UNIVERSITY of MOUNT UNION

ATHLETE MEDICAL FORM

Sports:

☐ Men's

☐ Women's

_____ Baseball	_____ Football	_____ Softball	_____ Tennis
_____ Basketball	_____ Golf	_____ Soccer	_____ Volleyball
_____ Cheer	_____ Lacrosse	_____ Swimming & Diving	_____ Wrestling
_____ Cross/Track & Field			

Student Name _____ Student ID # _____
(Last) (First) (Middle)

Date of Birth _____ Sex ____

Permanent Address _____ Phone (_____) _____
(Street) (City) (State) (Zip)

Local Address _____ Phone (_____) _____
(Street Address or Dorm) (Dorm Room #)

Person to be notified in case of emergency:

Name _____ Relationship _____

Address _____

Phone _____ Cell phone _____

E-mail _____

Parent's Information:

Father's full name _____ Living? ___ Yes ___ No

Mother's full name _____ Living? ___ Yes ___ No

Parents' Address _____

Phone (H) _____

Father (W) _____ Mother (W) _____

Father (C) _____ Mother (C) _____

Email: _____ Email: _____

If you have an HMO or PPO Primary Insurance Policy, list the name of your preferred Provider, phone number and address:

Physician Name _____ Physician Phone _____

Physician Address _____

Our Policy for the Use and Disclosure of Your Health Information:

Your health information is confidential and may be protected under the Family Education Rights and Privacy Act (FERPA) or the Health Insurance Portability and Accountability Act (HIPAA). We generally will not disclose health information in this sports participation record and your medical condition and treatment you receive while participating in sports without your written authorization. There are certain use and disclosures of your health information we need to make. You must agree to these uses and disclosures as a condition to participating in sports. We will share health information with doctors performing a sports physical examination. We also will share health information with members of the Athletic Department, including coaches, team physicians, trainers and student trainers. We will share health information with physicians and other healthcare providers for treatment and billing purposes. We will share health information as required by NCAA rules. We will list your height and weight in programs and athletic directories.

PRE-PARTICIPATION EVALUATION HISTORY

1. Are you currently ill or injured? ___ Y ___ N
2. Are you currently under the care of a physician? ___ Y ___ N
3. Have you been treated for an injury or illness within the last year? ___ Y ___ N

Comments:

Cardiovascular

1. Has anyone in your family died suddenly of heart problems before age 50? ___ Y ___ N
2. Have you ever been dizzy or passed out during or after exercise? ___ Y ___ N
3. Have you ever been told you have a murmur? ___ Y ___ N
4. Does your heart skip a beat or beat too fast at times? ___ Y ___ N
5. Do you have chest pains during or after exercise? ___ Y ___ N
6. Have you had a severe viral infection (ex. Mono) or other infection in the past 6 months? ___ Y ___ N
7. Have you ever been told by a doctor that you have had pericarditis, myocarditis or endocarditis? ___ Y ___ N
8. Has any family member suffered a heart attack or any other heart conditions? ___ Y ___ N

Comments:

Neurological

1. Have you had any "bell ringers", concussions, or been knocked out in the past? ___ Y ___ N
2. Have you had any of the above in the past year? ___ Y ___ N
3. How many concussions have you had? _____
4. What is the longest amount of time you have been unconscious? _____
5. Did you have symptoms of headache or concentration difficulties after a head injury? ___ Y ___ N
6. Do you have frequent headaches? Migraines? ___ Y ___ N
7. Are headaches or migraines associated with sports activities? Weight lifting? ___ Y ___ N
8. Have you ever had a stinger, a burner, or pinched nerve? ___ Y ___ N
9. Have you had recurrent symptoms or persistent numbness following a stinger? ___ Y ___ N
10. Have you had any other neck injuries? ___ Y ___ N

Comments:

Respiratory

1. Do you have any trouble with shortness of breath with exercise? ___ Y ___ N
2. Do you have recurrent cough with exercise? ___ Y ___ N
3. Any history of seasonal allergies, allergic rhinitis, wheezing with infections or other times? ___ Y ___ N
4. Do you use or have you used any inhalant medications? ___ Y ___ N
5. Do you ever have hives or intense itching with exercise? ___ Y ___ N
6. Do you have asthma or exercise-induced asthma? ___ Y ___ N
7. Have you ever had a collapsed lung? ___ Y ___ N

Comments:

Musculoskeletal

1. Have you had any knee injuries? Date of injury _____ ___ Y ___ N
   Did this require surgery? Date of surgery _____ ___ Y ___ N
2. Do your knees swell, lock, or give way? ___ Y ___ N
3. Have you had ankle sprains? How many? _____ How were these treated? _____ ___ Y ___ N
4. Do your ankles feel weak or sprain easily? ___ Y ___ N
5. Have you had any serious shoulder problems or dislocations? How were these treated? _____ ___ Y ___ N
6. Have you had any other joint injuries? Dislocations? ___ Y ___ N
7. Have you had any fractures? ___ Y ___ N
8. Do you have any back problems? ___ Y ___ N

Comments:

Heat Illness

1. Do you have severe cramps in hot weather? ___ Y ___ N
2. Have you ever fainted in the heat? ___ Y ___ N
3. Have you ever had heat stroke or required IV therapy after exposure to heat? ___ Y ___ N
4. Have you ever fainted or passed out? ___ Y ___ N

Comments:

General Medical

1. Do you or any family members have diabetes? ___ Y ___ N
2. Do you have any chronic skin conditions? ___ Y ___ N
3. Do you have any visual problems or use glasses or contacts? ___ Y ___ N
4. Do you have dentures or partials? ___ Y ___ N
5. Have you lost any paired organ – e.g., kidney, eye, testicle? ___ Y ___ N
6. Do you have any other active medical problems? ___ Y ___ N
7. Do you or any family members have a history of sickle-cell anemia or possess the sickle-cell trait? ___ Y ___ N
8. Is there a family history of Marfan Syndrome? ___ Y ___ N
9. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (ex: knee brace, special neck roll, foot orthotics, detal retainer, hearing aid) ___ Y ___ N

Comments:

Miscellaneous

1. Do you have any personal or other health questions you would like to discuss with the doctor? ___ Y ___ N
2. Have you ever had a seizure or a bout(s) with epilepsy? ___ Y ___ N
3. Have you ever consulted a physician for ulcers, or a disease of the stomach, intestine, liver or gall bladder? ___ Y ___ N
4. Have you ever had a hernia or disease of the muscle or skin? ___ Y ___ N
5. Have you ever had any form of cancer, tumor, or growth of any kind? ___ Y ___ N
6. Have you ever been diagnosed with an eating disorder? ___ ___ Y
7. Were you born with two normal
   Eyes ___ Y ___ N
   Ears ___ Y ___ N
   Kidneys ___ Y ___ N

Comments:

For Men Only

1. Were you born with two normal testes? ___ Y ___ N
2. Have you ever had surgery to remove or repair a testicle? ___ Y ___ N

Comments:

_____

_____

For Females Only

1. Are you currently taking any female hormones (estrogen, progesterone, birth control pills) for the purpose of regulating your periods? ___ Y ___ N
2. What brand of birth control pills are you taking? _____
3. What is the date of your last period? _____
4. How many periods have you had in the last year? _____
5. What is the usual number of days of blood flow? _____
6. How would you describe your periods? Circle one: _____

Regular Regular/Painful Irregular Irregular/Painful Absent

Medication Use

1. What medicines do you regularly take? _____

_____

2. Do you use over-the-counter pain medications (e.g. Advil, Aleve, Tylenol)? ___ Y ___ N
3. What vitamins, herbs, or supplements do you take? _____

_____

4. Have you ever used anabolic steroids? ___ Y ___ N
5. Do you smoke or use any form of tobacco? ___ Y ___ N
6. How much alcohol do you drink? _____
7. Do you use any illegal drugs? ___ Y ___ N
8. Do you have an allergy to a medication or other substances (food, environmental, insect) ? List all below. ___ Y ___ N

Comments:

_____

_____

_____

Verification, Authorization, and Consent to Treat:

By signing below, I verify that all the information is accurate and complete. I understand that failure to disclose previous conditions may result in a medical disqualification. I understand that University of Mount Union is not responsible for expenses related to any previously existing conditions.

My signature below also authorizes the members of the University of Mount Union Athletic Training Staff and Physicians to treat any injury or illness that I may suffer from during the participation in an intercollegiate sport. I also allow the release of the medical information to the medical staff pertaining to any injuries or illnesses as a result of my participation for the sole purpose of diagnosis, treatment and rehabilitation of my injury/illness. This authorization shall expire at the end of the competitive season or until cleared by the team physician.

Athlete's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

For Athletic Training Staff Use Only:

_____ Name on form _____ DOB and Cell # _____ Signature
_____ Medical History _____ BP and Pulse _____ Height and Weight

Reviewing AT Signature _____ Date _____

Urine: Protein _____
Glucose _____
Blood _____
Other _____

Height _____
Weight _____
Tetanus Date _____
Blood Pressure _____/_____
Athletes with Asthma: Baseline Peak Flow _____

MEDICAL EXAMINATION OF: _____
(Student Name)

☐ **New Athlete** ☐**Returning Athlete** **Sport:** _____

	OK	**Abnormal**	**Comment**
Concussions			
Eyes			
Ears, nose, throat			
Head and neck			
Shoulder			
Skin and scalp			
Lymphatic			
Thorax			
Lungs			
Heart			
Abdomen			
Hernia			
Genitalia			
Neurologic			
Elbows, hands, wrists			
Back			
Knees			
Ankles			
Feet			

Physician Evaluation

____ No athletic participation
____ Limited athletic participation
____ Clearance withheld until _____
____ Full, unlimited athletic participation

ALLERGIES:

Comments:

_____

_____

Physician's Signature _____ Date _____