

Huntington University

Physical Examination for Athletic Participation

Medical History Questionnaire to be completed by the Student-Athlete

Explain "Yes" answers:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized for a serious illness or injury?.....
Date: Illness / Condition Date Released:

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery?.....
Date: Surgeon: Procedure: Date Released:

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently under a doctor's care?.....
Explain any current illness or pre-existing medical conditions that could affect your participation:

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you presently taking any medications or pills including birth control or medication for ADHD?
List all medications you are currently taking:
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any allergies?.....
List all allergies (foods, medicine, bees or stinging insects, latex, iodine and anesthesia reactions):
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had discomfort, pain or pressure in your chest during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get more tired than your friends during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had high blood pressure or high cholesterol?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been told that you have a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had racing of your heart or skipped heartbeats?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a severe viral infection (myocarditis or mononucleosis) within the last year?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has anyone in your family died of heart problems or a sudden death before age 50?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has anyone in your family had Marfan's syndrome?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has a physician ever ordered a test (ECG, echocardiogram) on your heart?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems?.....
Explain any "Yes" answer to questions 7 – 18

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have trouble breathing or do you cough during or after activity?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has a doctor ever told you that you have asthma or allergies?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Is there anyone in your family that has asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever used an inhaler or taken asthma medicine?.....
Explain any "Yes" answer to questions 19 – 22

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a head injury or concussion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever been knocked out or unconscious or lost your memory due to a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have headaches with exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 26. Have you ever had a seizure or epilepsy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever had a stinger, burner or pinched nerve?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been unable to move your arms or legs after being hit or falling?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain any "Yes" answer to questions 23 – 29

- | | | |
|---|--------------------------|--------------------------|
| 30. Have you ever had heat cramps, heat illness or muscle cramps?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you have any skin problems (itching, rashes, acne)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you use any special equipment (pads, braces, neck rolls, eye guards, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you had any problems with your eyes or vision?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you wear glasses or contacts or protective eye wear?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Are you missing an eye, kidney, testicle or ovary?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Are you happy with your weight?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Are you trying to gain or lose weight?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Has anyone recommended you change your weight or eating habits?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you limit or control what you eat?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain any "Yes" answer to questions 32 – 40

41. Are you currently or considering taking any nutritional supplements including vitamins or herbal remedies?.. Yes No
- List brand names and the indication of the products to be used.
-
-

42. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints?..... Yes No

<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Thigh	<input type="checkbox"/> Knee
<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand

Date: _____ Injury: _____ Date Released: _____

- | | | |
|--|--------------------------|--------------------------|
| 43. Have you had any other medical problems (diabetes, anemia, Sexually Transmitted Disease, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you had a medical problem or injury since your last evaluation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you need / want to see the team physician for any reason?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Explain any "Yes" answer to questions 43-45

All of this information is complete to the best of my knowledge.

Student-Athlete's Signature: X _____

Date: _____

Huntington University

Physical Examination for Athletic Participation

Physical Examination to be completed by a Licensed Physician

Height: _____ in. Weight: _____ lbs. Blood Pressure: _____ mm HG Pulse: _____ BPM

Vision: Right: _____ Left: _____ Corrected: Contacts / Glasses

ORTHOPEDIC SCREENING

		Normal	Abnormal	Specific Findings
Neck	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	
Back	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	Hyperextension / Hyperflexion
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	
	Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis / Lordosis / Kyphosis / Valsalva
Shoulder	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	Impingement
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	Subluxation / Dislocation / AC Joint
Elbow / Wrist / Hand	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	Hyperextension / Hyperflexion
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	Valgus / Varus
Hip / Thigh	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	Hyperextension / Hyperflexion
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	Subluxation / Dislocation
Knee	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	Hyperextension / Hyperflexion
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	Valgus / Varus / Ant. Drawer / Post Drawer
Shin / Ankle / Foot	ROM / MMT	<input type="checkbox"/>	<input type="checkbox"/>	
	Stability	<input type="checkbox"/>	<input type="checkbox"/>	Pronation / Supination / Rigid Flat Feet
	Other	<input type="checkbox"/>	<input type="checkbox"/>	Bunions / Corns / Blisters

BODY SYSTEMS EVALUATION

		Normal	Abnormal	Specific Findings
Head	Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose & Throat	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Loss or muffled
	Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Deviation of Septum
	Glands	<input type="checkbox"/>	<input type="checkbox"/>	Swollen
Eyes	Pupils	<input type="checkbox"/>	<input type="checkbox"/>	Equal / Unequal
	Reactivity	<input type="checkbox"/>	<input type="checkbox"/>	Equal / Unequal
Lung & Chest	Rales / Rhonci	<input type="checkbox"/>	<input type="checkbox"/>	Clear vs. Congestion
	Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Normal vs. Labored
Heart & Vascular	Marfan's Stigmata	<input type="checkbox"/>	<input type="checkbox"/>	Limb length / Joint laxity
	Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Regular vs. Irregular
	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Supine / Standing
Pulses	Brachial	<input type="checkbox"/>	<input type="checkbox"/>	Present vs. Absent
	Femoral	<input type="checkbox"/>	<input type="checkbox"/>	Present vs. Absent
Abdominal	Rebound	<input type="checkbox"/>	<input type="checkbox"/>	Soft vs. Rigid
	Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Normal vs. Abnormal
Neurological	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Brachialradialis / Biceps / Triceps Reflexes
	Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Patellar / Achilles/ Babinski Reflexes
Genitalia / Hernia		<input type="checkbox"/>	<input type="checkbox"/>	
Skin		<input type="checkbox"/>	<input type="checkbox"/>	Ulcers / Lesions / Sores

Urinalysis / Laboratory findings: _____

_____ **NO RESTRICTION** for collegiate athletic participation

_____ **RESTRICTED PARTICIPATION** to _____

Physician's Signature: _____

Date: _____

Huntington University Athletic Department Insurance Information Form

A. Receipt of injury and Medical Policy

I hereby acknowledge receiving one copy of the Huntington University Athletic Injury Medical and Insurance Policy. I understand the University's responsibility to an athlete injured as a result of participation in an intercollegiate sport at Huntington University.

Athlete's Name _____ Sport(s) _____

School Address _____ School Phone _____

Birth Date _____ Age _____ S.S.# _____

B. Insurance Policy Holder

Parent/Guardian _____ S.S.# _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

C. Parent/Guardian

My son/daughter is covered under the following carrier. I authorize the claim procedures of Huntington University to be followed for any medical/dental expenses due to his/her participation in intercollegiate athletics at Huntington University for the current school year.

Insurance Carrier _____

Address _____ City _____ State _____ Zip _____

Group # _____ Policy # _____ Phone (____) _____

D. Authorization

I hereby authorize Huntington University to inspect or secure copies of case history records, laboratory reports, diagnostic x-ray and any other data covering this and/or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original. This authorization shall be considered valid unless revoked in writing.

I UNDERSTAND THAT I WILL NOT BE ALLOWED TO PARTICIPATE IN ANY PRACTICE OR CONTEST UNTIL THIS FORM AND THE PHYSICAL EXAM ARE COMPLETED AND RETURNED TO THE ATHLETIC DEPARTMENT.

Student /Athlete Signature

Date

Parent/Guardian's Signature

Date

Huntington University Consent for Athletic Participation

I am aware that playing or practicing in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing in any sport include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my own body, general health or well being.

Because of the dangers of participating in any sport, I recognize the importance of following the coach's instructions regarding playing techniques, training rules of the sport, other team rules, and to obey such instructions. All participants have the responsibility to help reduce the chance of injury. Therefore, all student-athletes must obey all safety rules and regulations, report all physical problems to the coach and athletic trainer and follow a proper conditioning program, and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport, especially in contact sports.

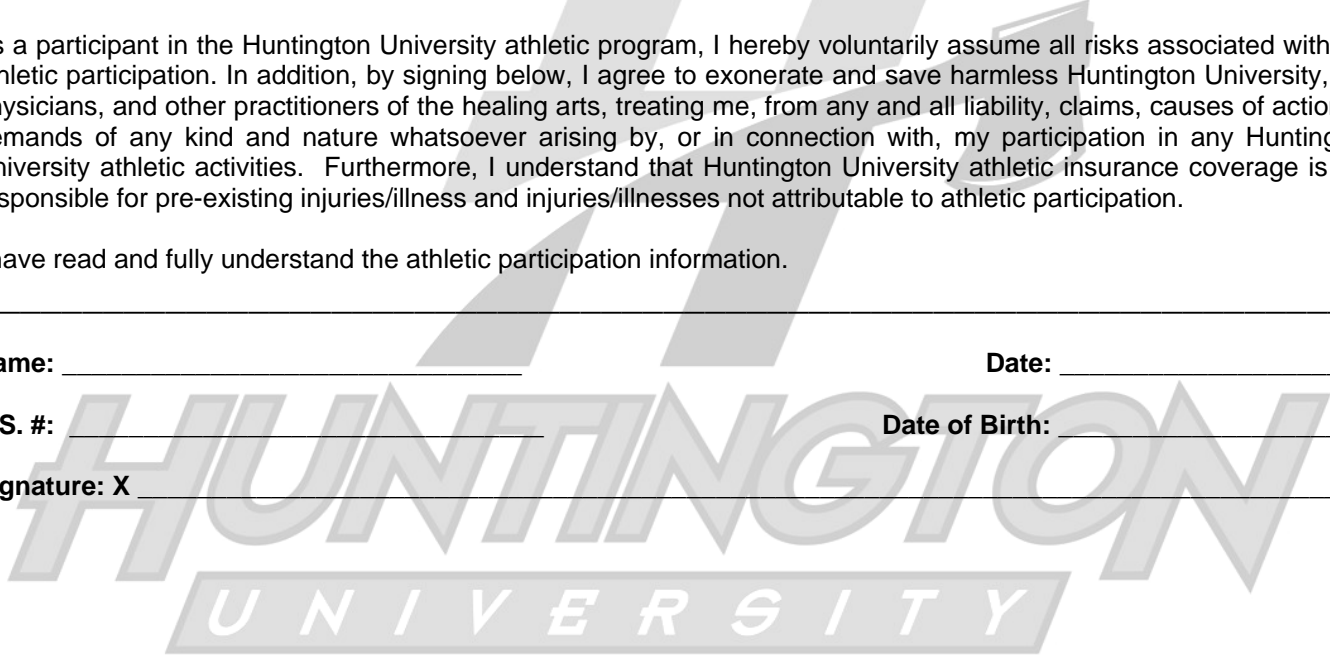
As a participant in the Huntington University athletic program, I hereby voluntarily assume all risks associated with my athletic participation. In addition, by signing below, I agree to exonerate and save harmless Huntington University, the physicians, and other practitioners of the healing arts, treating me, from any and all liability, claims, causes of action or demands of any kind and nature whatsoever arising by, or in connection with, my participation in any Huntington University athletic activities. Furthermore, I understand that Huntington University athletic insurance coverage is not responsible for pre-existing injuries/illness and injuries/illnesses not attributable to athletic participation.

I have read and fully understand the athletic participation information.

Name: _____ Date: _____

S.S. #: _____ Date of Birth: _____

Signature: X _____





Consent to Treat and Authorization for Release of Medical Information

I hereby authorize medical treatment for said athlete at _____ (name of educational institution) by the athletic trainers, physicians, and staff of Orthopaedics Northeast, P.C. A family member can be reached at _____ (phone number) in the case that additional treatment or information is required. I understand that if the said athlete is seen by a physician at Orthopaedics Northeast, P.C. and my insurance requires prior approval, I will be responsible for notifying my family physician.

I also hereby authorize the release of any and all information regarding any medical treatment received by me for injury or illness while participating in athletics at said educational institution to that institution's Athletic Training staff, which consists of employees of Orthopaedics Northeast. I expressly authorize communications between the Head Athletic Trainer, or any designated member of the athletic training staff, and physicians at Orthopaedics Northeast, or any other physician or health care professional regarding my physical condition as it relates to my participation in athletics at said institution. I also authorize the athletic training staff to release said information to said institution's administration and to my current coaching staff for the purpose of informing them of my playing status.

If I am over 18: I authorize the athletic training staff to release my medical information to my parent(s)/guardian(s).

If I am younger than 18: As the parent/legal guardian, I authorize the athletic training staff to release my minor athlete's medical information to my minor athlete.

Orthopaedics Northeast employees may disclose information to the aforementioned individuals; however, this does not prevent those individuals from disclosing the information further, and Orthopaedics Northeast will not be held responsible for such further disclosure of information.

This authorization is valid until and unless revoked by me in writing.

A photocopy of this authorization shall be considered as valid as the original.

NAME _____ DATE _____

S.S.# _____ DATE OF BIRTH _____

SIGNATURE _____

WITNESS _____

Signature of parent/guardian if the athlete is under the age of 18:

SIGNATURE _____ DATE _____

WITNESS _____