Weber State University
Preparticipation Physical Exam
Student Details

Print clearly please.

First Name: _____ Last Name: _____

Student W#_____ Sport _____

Class: __ *Freshman* __ *Sophomore* __ *Junior* __ *Senior*

Marital Status: ___ *Married* ___ *Single* ___*Widowed* ___*Separated* ___*Divorced*

International Student: __ *Yes* ___ *No*

Address: _____

City: _____

State: _____

Zip code: _____

Email: _____

Home Phone: _____ Mobile Phone: _____

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction AND has completed required sickle cell testing/signed waiver. Sickle cell test: POS NEG Date: _____

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

WEBER STATE UNIVERSITY
Department of Intercollegiate Athletics

Assumption of Risk

I understand that while I am participating in intercollegiate athletics, there is risk of injury. I understand that such an injury can range from a minor injury to a major injury. Such injuries could cause permanent disability such as paralysis, permanent bone or joint injury, other chronic disabling conditions and even death.

I hereby accept and assume the risk of injury and understand the possible consequences of such injury.

Signature:_____ Date:_____
Student Athlete

Print Name:_____

Consent For Treatment

I understand that I may be injured while participating in athletics at Weber State University. I authorize the school to obtain through a physician of its own choice any emergency care that may become necessary while participation in or traveling under the Weber State University's intercollegiate athletic program. I also authorize the University athletics team physician and athletic trainers to administer those treatments deemed necessary.

Signature:_____ Date:_____
Student Athlete

Print Name:_____

WEBER STATE UNIVERSITY
RELEASE OF MEDICAL RECORDS

I,_____, as a condition of participating in
Athlete's name
_____, do hereby authorize the release of any and all of my medical
Sport
records to the Weber State University Athletic Department, sports medicine staff(Team Physicians, Physical Therapists, Athletic trainers, etc.). I hereby release these records of my own free will volition and waive any privacy claims that I may have pursuant to release of said records. I understand that these records will be used in the official capacity of Weber State University in the administration of its athletic program and for no other purposes.

_____
Print athletes name

_____ _____
Athlete's signature Date

Weber State Athletic Training

Authorization for the Disclosure of Health Information

Photocopy or facsimile of the original authorization will be considered as valid as the original

Athlete

_____	_____
Athlete's Name	Date of Birth
_____	_____
Street Address	City / State / Zip Code

Authorizes:

Information to be released from:
Weber State Athletic Trainers and Physicians providing medical coverage to WSU athletes

Information released to:
All coaching staff, athletic directors, and other school officials that require health information that directly impacts my ability to participate in sports and to receive sports related emergency medical care.

Information to be Released Includes:

All information concerning my health that impacts my ability to participate in sports. This may include information about injuries (such as sprains, strains), surgeries (such as ACL reconstruction, rotator cuff repair), concussions (Impact testing results), or medical conditions (such as asthma).

Need for the Disclosure:

The purpose of the release of this information is:

- To inform the coaching staff of my health related limitation and abilities to continue to participate in sporting events.
- To provide coaching staff with information about my injury to help me participate in sporting events safely.

Your Rights With Respect to this Authorization:

Right to Inspect or Copy the Health Information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Head Athletic Trainer. **Right to Receive Copy of this Authorization –** I understand that if I agree to sign this authorization, which I am not required to do so, I can be provided with a signed copy of the form. **Right to Refuse to Sign this Authorization –** I understand that I am under no obligation to sign this form. **Right to Withdraw this Authorization –** I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Head Athletic Trainer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information already made in reference to this authorization.

Signature of Athlete / Legal Representative:

_____Date: _____

WEBER STATE UNIVERSITY
SPORTS MEDICINE

CONSENT TO TESTING OF URINE SAMPLE, AUTHORIZATION FOR RELEASE OF INFORMATION AND DRUG TESTING NOTIFICATION FORM

I hereby acknowledge that I have received a copy of the Weber State University Intercollegiate Athletics Drug Abuse Program. I further acknowledge that I have read the said program, that it has been outlined to me, that I fully understand the provisions of the program and that I agree to voluntarily participate in the program as described. I understand that I may choose not to sign this form and thereby forgo the privilege of participation in intercollegiate athletics at Weber State University.

I hereby consent to have a sample of my urine collected and tested for the presence of certain drugs of substances in accordance with the provisions of the Weber State University Intercollegiate Athletics Drug Education Program at such times as urinalysis testing is required under the program during the academic year. I understand that any urine samples will be sent to a qualified laboratory for actual testing.

I further authorize you to make a confidential release to my parent(s), legal guardian(s), or spouse; the athletic trainer(s), team physician(s), and athletic director of Weber State University; The head coach of any intercollegiate sport in which I am participating as a team member; and any professional advisor or drug counselor with whom I may become involved, all information and records, including test results, you may have relating to the screening or testing of my urine sample(s) in accordance with provisions of the Weber State University. I waive any privilege I may have in connection with such information only to the limited extent set forth in this document.

I understand any sanctions brought against me for violation of this drug policy will by maintained consecutively throughout the athletic career at Weber State University.

Weber State University, its Board of Regents, Institutional Council, and individual officers, employees and agents are hereby released from legal responsibility or liability for the release of such information and records as authorized by this form.

I understand that if I fail to comply with such a request I will be deemed to have tested positive.

_____ _____
Print Athletes Name Date

_____ _____
Parents Signature Date
(if athlete is under 18 years)

_____ _____
Athletes Signature Date

WEBER STATE UNIVERSITY
SPORTS MEDICINE
STUDENT-ATHLETE EMERGENCY INFORMATION

STUDENT-ATHLETE_____DATE_____

IN CASE OF SERIOUS INJURY OR ILLNESS, WHO SHOULD BE NOTIFIED?

NAME:_____RELATIONSHIP_____

HOME PHONE:_____WORK PHONE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

COUNTRY:_____

IN CASE THE ABOVE PERSON CANNOT BE CONTACTED, WHO WOULD MOST LIKELY KNOW WHERE THAT PERSON COULD BE REACHED?

NAME:_____RELATIONSHIP_____

HOME PHONE:_____WORK PHONE_____

PERMISSION FOR MEDICAL CARE

IN CASE OF SERIOUS INJURY OR ILLNESS, I UNDERSTAND THAT REASONABLE EFFORT WILL BE MADE TO CONTACT THE ABOVE PERSON(S). I HEREBY GIVE CONSENT AND PERMISSION FOR MEDICAL TREATMENT TO BE ADMINISTERED (INCLUDING SURGERY) TO MY "SON/ DAUGHTER/ SPOUSE" AS DEEMED NECESSARY AND PROPER.

_____
SIGNATURE OF PARENT OR GUARDIAN

IS THE ATHLETE ALLERGIC TO ANY MEDICINES? YES_____NO_____ IF SO, WHAT?_____
DOES HE OR SHE HAVE ANY CONDITIONS FOR WHICH MEDICATION IS REGULARLY TAKEN? YES_____NO_____ IF SO, WHAT IS THE NAME OF THE MEDICATION AND FOR WHAT CONDITIONS?_____
_____
_____