EQUESTRIAN PHYSICAL FORM

All Equestrian Studies students are required to turn in a Pre-participation Physical Examination PRIOR to any type of activities at The University of Findlay equestrian campuses. This includes being able to ride and earning credit for barn chores.

WESTERN RIDERS:
You may mail these papers to the Western Farm prior to your arrival on campus, fax or scan them to Carol Browne (details below), or you may bring them with you on the first day of class. Please copy your papers before mailing them in case they are lost in the mail.

Western Equestrian Physicals
14700 US Rt. 68
Findlay, OH 45840

Carol Browne
419-434-6358
brownec@findlay.edu
419-420-1736 (Fax)

ENGLISH RIDERS:
You may mail these papers to the English Farm prior to your arrival on campus, fax or scan them to Trisha Boutwell (details below), or you may bring them with you on the first day of class. Please copy your papers before mailing them in case they are lost in the mail.

English Equestrian Physicals
11178 TR 201
Findlay, OH 45840

Trisha Boutwell
419-434-4859
trisha.boutwell@findlay.edu
419-434-4860 (Fax)

These forms must be turned in BEFORE you will be allowed to ride any horse on campus (including your own) or earn credit for barn chores.

A physical must be submitted each academic year.

EQUESTRIAN PRE-PARTICIPATION PHYSICAL EXAMINATION

Full Name (First, Middle, Last):	Circle One: ENGLISH WESTERN BOTH
Date of Birth:	Gender:
Local Address (Where you will live for the school year – Dorm; Apartment, etc):	UF Student ID#:
UF Email Address:	Cell Phone:
Emergency Contact Name:	Emergency Contact Relationship:
Home/Cell Phone for Emergency Contact:	Home/Cell Phone for Emergency Contact:

MEDICAL HISTORY

Please answer the questions in as much detail as possible. Check appropriate box and comment on all yes answers.

Have you ever:	**Y**	**N**	**Date/Comments**
▪ Had a physician deny or restrict your participation in sports for any reason?	☐	☐	_____
▪ Been hospitalized overnight?	☐	☐	_____
▪ Had any surgery (What & When?)	☐	☐	_____
Have you ever had, or do you now have:	**Y**	**N**	**Date/Comments**
▪ A severe viral infection (e.g. mono) in the last month?	☐	☐	_____
▪ Discomfort, pain, tightness, or pressure in your chest DURING or AFTER exercise?	☐	☐	_____
▪ Dizziness DURING or AFTER exercise?	☐	☐	_____
▪ Passed out DURING or AFTER exercise?	☐	☐	_____
▪ High blood pressure?	☐	☐	_____
▪ Racing of the heart/irregular rhythm?	☐	☐	_____
▪ Heart murmur?	☐	☐	_____
▪ Heart infection?	☐	☐	_____
▪ Test for your heart (ECG – echocardiogram)?	☐	☐	_____
▪ Kawasaki disease?	☐	☐	_____
▪ Epilepsy/Convulsions/Seizures?	☐	☐	_____
▪ Diabetes?	☐	☐	_____
▪ Asthma, wheezing/cough with exercise?	☐	☐	_____
▪ Loss of function or absence of any organ? (e.g. testicle, kidney etc. Please list which organ)	☐	☐	_____
▪ Severe headaches or migraines?	☐	☐	_____
▪ Hearing loss or perforated eardrum? (Which ear?)	☐	☐	_____
▪ Impaired vision? (Wear glasses/contacts/both?)	☐	☐	_____
▪ Unequal pupils? (R or L larger?)	☐	☐	_____

Have you ever had, or do you now have:	Y	N	Date/Comments
▪ Heat exhaustion or heat intolerance?	☐	☐	_____
▪ Eating disorder?	☐	☐	_____
▪ Use of weight loss meds, laxatives, self-induced vomiting?	☐	☐	_____
▪ Treatment for a mental health condition? (Condition, when, where treated)	☐	☐	_____
▪ Frequent anxiety, depression, insomnia?	☐	☐	_____
▪ Been prescribed any medications by a mental health professional? *(List medications)*	☐	☐	_____

List ALL medications and/or supplements you are currently using (including over-the-counter medications and inhalers):_____

_____

List any allergies (medicine, bees etc.)_____

Have you ever had:	Y	N	Date/Comments
▪ Loss of consciousness?	☐	☐	_____
▪ Concussion?	☐	☐	_____
▪ How many concussions? (List number and year)			_____
▪ Numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐	_____

Have you ever sprained/strained, dislocated, fractured (including stress fractures), broken, or had repeated swelling or other injuries to any bones or joints? YES ☐ NO ☐

Circle: Head Neck Face Chest Shoulder Upper arm

Elbow Forearm Wrist Hand Fingers Back Hip

Thigh Knee Shin/Calf Ankle Foot Toes

Please provide dates and explanations for all circled items:_____

_____

_____

Do you have any other medical or physical condition not mentioned above?

YES ☐ NO ☐ _____

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE TO MY KNOWLEDGE. I CONFIRM THAT I HAVE DISCLOSED ALL PERTINENT INFORMATION TO THE BEST OF MY KNOWLEDGE.

Signature _____Date _____

Parent/Guardian (if under 18):_____

PHYSICAL EXAMINATION (To be completed by MD, DO, NP, PA only)

Date _____ Name _____ DOB _____

BP _____ Pulse _____ Height _____ Weight _____

Medical	Nml	Abml	Comments
Eyes/ears/nose/throat	☐	☐	_____
▪ Pupils equal	☐	☐	_____
▪ Hearing	☐	☐	_____
Lymph nodes			
Cardiovascular			
▪ Murmurs (auscultation, standing, supine, +/- Valsalva)	☐	☐	_____
▪ Simultaneous femoral & radial pulse	☐	☐	_____
Lungs	☐	☐	_____
Abdomen	☐	☐	_____
Genitourinary (males only)	☐	☐	_____
Skin	☐	☐	_____
Neurologic	☐	☐	_____

Musculoskeletal	Nml	Abml	Comments
Neck	☐	☐	_____
Back	☐	☐	_____
Shoulder/arm	☐	☐	_____
Elbow/forearm	☐	☐	_____
Wrist/hand/fingers	☐	☐	_____
Hip/thigh	☐	☐	_____
Knee	☐	☐	_____
Leg/ankle	☐	☐	_____
Foot/toes	☐	☐	_____

I certify that I have reviewed the history and examined the above student and I recommend:

_____ Clearance for equine studies including horse riding, barn duties, and physical training with no limitations.

_____ Clearance pending further evaluation or testing. (Please explain)_____

_____ Clearance with specific limitations. (Please explain) _____

_____ Disqualified from competition. (Please explain) _____

Name of Examining Practitioner (Please print) _____

Practitioner's credentials _____

Address _____ Phone _____

_____

Practitioner Signature _____ Date _____