Virginia Commonwealth University
EVALUATION FOR PARTICIPATION IN ATHLETICS

Name:______________________________ Sport:________________________ Date:___/___/___

DOB:___/___/____ S.S. #_________________ Sex: □ Male □ Female

Local Address:____
Street City State Zip

Permanent Address:____
Street City State Zip

Phone Number:__________________________ Cell Phone Number:__________________________

Name of Parent/Guardian:__________________________ Phone Number:______________________

Emergency Contact:______________________________ Phone Number:______________________

Relationship to Student-Athlete:______________________________________

Pre-Existing Medical History Questionnaire: (to be completed by student athlete or parent/guardian) Please explain "Yes" answers below. Circle any questions you do NOT know the answers to.

GENERAL QUESTIONS:

1. Has a doctor ever denied or restricted your participation in sports for any reason? YES NO
2. Do you have any ongoing chronic illnesses? YES NO
3. Have you ever been hospitalized? YES NO
4. Have you ever had surgery? YES NO
5. Have you ever taken any supplements or vitamins to help you gain/lose weight or improve performance? YES NO

If YES, explain:

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GENERAL MEDICAL:

1. Do you have any allergies (seasonal, bee stings, latex)? YES NO
2. Do you have any allergies to medications (e.g. Penicillin, Ibuprofen)? YES NO
3. Are you currently taking any prescription or non-prescription medications or pills? YES NO
4. Do you wear contact lenses or glasses? YES NO
5. Do you have any metal or implanted device in your body? YES NO
6. Do you have any missing organs (e.g. Kidneys, testicles)? YES NO
7. Have you ever been diagnoses with Hepatitis or Anemia? YES NO
8. Do you have any ear, nose and throat problems? YES NO
9. Do you have diabetes, thyroid or other endocrine problems? YES NO

If YES, explain:

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GENERAL MEDICAL

10. Do you have any stomach or bowel problems? YES NO
11. Do you have any kidney or bladder problems? YES NO
12. Do you wish to gain or lose weight? YES NO

If YES, explain:

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FEMALES ONLY:

1. Do you have regular menstrual periods? YES NO
2. How many per year do you have?____
3. When was your last period?___

CARDIAC/CIRCULATORY

1. Have you ever passed out during or after exercise? YES NO
2. Have you ever been dizzy during or after exercise? YES NO
3. Have you ever had chest pain during or after exercise? YES NO
4. Have you ever been diagnosed with a heart related problem? YES NO
5. Have you ever been told you have high blood pressure and/or high cholesterol? YES NO
6. Have you ever been told you have a heart murmur? YES NO
7. Have you ever been evaluated for abnormal heart beats or chest pain? YES NO
8. Do you have a family member die under the age of 35 from heart related conditions or sudden death? YES NO

If YES, explain:

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9. Have you or anyone in your family been diagnosed with **Marfan's Syndrome**? YES NO
10. Have you or anyone in your family been diagnoses with **Sickle Cell Trait** or **Sickle Cell Anemia**? YES NO

If YES, explain:

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RESPIRATORY:

1. Have you ever had trouble with your lungs? YES NO
2. Have you had difficulty with sortness of breath or coughing spells? YES NO
3. Do you cough, wheeze or have trouble breathing during activity? YES NO
4. Have you ever been diagnosed with asthma? YES NO
5. Do you have any history of childhood asthma? YES NO
6. Do you have any history of taking medicine for asthma, inhalers or pills? YES NO
7. Do you have any history of exposure to tuberculosis? YES NO

If YES, explain:

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HEAD/CONCUSSION HISTORY:

1. Do you have any problems with frequent headaches, blurred vision, or dizziness? YES NO
2. Do you have frequent or severe headaches? YES NO
3. Have you ever had a seizure? YES NO
4. Do you have any chipped, loose or missing teeth? YES NO
5. Do you have any dental implants (bridges, braces, etc)? YES NO
6. Have you ever has a head injury? YES NO
7. Have you ever had a concussion? YES NO
   a. If yes, how many?_______
   b. When was last one?_____
8. Have you ever been knocked out or lost consciousness? YES NO

If YES, explain:

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NECK:

1. Do you have a history of neck problems? YES NO
2. Have you ever had a burner/stinger? YES NO
3. Do you have any numbness in your arms or legs? YES NO
4. Do you have any trouble with your back? YES NO

If YES, explain:

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GENERAL ORTHOPEDIC:

1. Have you broken or fractured any bones or dislocated any joints, including stress fractures/reactions? YES NO
2. Have you ever had a sprain, strain, or swelling after injury? YES NO
   a. If YES check appropriate blank and explain below:

___Head ____Elbow ___Hip
___Neck ____Forearm ___Thigh
___Back ____Wrist ___Knee
___Chest ____Hand ___Shin
___Shoulder ___Finger ___Calf
___Upper Arm ___Foot ___Ankle

3. Have you ever had surgery? YES NO
   a. If YES check appropriate blank and explain below:

___Head ____Elbow ___Hip
___Neck ____Forearm ___Thigh
___Back ____Wrist ___Knee
___Chest ____Hand ___Shin
___Shoulder ___Finger ___Calf
___Upper Arm ___Foot ___Ankle
___General/Internal Surgery (appendix, hernia, etc)
___Oral Surgery (i.e. Wisdom teeth)

If YES, explain:

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4. Do you wear any brace or support to play? YES NO
5. Do you have any type of pin, screw or plate in your body? YES NO

If YES, explain:

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HEAT ISSUES

1. Have you ever become ill from exercising in the heat? YES NO
2. Have you ever been given I.V. fluids or been transported to the emergency room because of heat issues? YES NO

If YES, explain:

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____

OTHER:

1. Do you think you are too fat or too thin? YES NO
2. Do you wish to gain or lose weight? YES NO

If YES, explain:

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____

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ADDITIONAL INFORMATION:

PLEASE PRINT CLEARLY

Use the space below to further explain any "YES" answers to the questions above, or provide any additional pertinent information: (please include any and all date(s) of injury, or surgery, side of injury, etc.)

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MEDICATION FORM

MEDICATION SUMMARY:

Drug Allergies:

NAME	REACTION

Current Medications:

**Please list any and ALL medications (over-the-counter or prescription) that you are currently taking or have taken within the last 60 days:

NAME	REASON FOR TAKING

_______________________________ Signature

_______________ Date

Virginia Commonwealth University
PHYSICAL EXAMINATION FORM

Student-Athlete Name____

PHYSCIAL EXAMINATION: (to be completed by a licensed physician, licensed physician assistant or nurse practitioner)

Height: ___________ Weight___________ Pulse: ____________ Blood Pressure: ________/________

Vision: Right: 20/_______ Left: 20/________ Corrected: YES NO (circle one) If YES, explain: ______________________

MEDICAL FINDINGS	Normal	Abnormal	Not Examined	Comments
Eyes				
Ears, Nose, Throat				
Mouth, Teeth				
Neck				
Chest, Lungs				
Heart				
Genitalia, hernia (men only)				
Skin, Lymphatics				
Abdomen				

MUSCULOSKELETAL FINDINGS	Normal	Abnormal	Not Examined	Comments
Neck				
Back				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Hip/Thigh				
Knee				
Leg/Ankle				
Foot				

*****Sickle Cell Solubility Test Results**____

- Student-Athletes must show proof of test, including results, or have a signed VCU waiver before being allowed to participate in ANY athletic activity.

Other Laboratory tests (as indicated): ____

PARTICIPATION RECOMMENDATIONS

□ No history or physical findings on this exam would prohibit this student from participating in the sports requested. Comments:

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□ This student should have the following health problem(s) evaluation or treated before participation recommendations can be made:

____

____

□ This student has health problem(s) that prohibit him/her from participating in the requested sport of: ____________________
However, this student can participate in the following requested sport(s): ______________________________

________________________________ ________________________
Examiner's Signature Telephone Number

________________________________ ________________________
Examiner's Printed Name Address

________________________________ ________________________
Date of Physical Exam City, State, Zip