



Miami Dade College

Athletics

Sports Medicine Packet

SPORT(S): _____

NAME (Print): _____
First Last

STUDENT ID#: _____

INSTRUCTIONS:

- DO NOT remove any papers – this includes the four physical exam papers.
- If downloading from the website, print all pages in order and staple together.
- DO NOT copy pages front to back. Print each page individually.
- All pages must be completed before turning this packet in to your coach.

Miami Dade College

Pre- Participation Exam

PLEASE PRINT CLEARLY

Name: _____ Sport(s): _____

Age: _____ Date of Birth: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Person: _____ Phone: _____

Please answer the following questions for review by the doctor and explain all "Yes" answers in the space provided at the end of the section. Circle any questions you do not know how to answer.

- | | | |
|---|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | Yes | No |
| 2. Do you have any ongoing medical condition (like diabetes or asthma)? | Yes | No |
| 3. Are you currently taking any prescriptions or nonprescription (OTC) medicine or pills? | Yes | No |
| 4. Do you have allergies to medicines, pollens, foods or stinging insects? | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING exercise? | Yes | No |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | Yes | No |
| 7. Have you ever had discomfort, pain or pressure in your chest during exercise? | Yes | No |
| 8. Does your heart race or skip beats during exercise? | Yes | No |
| 9. Has a doctor ever told you that you have (check all that apply): | Yes | No |

High blood pressure Heart murmur High cholesterol Heart infection

- | | | |
|--|-----|----|
| 10. Has a doctor ever ordered a test for your heart? (example: EGG, echocardiogram) | Yes | No |
| 11. Has anyone in your family died for no apparent reason? | Yes | No |
| 12. Does anyone in your family have a heart problem? | Yes | No |
| 13. Has any family member or relative died of heart problems or died suddenly before age 50? | Yes | No |
| 14. Does anyone in your family have Marfan Syndrome? | Yes | No |
| 15. Have you ever spent the night in a hospital? | Yes | No |
| 16. Have you ever had surgery? | Yes | No |
| 17. Have you ever had a sprain, muscle or ligament tear, or tendonitis, which caused you to miss a practice or a game? If yes, please circle below. | Yes | No |
| 18. Have you had a broken or fractured bone or dislocated joint? If yes, please circle below. | Yes | No |
| 19. Have you had a bone or joint injury that required X-rays, MRI, CT, Surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, please circle below. | Yes | No |
- Head Neck Shoulder Upper-arm Elbow Forearm Hand/Fingers Chest
 Upper-Back Lower-Back Hip Thigh Knee Calf/Shin Ankle/ Foot/ Toes

- | | | |
|--|-----|----|
| 20. Circulatory problems? | Yes | No |
| 21. Anemia supplements, neurological problems? | Yes | No |
| 22. Have you ever had a stress fracture? | Yes | No |
| 23. Have you been told that you have (or have you had an x-ray for) atlantoaxial (neck) instability? | Yes | No |
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | Yes | No |
| 25. Is there anyone in your family who has asthma? | Yes | No |
| 26. Have you ever used an inhaler or taken asthma medicine? | Yes | No |
| 27. Were you born without or are you missing a kidney, eye, testicle or any other organ? | Yes | No |
| 28. Have you had infectious mononucleosis (mono) <u>within the last month</u> ? | Yes | No |
| 29. Do you have any rashes, pressure sores, or other skin conditions? | Yes | No |
| 30. Have you had a herpes skin infection? | Yes | No |
| 31. Have you ever had a head injury or concussion | Yes | No |
| 32. Have you ever been hit in the head and been confused or lost your memory? | Yes | No |
| 33. Have you ever had a seizure? | Yes | No |
| 34. Do you have headaches with exercise? Migraines? | Yes | No |
| 35. Have you ever had numbness, tingling, or weakness in your arms/legs after being hit or falling? | Yes | No |
| 36. Have you ever been unable to move your arms or legs after being hit or falling? | Yes | No |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill? | Yes | No |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell? | Yes | No |
| 39. Have you ever had any problems with your eyes or vision? | Yes | No |
| 40. Do you wear contact lenses or glasses? | Yes | No |
| 41. Do you wear protective eyewear, such as goggles or a face shield? | Yes | No |
| 42. Are you happy with your weight? | Yes | No |
| 43. Are you trying to gain or lose weight? | Yes | No |
| 44. Has anyone recommended you change your weight or eating habits? | Yes | No |
| 45. Do you limit or carefully control what you eat? | Yes | No |
| 46. Do you have any concerns you would like to discuss with a doctor? | Yes | No |
| 47. Any weak joints to discuss and trainer for program? | Yes | No |

EXPLAIN ALL YES ANSWERS BELOW

Question# Explain

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY SHOULD BE REVIEWED BY PHYSICIAN

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

Signature of Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____

For athletes under the age of 18

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____

BP _____/_____/_____ (_____/_____/_____) (_____/_____/_____)

Vision R-20 _____ L-20 _____ Corrected Y N Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only) +			
Skin			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* Multiple-examiner set-up only

+ Having a third party present is recommended for the genitourinary examination.

NOTES _____

Name of physician (print/type) _____ Date of exam _____

Address _____ Phone _____

PHYSICIAN SIGNATURE _____, MD or DO

PHYSICIAN OFFICE STAMP:

PHYSICIAN CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of Birth _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for:

_____ Not Cleared for: All Sports Certain Sports: Reason: _____

Recommendations:

EMERGENCY INFORMATION:

Allergies _____

Other Information _____

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

PHYSICIAN SIGNATURE _____, **MD or DO**

PHYSICIAN OFFICE STAMP:

FOLLOW-UP CLEARANCE FORM

Only to be completed if "not clear" above

Name _____ Sex _____ Age _____ Date of Birth _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for:

_____ Not Cleared for: All Sports Certain Sports: Reason: _____

Recommendations/Allergies/other information: _____

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

PHYSICIAN SIGNATURE _____, **MD or DO**

PHYSICIAN OFFICE STAMP:



Miami Dade College

Student Athlete's Name: _____

Please read the following consent forms carefully. The student athlete's signature or parent's signature (for students under age 18) is required.

Medical Consent

I hereby grant permission to Miami Dade College and team physicians and/or their consulting physicians and other medical personnel under their direction to render to my son/daughter/self any treatment or surgical care that they deem reasonably necessary to the health and well-being of the student-athlete. I also hereby authorize the athletic trainers at Miami Dade College, who are under the direction and guidance of their team physicians, to render to my son/daughter/self any preventative, first aid, rehabilitative, or emergency treatment that they deem reasonably necessary to the health and well-being of the student-athlete. I also hereby authorize the coaching staff at Miami Dade College to render first aid and seek treatment for my son/daughter/self as deemed necessary. Also, when necessary for executing such case, I grant permission for emergency transportation and hospitalization at an accredited hospital. This consent specifically includes consent to release all information that may be required for treatment, including but not limited to insurance information.

STUDENT ATHLETE'S SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____
(Athlete under age 18)

Release and Assumption of Risk

Participation in a sport involves inherent risk of bodily harm and requires an acceptance of risk of injury. Student-athletes must assume that their participation can result in injury to them, even serious injury.

I understand that by willingly participating in athletics at the collegiate level, I am knowingly undertaking and assuming a non-controllable risk which may result in an injury that may be severe in nature. Such an injury may result in paralysis or death. I understand these risks and agree to accept full personal responsibility for all risks, foreseen and unforeseen, in connection with my participation in athletics at the collegiate level.

I hereby assume all risks associated with participation in athletics at Miami Dade College (including transportation to and from events) and agree to waive from liability and hold harmless Miami Dade College, its employees, agents, representatives, coaches, volunteers, and athletic trainers from and against any and all claims, demand, losses, or liabilities of any kind or nature which may in connection with injuries suffered while participating in, or in any way in connection with, intercollegiate athletic.

STUDENT ATHLETE'S SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____
(Athlete under age 18)

Authorization for Release of Information

In signing the Authorization for Release of Information form, I authorize hospitals, physicians, certified athletic trainers, rehabilitation clinics, and student health services to release medical information to the Miami Dade College Athletic Training Staff, team physicians, and coaches concerning my health and welfare. The medical information may relate to past, present and future medical conditions, injuries, or illnesses that may occur, or already have occurred, in connection with or relevant to intercollegiate athletics at Miami Dade College or otherwise.

Also, by giving the authorization for the release of medical information, I permit the representatives of Miami Dade College, medical staff, and athletic training staff to disclose information concerning my health to parents/guardians, potential professional scouts, or college coaches interested in recruiting me, if the opportunity arises in the future. I understand that a record and date will be kept of all individuals receiving such information.

STUDENT ATHLETE’S SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____
(Athlete under age 18)

Medical Insurance

_____ I DO NOT CURRENTLY HAVE MEDICAL INSURANCE

_____ I HAVE MEDICAL INSURANCE:

INSURANCE COMPANY: _____

PHONE NUMBER: _____

POLICY NUMBER: _____

GROUP NUMBER: _____

ADDRESS _____

POLICY DEDUCTIBLE _____

DOES YOUR INSURANCE POLICY EXCLUDE INTERCOLEGITATE INJURIES? Y__ N__

Please be sure to attach a copy of your insurance card back and front

Notary Public Acknowledgement

State of _____ County of _____

On this _____ day of _____ before me personally appeared

_____ to me known to be the person who executed the foregoing instrument, and acknowledged that he executed the same as his/her free act and deed.

SEAL (signed) _____

Notary Public