MARYLAND
SPORTS MEDICINE

TRYOUT STUDENT-ATHLETE CHECKLIST

The following materials must be completed in its entirety and returned the sport's staff athletic trainer prior to the walk-on tryout date. Failure to comply will forfeit the prospective student-athletes ability to participate in the tryout.

Student-Athlete Name ______________________________ UID ______________________________

1.	☐	Initial health appraisal form
2.	☐	Documentation of a physical examination by a licensed physician (MD, DO or NP) within the last six months that clears the prospective tryout student-athlete to participate in intercollegiate athletics (generic one is provided at the end of this packet if needed)
3.	☐	Sickle cell education form
4.	☐	Sickle cell solubility lab results (SST)
5.	☐	Concussion education sheet and waiver form
6.	☐	Big Ten injury and illness reporting acknowledgement form
7.	☐	ADD/ADHD education sheet and medical exception notification form
8.	☐	Assumption of risk form
9.	☐	Tryout release and waiver of liability form
10.	☐	Tryout student-athlete insurance information sheet
11.	☐	Proof of valid personal/primary health insurance that provides coverage for intercollegiate athletic activates (must attach a photocopy of the front and back of current health insurance card)

☐ Complete ☐ Incomplete

Notes ____

Sports Medicine Signature ______________________________ Date ____________________

Initial Health Appraisal

(Please print clearly in black ink only)

First Name______________________Middle__________________Last______________________________Date ______________

Date of Birth ______________________

Race: ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other ___________________

Sport(s)_____________________________________ UID ____

Height________________________Weight______________________________ ☐ Right Handed ☐ Left Handed

Family History *(please complete / check appropriate boxes):*

	FATHER	MOTHER
Current Age		
If Deceased, Cause of Death		
Age @ Death		
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)		
History of Diabetes		
History of heart disease, high blood pressure, and/or high cholesterol		
History of stroke		
History of tuberculosis		
History of Cancer		

	SIBLING 1	SIBLING 2	SIBLING 3	SIBLING 4
Current Age				
If Deceased, Cause of Death				
Age @ Death				
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)				
History of Diabetes				
History of heart disease, high blood pressure, and/or high cholesterol				
History of stroke				
History of tuberculosis				
History of Cancer				

I. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________________

Do you cough, wheeze, and/or have trouble breathing during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ____________________

Do you get tired more quickly than your teammates / friends do during exercise / practice? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please Describe ____________________

Has any family member or relative died or heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please Describe ____________________

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / Please Describe ____________________

Does anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been told that you have / had high blood pressure? ☐ YES ☐ NO

- Please Describe ____________________

Does anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please Describe ____________________

Have you even been told that you have / had high blood cholesterol? ☐ YES ☐ NO

- Please Describe ____________________

II. Allergies:

Have You Ever Been Diagnosed With Seasonal Allergies? ☐ YES ☐ NO

- Please Describe ______

Are You Presently Taking/Have You Previously Taken Any Allergy Medications? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? ☐ YES ☐ NO

- Please Describe ______

III. Asthma:

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ______

Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ___

How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week? ___

How Many Acute Asthma Attacks Have You Had In The Past 12 Months? ______

- Date(s)? ______
- Please Describe ______

Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? ☐ YES ☐ NO

- Please Describe ______

IV. Sickle Cell Trait:

Have you ever been tested for Sickle Cell Anemia and/or **Sickle Cell Trait** that you are aware of? ☐ YES ☐ NO

- Date? ______ Result? ______

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe ______

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO

- Please Describe ______

Have you ever restricted, modified, and/or been instructed to restrict or modify your participation in sports due to muscle pain and/or cramping during or after exercise? ☐ YES ☐ NO

- Please Describe ______

V. Head Injuries / Concussion:

Have You Ever Suffered A Head Injury / Concussion ***(no matter how minor)?*** ☐ YES ☐ NO

If YES, please complete the following chart for each head injury / concussion

DATE					
Signs / Symptoms (please check the appropriate box)					
Headache(s) and/or "Pressure in the Head"					
Dizziness and/or Balance Problems					
Loss of Consciousness / "blacked out"					
Loss of Memory					
Ringing in the Ears / Hearing Problems					
Nausea and/or vomiting					
Vision problems (double vision; blurred vision)					
Balance problems					
Difficulty concentrating / Confusion					
Difficulty sleeping					
Lethargy / Drowsiness / Fatigue					
Irritation / Anxiety / Nervousness					
Sensitivity to Light and/or Noise					
Sadness / Depression / "Feeling in a Fog"					
Other (please describe)					
Care / Treatment (please check the appropriate box)					
Evaluation by a physician					
Emergency Room / Hospitalization					
Neuropsychological Testing (e.g. ImPACT, etc.)					
Balance and/or Vision Testing					
Diagnostic Testing (e.g. CT Scan, MRI, x-ray, etc.)					
Other (please describe)					
Time Missed					
Days					
Practices					
Games					

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? ☐ YES ☐ NO

- Please Describe ______________________________

Do You Suffer From Headaches? ☐ YES ☐ NO

- When? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
- Where Are Your Headaches Located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Your Head

Do You Have A History of Migraine Headaches? ☐ YES ☐ NO

- How Often______________________ Please Describe ______________________
- Medications Taken for Migraines? ______________________________

Have You Had Headaches For More Than Three (3) Months? ☐ YES ☐ NO

- If yes, please explain ______________________________

VI. Eye:

When Was Your Last Eye Exam? ______________________________

- Findings? ______________________________

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________________

Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________________

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO

- Please Describe ______________________________

Do you routinely wear glasses? ☐ YES ☐ NO

Do you routinely wear contact lenses? ☐ YES ☐ NO Type ______________________________

Do you require any special devices / equipment? ☐ YES ☐ NO Type ______________________________

VII. Ear / Nose / Throat:

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________________

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________________

VIII. Dental:

When Was Your Last Dental Exam? ______________________________

- Findings? ______________________________

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________________

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? ☐ YES ☐ NO

- Please Describe ______________________________

IX. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________
- Please Describe ____________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- When?____________ Where? ____________
- Please Describe ____________

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? ☐ YES ☐ NO

- How Many?____________ Date(s)/Time Missed? ____________

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ☐ YES ☐ NO

- Date(s)? ____________
- Please Describe? ____________

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? ☐ YES ☐ NO

- When?____________ Surgeon? ____________
- Please Describe ____________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- Please Describe ____________

Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? ☐ YES ☐ NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

☐ YES ☐ NO If yes, please explain ____________

X. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________
- Please Describe ____________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- When?____________ Where? ____________
- Please Describe ____________

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ☐ YES ☐ NO

- When?____________ Surgeon? ____________
- Please Describe ____________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- Please Describe ____________

XI. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? ☐ YES ☐ NO

- When?______ Where? ______
- Please Describe ______

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? ☐ YES ☐ NO

- When?______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury? ☐ YES ☐ NO

- Please Describe ______

XII. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- When?______ Where? ______
- Please Describe ______

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? ☐ YES ☐ NO

- When?______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- Please Describe ______

XIII. Spine / Low Back / Sacroiliac Joint:

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? ☐ YES ☐ NO

- When?________________ Where? ______________________________
- Please Describe ______________________________

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- When?________________ Surgeon? ______________________________
- Please Describe ______________________________

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? ☐ YES ☐ NO

- Date(s)/Time Missed? ______________________________
- Please Describe? ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? ☐ YES ☐ NO

- Please Describe ______________________________

XIV. **Hip / Groin:**

Have You Ever Suffered An Injury To Your Hip / Groin *(including hernias and/or sports hernias)?* ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury? ☐ YES ☐ NO

- When?________________ Where? ______________________________
- Please Describe ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? ☐ YES ☐ NO

- Please Describe ______________________________

XV. Thigh / Hamstring / Quadriceps:

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When?______________ Where? ______________________
- Please Describe ______________________

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When?______________ Surgeon? ______________________
- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? ☐ YES ☐ NO

- Please Describe ______________________

XVI. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When?______________ Where? ______________________
- Please Describe ______________________

Have You Ever Had Surgery For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When?______________ Surgeon? ______________________
- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever/Do You Presently Wear A Knee Brace? ☐ YES ☐ NO

- Which Knee?______________ Brand / Model of Brace? ______________________
- Reason for Wearing? ______________________

XVII. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________
- Please Describe ____________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When?____________ Where? ____________
- Please Describe ____________

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When?____________ Surgeon? ____________
- Please Describe ____________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- Please Describe ____________

Do You Presently ☐ Tape Your Ankle(s) ☐ Use Ankle Brace(s) ☐ Other

- Please Describe ____________

XVIII. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________
- Please Describe ____________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? ☐ YES ☐ NO

- When?____________ Surgeon? ____________
- Please Describe ____________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? ☐ YES ☐ NO

- Please Describe ____________

XIX. Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________
- Please Describe ____________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? ☐ YES ☐ NO

- When?____________ Where? ____________
- Please Describe ____________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? ☐ YES ☐ NO

- Please Describe ____________

XX. Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Have You Ever Suffered An Injury To Your Abdomen? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? ☐ YES ☐ NO

- When?____________________ Where? ____________________
- Please Describe ____________________

Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? ☐ YES ☐ NO

- Please Describe ____________________

Do you Routinely Suffer From Chronic or Recurrent Diarrhea? ☐ YES ☐ NO

- Please Describe ____________________

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO

- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? ☐ YES ☐ NO

- Please Describe ____________________

XXI.**Medical Testing**:

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)?

☐ YES ☐ NO

- List Dates/Time Missed ____________________
- Please Describe ____________________

XXII.**Dermatological (Skin):**

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been diagnosed with ringworm, herpes, impetigo, or other type of bacterial, viral, or fungal skin infection? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

- Please Describe ____________________

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ YES ☐ NO

- Please Describe ____________________

XXIII. **Prescription Medications:**

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

MEDICATION	**PURPOSE**	**DOSAGE**	**DATE(S)**

XXIV. **Supplements / Ergogenic Aids:**

Please List **ALL** Vitamins, Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

SUPPLEMENT	**PURPOSE**	**DOSAGE**	**DATE(S)**

XXV. **Heat Related Problems:**

Have You Ever Suffered From A Heat Related Injury? ☐ YES ☐ NO (check all that apply):

- ☐ Heat Cramps- Date(s)? ____________________
- ☐ Heat Syncope (Fainting)-Date(s)? ____________________
- ☐ Heat Exhaustion- Date(s)? ____________________
- ☐ Heat Stroke- Date(s)? ____________________

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? ☐ YES ☐ NO

- Date(s)? ____________________

Have You Ever Been Hospitalized For a Heat-Related Problem? ☐ YES ☐ NO

- Date(s)?____________________ Where? ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? ☐ YES ☐ NO

- Please Describe ____________________

XXVI. **Diabetic History:**

Have You Ever Been Diagnosed With Diabetes? ☐ YES ☐ NO

- Date? ______________________________

Are You Presently Taking or Have You Taken Any Diabetic Medications? ☐ YES ☐ NO

Medication	**Form**	**Dosage**	**Frequency**

Do You Daily Monitor Your Blood Sugar Level? ☐ YES ☐ NO

- How Many Times Per Day? ______________ What Is Your Average Level? ______________

Have You Had Your A1C Level Checked Within The Last Three (3) Months? ☐ YES ☐ NO Level ______________

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? ☐ YES ☐ NO

- Please Describe ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? ☐ YES ☐ NO

- Please Describe ______________________________

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

____

XXVII. **For Females Only:**

At what age did you have your first menstrual period? ______________

☐ YES ☐ NO Have you had menstrual periods within the past 12 months?

- If yes, how many? ______________ When was your most recent menstrual period? ______________
- How much time do you usually have from the start of one period to the start of another? ______________
- What was the longest time between menstrual periods within the past year? ______________

☐ YES ☐ NO Do you have painful or heavy menstrual periods?

☐ YES ☐ NO Do your menstrual periods change with changes in your training regimen? If yes, please explain? ______________

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? ______________

☐ YES ☐ NO Do you take birth control pills? If yes, what brand? ______________

☐ YES ☐ NO Have you ever had any problems with your breasts?

☐ YES ☐ NO Have you had a pelvic examination within the last year?

☐ YES ☐ NO Do you take a calcium or iron supplement? If yes, what brand / strength? ______________

XXVIII. **Please Circle:** *{All questions are strictly* ***CONFIDENTIAL*** *& will not be shared with parents or coaches!}*

YES	NO	Have you ever had any injury or illness other than those already noted?
YES	NO	Do you have any ongoing or chronic illnesses?
YES	NO	Have you ever been hospitalized overnight?
YES	NO	Have you ever been told by a physician to restrict your sports activity and/or not to participate in a sport?
YES	NO	Are you currently under a physician's care for any medical conditions?
YES	NO	Have you ever been under the care of a psychiatrist and/or psychologist?
YES	NO	Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
YES	NO	Have you ever had a rash or hives develop during and/or after exercise?
YES	NO	Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants?
YES	NO	Have you ever been told that you have kidney disease?
YES	NO	Have you ever been told that you cannot donate blood?
YES	NO	Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
YES	NO	Have you ever had a stomach and/or duodenal ulcer?
YES	NO	Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past twelve (12) months?
YES	NO	Have you ever had seizures, convulsions, and/or epilepsy?
YES	NO	Have you ever had gall bladder disease and/or a urinary problem?
YES	NO	Do you have ringing in your ears or trouble hearing?
YES	NO	Do you have frequent ear infections or nosebleeds?
YES	NO	Have you ever had an abnormal chest x-ray and/or pneumonia?
YES	NO	Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
YES	NO	Have you ever had the chickenpox? If yes, when? ______________________
YES	NO	Are you aware of any reasons why you should not participate in intercollegiate athletics at the University of Maryland at this time?
YES	NO	Have you had a tetanus booster within the past five (5) years? If yes, when? ______________________
YES	NO	Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? ______________
YES	NO	Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
YES	NO	Do you use alcohol? If yes, how often? ______________________
YES	NO	Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
YES	NO	Do you have any questions regarding drugs, tobacco, or alcohol?
YES	NO	Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
YES	NO	Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
YES	NO	Are you a vegetarian? If yes, what type? ______________________
YES	NO	Do you regularly lose weight to participate in your sport?
YES	NO	Do you want to weigh more or less than you presently do?
YES	NO	Do you experience cramps or upset stomach when drinking milk or eating dairy products (e.g. yogurt, cheese, ice cream)
YES	NO	Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
YES	NO	Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
YES	NO	Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain: ______________________________________

____

____

____

____

____

____

____

____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements in the initial health appraisal are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature — Date

Student-Athlete Print Name

Parent/Guardian Signature *(if under 18 years of age)* — Date

Parent/Guardian Print Name

Witness — Date

Reviewed By:

Reviewer's Signature — Date

Reviewer Print Name

MARYLAND
SPORTS MEDICINE

SICKLE CELL TRAIT TESTING

In compliance with NCAA Proposal 2009-75-B-1, the University Of Maryland Department Of Intercollegiate Athletics requires all student-athletes, including those participating in walk-on tryout activities, to have documentation of a sickle cell solubility test (SST) as part of his / her pre-participation physical examination. Documentation must be present BEFORE the student-athlete is permitted to participate in any athletically related activities, including, but not limited to tryout activities, practices, strength and conditioning sessions, and/or compete in any intercollegiate athletic events.

Tryout Student-athletes can meet this requirement in one of three ways-

1. **University of Maryland Health Center-**
   a. Meet with a physician at the health center to get a prescription for the test. Testing can performed at the health center.
2. **Pediatrician / Primary Care Physician-**
   a. Obtain a copy of appropriate documentation from your pediatrician / primary care physician (PCP)
      i. Appropriate documentation is a copy of laboratory results indicating the student-athlete's sickle cell status. A statement from a physician on letterhead or a prescription pad will not be accepted.
3. **Quest Diagnostic Labs-**
   a. Go to the Quest Diagnostic Labs / Medivo website (https://sicklecelltesting.medivo.com/order/am) to order your sickle cell trait test.
   b. Follow the directions on the screen and complete all required information.
   c. Go to the nearest Quest Diagnostics Patient Service Center to have your blood drawn
   d. Results will be emailed to the student-athlete in 24-48 hours

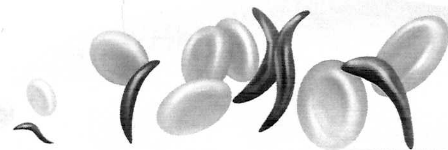
Please make sure you come with a copy of the laboratory results to the tryout.

If you have any questions or concerns regarding the Sickle Cell Trait testing requirements or process and/or other general questions regarding any aspects of the University of Maryland pre-participation physical exam process, please do not hesitate to contact University of Maryland Sports Medicine personnel at mdsportsmedicine@umd.edu.

Thank you

.

SICKLE CELL TRAIT



WHAT IS SICKLE CELL TRAIT?

Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

- During intense exercise, red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or "sickle."
- Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles.
- During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.
- Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

DO YOU KNOW IF YOU HAVE SICKLE CELL TRAIT?

People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

- Sickle cell trait occurs in about 8 percent of the U.S. African-American population, and between one in 2,000 to one in 10,000 in the Caucasian population.
- Most U.S. states test at birth, but most athletes with sickle cell trait don't know they have it.
- The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.
- Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, allowing you to thrive in your sport.

HOW CAN I PREVENT A COLLAPSE?

- Know your sickle cell trait status.
- Engage in a slow and gradual preseason conditioning regimen.
- Build up your intensity slowly while training.
- Set your own pace. Use adequate rest and recovery between repetitions, especially during "gassers" and intense station or "mat" drills.
- Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.
- If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.

- Maintain proper asthma management.
- Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.
- Beware when adjusting to a change in altitude, e.g., a rise in altitude of as little as 2,000 feet. Modify your training and request that supplemental oxygen be available to you.
- Seek prompt medical care when experiencing unusual physical distress.

For more information and resources, visit www.NCAA.org/health-safety

Sickle Cell Trait Screening

I, ________________________, understand and acknowledge that the NCAA and the University of Maryland
Student-Athlete Name
Intercollegiate Athletics mandate that all student-athletes have knowledge of sickle cell trait and how it may affect their well being. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell trait testing. I understand that Sickle Cell Trait test is needed in order to compete in college athletics.

I have read and signed this document with full knowledge of its significance. I have received a Sickle Cell Education Materials Packet provided by the University of Maryland Sports Medicine Staff. I understand the results of this test will not affect my eligibility nor influence depth chart decisions. I further attest that I am at least 18 years of age and competent to sign this waiver.

____ ____________________________

Student-Athlete Signature Date

____

UID

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

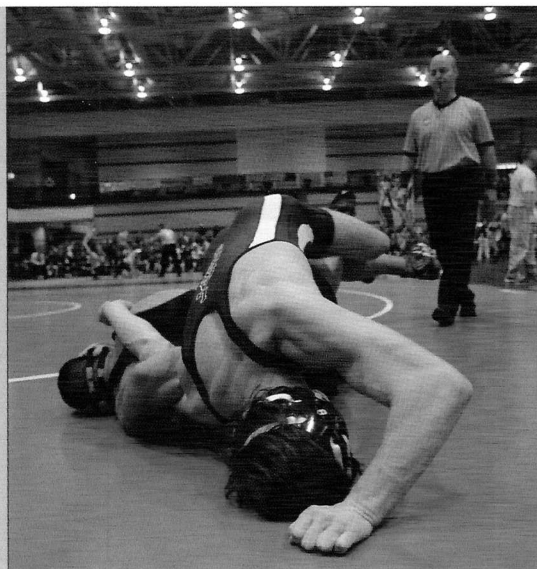
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.

Concussion Acknowledgement Form

I,_________________________, acknowledge that as student athlete at the University of Maryland, I accept responsibility for supporting my university's policy on concussion management.

I understand that student-athletes are at risk of head injury and/or concussion. I also understand the importance of reporting any symptoms of a head injury/concussion to an athletic trainer and/or team physician. I also accept responsibility for reporting signs or symptoms that I may witness.

By signing below, I acknowledge that my institution has provided me with educational materials on concussion symptoms, including institutional policies regarding concussion management and I have had the opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, ___________________ have read the above and agree that the statements are accurate.

___________________________________ ____________________
Student athlete's Signature Date

____
UID

___________________________________ ____________________
Athletic Trainer's Signature Date

Big Ten Injury and Illness Reporting
Acknowledgement Form

I, ________________________, acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physician, athletic training staff). I recognize that my true physical condition is dependent upon my accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that my institution has provided me with educational materials on what a concussion is and given me an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, ______________________ have read the above and agree that the statements are accurate.
Student-athlete's name

________________________________ ________________________
Signature of student-athlete Date

________________________________ ________________________
Name of person obtaining consent Signature of person consenting

Information regarding the use of stimulants for treatment of ADHD, ADD, and/or similar conditions

Background-

The NCAA bans classes of drugs that can be harmful to student-athletes and that can create unfair advantages during competition (NCAA Bylaw 31.2.3).Some medications that student-athletes are prescribed for legitimate medical reasons contain NCAA banned substances

The NCAA, through the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) has a ***Medical Exceptions Procedure*** procedure to review and approve the use of medications that contain NCAA banned substances. Effective **August 1, 2009**, with respect to the use of banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and/or like conditions, (e.g. Ritalin, Stattera, Adderall, Concerta, etc.), the NCAA now requires documentation of a comprehensive clinical evaluation to support treatment with NCAA banned stimulants and a current prescription.

What should student-athletes who are prescribed stimulant medications for ADHD, ADD, and/or like conditions do?

Student-athletes who have been prescribed stimulant medications for the treatment of ADHD, ADD, and/or like conditions should immediately notify a member of the Sports Medicine Department to ensure that they have the necessary documentation on file.

What documentation must the student-athlete obtain from his/her prescribing physician?

At a minimum, student-athletes prescribed NCAA banned stimulants for the treatment of ADHD, ADD, and/or like conditions must have their prescribing physician complete the **University of Maryland ADHD / ADD Medical Exceptions packet**. The prescribing physician must provide the following documentation-

1. Evidence of comprehensive clinical evaluation (recording observations and results from standardized rating scales and/or neuropsychological testing), a physical exam and any lab work (attaching all documentation);
   - ***A simple statement from a prescribing physician that he/she is treating the student-athlete for ADHD, ADD, and/or like conditions with the prescribed stimulant IS NOT adequate documentation***
2. Statement of diagnosis, including when diagnosis was confirmed;
3. History of ADHD, ADD, and/or like conditions treatment (previous and ongoing);
4. Recommended treatment (attaching current prescription);
5. Statement that a non-banned ADHD alternative has been considered and why banned stimulant was prescribed; and
6. Follow-up notes with prescribing physician and updated letter or copy of medical record is required in each year of eligibility.
7. Copy of the most recent prescription.

When and where should documentation be sent?

- The aforementioned documentation must be on file with the University of Maryland Sports Medicine Department in order for the student-athlete to participate in intercollegiate athletics at the University of Maryland.
- All documentation should be sent to the following address- University of

  Maryland Sports Medicine
  Attn: Steve Nordwall
  Gossett Football Team House
  379 Field House Drive College Park, MD 20742
  Fax- 301-314-6549 {secure fax}
  Email- snordwal@umd.edu

Who can student-athletes, parents, coaches, etc. contact with questions regarding issues surrounding ADHD medications and the NCAA Medical Exceptions Policy?

Student-athletes and/or parents with questions regarding the use of prescribed stimulants to treat ADHD, ADD, and/or like conditions should start by directing questions to the physician who initially conducted the evaluation and diagnosis.

Individuals with specific questions regarding the NCAA Bylaw related to banned substances, drug testing, and/or medical exceptions can view the NCAA website (www.ncaa.org/health-safety) and/or contact Steve Nordwall (301- 314-2663; snordwal@umd.edu)

ADHD MEDICAL EXCEPTIONS NOTIFICATION FORM

I,____affirm that I have been informed by University of
Student-Athlete Print Name and UID

Maryland Sports Medicine personnel on____________________about the NCAA Banned Substances List
Date
and NCAA Medical Exceptions Policy as it specifically pertains to the use of banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. I attest that:

ONLY INITIAL ONE SECTION

Initial ____________	**I AM NOT** presently taking and/or have taken within the last 12 months any banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions.
Initial ____________	**I AM** presently taking and/or have taken within the last 12 months banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. Medication ____

I, the undersigned, do hereby affirm that I understand that I am to immediately notify a member of the University of Maryland Sports Medicine Department should I ever be prescribed the aforementioned stimulant medications and that I must obtain and submit appropriate documentation from the prescribing physician.

I further attest that I have had any and all questions regarding the NCAA ADHD Medical Exceptions Policy answered to my satisfaction.

____ ____________________
Student-Athlete Signature Date

____ ____________________
Athletic Trainer Signature Date

____
Athletic Trainer Print Name

ASSUMPTION OF RISK / RELEASE

In consideration of being allowed to participate in any way in the Intercollegiate Athletics program at the University of Maryland, College Park and/or related events and activities of the Intercollegiate Athletics program at the University of Maryland, College Park,

I: ____

Print Name and UID

a. Acknowledge and fully understand that I will be engaging in activities that involve risk or potentially serious injury including permanent disability and death, and severe social and economic losses which might result not only from my actions, inactions or negligence, but the actions, inactions or negligence of others, the rules of play or the condition of the premises or of any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.

b. Knowingly and freely assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death.

c. Understand that the University of Maryland and the Department of Intercollegiate Athletics has no appropriation for other funds which may be used to pay claims against the University of Maryland or the Department of Intercollegiate Athletics and their officers, agents and employees of any individual who may be injured in an accident while participating in a University of Maryland athletic program.

d. Understand that I have been advised by the University of Maryland and the Department of Intercollegiate Athletics to obtain a physical examination to determine that I am fit to participate in Athletic Department activities and to procure health and accident insurance to cover the cost incurred from injuries I may sustain as a result of my participation in Athletic Department activities.

e. Voluntarily assume all risks of loss, damage, illness, injury or death that I may sustain while participating in University or Athletic Department activities and in consideration of the right to participate in such programs, I covenant to refrain from instituting any claim, demand or cause of action for damages, costs or compensation against the University of Maryland or the Department of Intercollegiate Athletics or their officers, agents or employees for any injury or loss which may occur as a result of participation in University or Athletic Department activities.

f. Release, waive, discharge and covenant not to sue the University of Maryland, College Park, its officers, agents and employees all of which are hereinafter referred to as “releasees,” from any and all liability to me, my heirs, or next of kin for any and all claims, demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.

g. Have read and understand the content of the waiver and release and sign voluntarily.

____ ____________________

Signature Date

____ ____________________

Parent / Guardian Signature (if under 18 years old) Date

The University of Maryland and the Department of Intercollegiate Athletics are not authorized to provide medical, accident or health insurance. You are advised to obtain appropriate insurance on an individual basis. If you are presently insured, you should check your policy to assure yourself of sufficient and appropriate coverage.

MARYLAND

SPORTS MEDICINE

TRY OUT RELEASE & WAIVER OF LIABILITY

I,____, acknowledge that I am completely aware of the

Student-Athlete Print Name and UID

inherent risks associated with_______________________________________and with participation in a try-out for that

Sport

sport. I understand that, in addition to the risks of injury, which may include death, my participation in that sport may cause aggravation of pre-existing injuries. Knowing this, I take full responsibility for any injury that may occur as a result of my participation in the try-out. Further, in consideration of the University of Maryland granting me permission to participate in this tryout, I hereby agree to irrevocably and unconditionally release, hold harmless, and indemnify the State of Maryland, the University System of Maryland, the University of Maryland College Park, and their officers, employees and agents (hereinafter referred to as the "University") from any and all liability, demands, claims, and causes of action in the event that I become injured in any way as a result of my participation in the tryout period. I warrant that I am in adequate physical condition, and physically able to perform this tryout, and that I have no known physical conditions, which could be materially worsened or aggravated by my participation, unless stated below:

____

____

____

I also have accurately and completely filled out the attached Health History Questionnaire. It is my understanding that the University of Maryland Sports Medicine Department may deny my participation in a tryout due to a medical condition found in my health history. I understand that any pre-existing medical condition may have to be corrected prior to the try-out and/or acceptance to the team. In addition, all costs associated with any tests, consultations, and/or medical procedures needed to gain approval/certification for participation are the responsibility of myself, and/or my parent(s) / guardian(s). I further acknowledge that I am signing this waiver voluntarily, with complete understanding of the terms and conditions herein, and that, as applicable, I have discussed my participation and the related risks with my parents and/or guardians.

____ ________________________

Student-Athlete Signature Date

____

Student Identification Number

____ ________________________

Parent / Guardian Signature (if under 18 years of age) Date

____

Parent / Guardian Printed Name

____ ________________________

Witness Signature Date

MARYLAND
SPORTS MEDICINE

Student-Athlete Insurance Information Sheet

Student-Athlete's Name ______________________ Sport ______________________

Sex (circle) Male Female Date of Birth ______________ UID Number ______________

Email ______________________

Permanent Address ______________________ City ______________

State ________ Zip ______________ Phone ______________

Campus Address ______________________ Cell Phone ______________

Current Medication ______________________

Allergies / Asthma / sickle cell trait/ Medical Conditions?______________________

EMERGENCY CONTACT INFORMATION	SECONDARY EMERGENCY CONTACT INFORMATION
Name ______________	Name ______________
Relationship ______________	Relationship ______________
Home Address ______________	Home Address ______________
Phone ______________	Phone ______________
Email ______________	Email ______________

Student-Athlete Insurance Information

Insurance Company ______________

Address ______________

City ______________

Phone # ______________

Type of Insurance-

☐ HMO ☐ PPO ☐ PPS ☐ POS ☐ Military

☐ Other ______________

Policy / ID # ______________

Group # ______________

Rx Bin # ______________

Rx GRP # ______________

PCN # ______________

Policy Owner ______________

DOB ______________

Coverage-

☐ MEDICAL ☐ DENTAL ☐ PRESCIRPTION ☐ VISION

☐ OTHER ______________

Is preauthorization necessary for medical/diagnostic services?

☐ Yes ☐ No Phone # ______________

Primary Care Physician______________

Physician Phone #______________

PLEASE READ CAREFULLY!

- The University of Maryland Department of Intercollegiate Athletics' accident policy provides insurance for student-athletes with ***injuries occurring only when participating in the play or practice of intercollegiate athletics.*** This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will the University of Maryland's Department of Intercollegiate Athletics' insurance carrier consider payment for any remaining balances.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, the University of Maryland Department of Intercollegiate Athletics & their excess insurance company in a timely manner.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize the University of Maryland Sports Medicine Unit and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify the University of Maryland Sports Medicine Unit immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.

Policy Holder's Signature______________________ **Date** ______________

Student-Athlete's Signature______________________ **Date** ______________

PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: ________________________________ Date of Exam: ____________________

Address: ______________________________ Date of Birth: ____________________

Sex: ☐Male ☐Female

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS

CURRENT MEDICATIONS *(Attach a second page if needed):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: ____

Contraindicated Medication: ____

Please list any previous injuries (with dates) that required surgery or overnight hospitalization

____

____

____

____

____

____

____

____

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: _____/______ **Pulse:** ______ **Respirations:** _______ **Temp:** ______ **Height:** _____ **Weight:** _____

EVALUATION OF SYSTEMS

System Name	Normal findings?		Comments/Description		
Eyes	☐ Yes	☐ No			
Ears	☐ Yes	☐ No			
Nose	☐ Yes	☐ No			
Mouth/Throat	☐ Yes	☐ No			
Head/Face/Neck	☐ Yes	☐ No			
Breasts	☐ Yes	☐ No			
Lungs	☐ Yes	☐ No			
Cardiovascular	☐ Yes	☐ No			
Extremities	☐ Yes	☐ No			
Abdomen	☐ Yes	☐ No			
Gastrointestinal	☐ Yes	☐ No			
Endocrine	☐ Yes	☐ No			
Musculoskeletal	☐ Yes	☐ No			
Integumentary	☐ Yes	☐ No			
Renal/Urinary	☐ Yes	☐ No			
Reproductive	☐ Yes	☐ No			
Lymphatic	☐ Yes	☐ No			
Nervous System	☐ Yes	☐ No			
VISION SCREENING	☐ Yes	☐ No	Is further evaluation recommended by specialist?	☐ Yes	☐ No
HEARING SCREENING	☐ Yes	☐ No	Is further evaluation recommended by specialist?	☐ Yes	☐ No

Additional Comments:

Previous medical history reviewed? ☐ Yes ☐ No

Recommendations for health maintenance: *(including need for lab work at regular intervals, exercise, hygiene, weight control, etc.)*

Recommended diet and special instructions: ____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)* ☐ No ☐ Yes *(specify):*

____

Change in health status from previous year? ☐ No ☐ Yes *(specify):* ______________________________

Specialty consults recommended? ☐ No ☐ Yes *(specify)* ______________________________

The Patient is fit for recreational and or varsity sports? ☐ No ☐ Yes *If no, please explain:* ________________

____

______________________________ ______________________________ ____________

Name of physician ***(please print)*** **Physician's Signature** **Date**

Physician Address:____ **Physician Phone Number:** __________