasses Right_____Left _____

SYSTEM	Normal	Please describe abnormal findings.
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System (murmur, click) See Cardiac Recommendations next page		
Pericardial Activity		
Heart 1st &2nd sounds		
Abdomen (rectal if indicated)		
Genito-Urinary		
Pelvic (if indicated)		
Lymphatic		
Musculo-Skeletal		
Neurological		
Endocrine		
Psychological		

PRE-PARTICIPATIONEXAMINATION* (see Recommended Exam Protocol on next page)

MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

PRE-PARTICIPATION EXAMINATION *Revised 4/2023*

*Recommended EXAM PROTOCOL FOR THE PHYSICIAN

¨ **Musculoskelatal.**

Have patient:	To check for:
1. Stand facing examiner	AC joints, general habitus
2. Look at ceiling, floor, over shoulders, touch ears to shoulders	Cervical spine motion
3. Shrug shoulders (against resistance)	Trapezius strength
4. Abduct shoulders 90 degrees, hold against resistance	Deltoid strength
5. Externally rotate arms fully	Shoulder motion
6. Flex and extend elbows	Elbow motion
7. Arms at sides, elbows 90 degrees flexed, pronate/supinate wrists	Elbow and wrist motion
8. Spread fingers, make fist	Hand and finger motion, deformities
9. Contract quadriceps, relax quadriceps	Symmetry and knee/ankle effusion
10. "Duck walk" 4 steps away from examiner	Hip, knee and ankle motion
11. Stand with back to examiner	Shoulder symmetry, scoliosis
12. Knees straight, touch toes	Scoliosis, hip motion, hamstrings
13. Rise up on heels, then toes	Calf symmetry, leg strength

Heart Murmur Evaluation (Auscultation standing, supine, Valsalva) in a quiet room using the diaphragm and bell of a stethoscope.Location point of maximal impulse

	Rules out:
1. S1 heard easily; not holosystolic, soft, low-pitched	VSD and mitral regurgitation
2. Normal S2	Tetralogy, ASD and pulmonary
3. No ejection or mid-systolic click	Aortic stenosis and pulmonary stenosis
4. Continuous diastolic murmur absent	Patent ductus arteriosus
5. No early diastolic murmur	Aortic insufficiency
6. Normal femoral pulses (Equivalent to brachial/radial pulses in strength and arrival)	Coarctation
7. Brachial Artery Blood Pressure (sitting Position)	

Positive Testing for COVID-19: Physician should evaluate the patient for cardiac concerns

Marfan's Screening - Screen all men over 6'0" and all women over 5'10" in height with Echocardiogram and

1. Family history of Marfan's syndrome (this finding alone should prompt further investigation)
2. Cardiac murmur or mid-systolic click, aortic insuffciency
3. Kyphoscoliosis
4. Anterior thoracic deformity, pectus excatum, arachnodactyly, myopia, MVP
5. Arm span greater than height
6. Upper to lower body ratio more than 1 SD below mean

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As of 2021 the NCAA requires all Student Athlete to provide proof of Sickle Cell Trait testing. If during this physical you are testing for Sickle Cell Trait Blood Work Documentation must be provided in addition to completing the box below:

Please circle the results of the test for Sickle Cell Trait testing:	**Negative**	**Positive**	**No Testing Done**

Please list the date of the Sickle Cell Trait testing_____

Blood Work Documentation must be provided to verify results

CURRENT MAJOR AND CHRONIC PROBLEMS

_____

_____

ACUTE OR MINOR PROBLEMS

_____

_____

ALLERGIES:

_____

_____

ALL CURRENT MEDICATIONS

_____

_____

PHYSICAL LIMITATIONS OR RESTRICTIONS:

_____

_____

_____

DIETARY REQUIREMENTS:

_____

_____

_____

ADDITIONAL COMMENTS AND RECOMENDATIONS:

_____

_____

_____

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Last First M.I.

CLEARANCE

☐ CLEARED TO PARTICIPATE IN VARSITY ATHLETICS WITHOUT RESTRICTIONS OR LIMITATIONS

☐ CLEARED TO PARTICIPATE IN VARSITY ATHLETICS WITHOUT RESTRICTIONS OR LIMITATIONS

AFTER COMPLETING EVALUATION/REHABILITATION FOR:_____

☐ NOT CLEAR FOR:_____

REASON:_____

PHYSICIAN INFORMATION:

Print Health Care Provider's Name	
Address	
Phone Number	Fax Number
Health Care Provider's Signature	Date

Babson College Health Services
Babson Park, MA 02457-0310
Phone: (781) 239 6363

Department of Athletic Performance
BRAC Center/Babson Park, MA 02457-0310
781-239-5690