ATHLETE NUMBER-OFFICE USE ONLY

OMB Number: 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 10 minutes

Department of Veterans Affairs

GENERAL MEDICAL FORM

TO BE COMPLETED BY PARTICIPANT. PLEASE TYPE OR PRINT CLEARLY.

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

DATE			VA MEDICAL CENTER NAME	
NAME *(Last, First, MI)* E-MAIL ADDRESS			ADDRESS *(Street, City, State, Zip Code)*	
SOCIAL SECURITY NO. *(Last 4 digits only)*	AGE	DAYTIME TELEPHONE NUMBER *(Include area code)*	CELL PHONE NUMBER *(Include area code)*	EVENING TELEPHONE NUMBER *(Include area code)*
TEAM COORDINATOR/LEADER:			ALTERNATE TEAM CONTACT:	
TELEPHONE NUMBER	E-MAIL ADDRESS		TELEPHONE NUMBER	E-MAIL ADDRESS
In Case of Emergency, Notify *(Name)*: TELEPHONE NUMBER	RELATIONSHIP TO PATIENT		ADDRESS *(Street, City, State and Zip Code)*	

TO BE COMPLETED BY THE EXAMINING PHYSICIAN. PLEASE TYPE OR PRINT CLEARLY.

Dear Doctor: *Your detailed exam of the participant will be very helpful to the medical assistance team. If an assistant completes the form, please countersign the exam.*

OPERATIONS ***(Please list)***

1 _____
2 _____
3 _____

ALLERGIES ***(Are you allergic to anything? If yes, specify)*** ☐ YES ☐ NO

1 _____
2 _____
3 _____

DIAGNOSIS/TYPE OF INJURY

DATE OF INJURY OR DIAGNOSIS _____

☐ SPINAL CORD INJURY (SCI)--LEVEL OF INJURY _____
☐ MULTIPLE SCLEROSIS (MS)
☐ AMPUTEE
☐ HEAD INJURY
☐ OTHER *(Please specify)* _____

VA IDENTIFICATION CARD

PLEASE ATTACH A COPY OF VA IDENTIFICATION CARD HERE
(See below)

If you do not attach a copy of your VA IDENTIFICATION CARD you **must** fill out VA Form 10-10EZ including your full Social Security Number.

MEDICATIONS *(Please list all medications you are currently using. If you require more room, please attach an additional sheet.)*

	MEDICATION NAME	DOSAGE	HOW OFTEN TAKEN
1			
2			
3			
4			
5			

OTHER MEDICAL INFORMATION *(Please list all other medical information concerning your current health status.)*

1 _____
2 _____

PHYSICAL FORM

WEIGHT	BLOOD PRESSURE	HEAD & NECK	LUNGS	ABDOMEN

HEART	EXTREMETIES	SKIN	OTHER FINDINGS

PRESENT AND PAST MEDICAL HISTORY ***(Diabetes, heart disease, hypertension, etc.)***

IS THE PATIENT ON DIALYSIS?* *(Patient is responsible for setting up any dialysis treatment needed)* ☐ YES ☐ NO

IS THE PATIENT ON A VENTILATOR? ☐ YES ☐ NO

IS THE PATIENT ON ANTICOAGULANT DRUGS? *(If yes, which)* ☐ YES ☐ NO _____

PHYSICIAN CLEARANCE

IN MY OPINION, THE ABOVE INDIVIDUAL *(You **must** check on e of the following boxes)*

☐ **IS** CLEARED TO COMPETE OR ☐ **IS NOT** CLEARED TO COMPETE

IF NOT CLEARED, REASON WHY

PHYSICIAN INFORMATION

NAME OF EXAMINING PHYSICIAN *(Please print)*

ADDRESS *(Street, City, State and Zip Code)*

SIGNATURE OF EXAMINING PHYSICIAN

TELEPHONE NUMBER DATE

NVWG AND/OR USQRA CLASSIFICATION CARD(S)

PLEASE ATTACH A COPY OF YOUR CLASSIFICATION CARD(S)
(See below)

If applicable, please attach a **copy** (not the original) of you National Veterans Wheelchair Games, USQRA (quad rugby), and/ or Wheelchair Sports, USA classification card above.

May omit only if copy of current NVWG Classification card is stapled in the area provided in the General Medical Information Section on Page 1 of this form.

This section must be completed by someone familiar with direct muscle testing, i.e., a physician, physical therapist, kinesiotherapist, or occupational therapist.

NEURO EXAM *(Manual muscle test, 0-5)*

UPPER EXTREMITY	RIGHT	LEFT
DELTOID		
BICEPS		
WRIST EXTENSION		
WRIST FLEXION		
TRICEPS		
FINGER EXTENSION		
FINGER FLEXION		
FINGER ABD/ADD		

LOWER EXTREMITY	RIGHT	LEFT
HIP FLEXION		
HIP EXTENSION		
HIP ADDUCTION		
HIP ABDUCTION		
KNEE FLEXION		
KNEE EXTENSION		
DORSIFLEXION		
PLANTARFLEXION		

SITTING BALANCE *(Please check one)*

☐ NORMAL ☐ FAIR

☐ POOR ☐ NONE

HANDEDNESS *(Please check one)*

☐ RIGHT ☐ LEFT

TRUNK *(0-5 scale)*	UPPER	LOWER
ABDOMINALS		
SPINAL EXTENSORS		