2011-2012

REQUIRED MEDICAL FORMS CHECKLIST FOR SPIRIT PROGRAM
(1ST YEAR AND TRYOUT PARTICIPANTS)

Please ensure the forms listed below have been completed and the information provided is accurate. Any missing information will delay medical clearance. Participants will not be eligible to participate in any team related activity until all information is received. Please return this information immediately.

.

- Participant Acknowledgement Form- Pg. 2
- Health Insurance Form- Pg. 3
- Front and back copy of current health insurance card- Pg. 4
- Emergency Contact Form- Pg. 5
- Medical History Questionnaire- Pg. MH 1-9
- Medical records for any previous injuries or illnesses
- General medical and orthopaedic physical exam signed by a licensed physician. (Physicals exams conducted by anyone other than a licensed physician will not be accepted.)

Spirit participants who do not complete this task will **not be eligible to participate** in practices, strength and conditioning, and competition until the completed forms are received and reviewed by the UTSA Athletic Training Staff.

To be completed by spirit participant or parent/guardian if under the age of 18.

I have completed all UTSA Sports Medicine forms accurately. I have included any medical records pertaining to any significant injuries or illnesses I have experienced. I understand that the UTSA Sports Medicine Staff may ask for additional medical records and/or information pertaining to insurance or medical history and that failure to provide requested documents may delay participation in UTSA Spirit team activities.

_____ _____

Student-Athlete Signature DATE

_____ _____

Parent/Guardian Signature (If athlete is a minor) DATE

SPORTS MEDICINE
Spirit (NEW PARTICIPANT) Medical Forms
2011-2012

All UTSA Spirit participants must undergo the medical clearance process every year, prior to participation in intercollegiate Athletics. Please read the information below regarding annual medical clearance.

Preparticipation Physical Exam

All first year spirit participants on must complete a physical exam with a licensed physician prior to any participation in spirit team events. Physical exams conducted by anyone other than a licensed physician (MD or DO) will not be accepted.

Health Insurance

All spirit participants must provide insurance information on the appropriate forms. In the event that a participant's insurance coverage changes, the Sports Medicine Staff must be made aware immediately and provided with the most current insurance information. **All spirit participants must possess and provide valid proof of primary health insurance and must maintain coverage for the entire time they remain on the spirit roster.** For more information on health insurance, please contact the UTSA Sports Medicine Staff.

Emergency Contact Information

All UTSA spirit participants must complete the "Emergency Contact Form" as part of the medical clearance process.

*All required forms are in this packet. If you have any questions, please contact the UTSA Athletic Training Room at (210) 458-4178 or (210) 458-7696.

Please initial that you acknowledge and agree to the information provided. _____

UTSA Athletics Health Insurance Form - SPIRIT
2011-2012

(Please type or print legibly and complete all requested information)

PARTICIPANT INFORMATION

Name: _____ Sport (CIRCLE ONE): CHEER DANCE MASCOT

Bannier ID: _____ Date of Birth: _____
MM/DD/YYYY

Email: _____

INSURANCE INFORMATION

Insurance Company: _____ Telephone: (_____)_____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

Name of Policy Holder: _____

Policy Holders Date of Birth:_____

Policy or ID #: _____ Group #: _____

Effective Date: From _____ to _____ Deductible: $_____
MM/DD/YYYY MM/DD/YYYY

Please check the appropriate box.

This policy is a: ____PPO_____POS_____HMO_____Other:_____

Are there any restrictions to this insurance policy?

- ❑ NO
- ❑ YES - If you answer yes, please explain:

_____

Is the above participant covered under a Dental Policy? ____Yes ____No

Is the above participant covered under an eye care policy? ____Yes____No

Is the above participant covered under a drug prescription plan? ____Yes____No

I certify that the above insurance information to my knowledge is accurate and up-to-date. Should there be any changes in regards to the status of my health insurance I will notify the UTSA athletic training department immediately.

_____ _____
Signature of Policy Holder Date

Please hand-deliver or mail this completed form to

UTSA Athletics, ONE UTSA Circle, San Antonio TEXAS 78249
To protect your privacy and facilitate compliance with law,
PLEASE DO NOT EMAIL OR FAX THIS COMPLETED FORM.

UTSA SPORTS MEDICINE
HEALTH INSURANCE CARD - SPIRIT
2011-2012

[Attach photocopy of front of insurance card here]

[Attach photocopy of back of insurance card here]

To be completed by student-athlete or parent/guardian if the participant is a minor.

I certify the attached insurance card is current and reflects the insurance coverage I have at the present time. If at anytime my insurance coverage changes, I will notify the UTSA Sports Medicine Staff of the change and provide the most current insurance coverage immediately.

_____ _____
PARTICIPANT SIGNATURE DATE

_____ _____
Parent/Guardian Signature (if participant is a minor) DATE

Please hand-deliver or mail this completed form to

UTSA Athletics, ONE UTSA Circle, San Antonio TEXAS 78249
To protect your privacy and facilitate compliance with law,
PLEASE DO NOT EMAIL OR FAX THIS COMPLETED FORM.

UTSA SPORTS MEDICINE
Emergency Contact Form - SPIRIT
2011-2012

(Please type or print legibly and complete all requested information)

PARTICIPANT INFORMATION:

Name: _____ Sport: _____

Date of Birth: _____ Banner ID: _____
MM/DD/YYYY

Email: _____

Local Address: _____

Local Phone: (____)_____

City: _____ State: _____ Zip: _____

Name of Parent/Guardian: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Parents/Guardian Phone: (____)_____

EMERGENCY CONTACT INFORMATION:

Primary Contact Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ CellPhone:(____)_____

Work Phone: (____)_____ Email: _____:

****For your secondary emergency contact, please list someone other than a coach, teammate, or parent/guardian.**

Secondary Contact Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:(____)_____ Cell Phone: (____)_____

Work Phone: (____)_____

Please hand-deliver or mail this completed form to

UTSA Athletics, ONE UTSA Circle, San Antonio TEXAS 78249
To protect your privacy and facilitate compliance with law,
PLEASE DO NOT EMAIL OR FAX THIS COMPLETED FORM.

UTSA Department of Intercollegiate Athletics
SPIRIT TEAM - Health and Medical History Questionnaire
2011-2012

Name:_____ Sport (CIRCLE ONE): cheer dance mascot

DOB: ___/___/_____ Grade (circle one): FR SO JR SR 5th

Banner ID: _____

Please print legibly. Please provide accurate information and complete all sections.

MEDICATION

Please list **ALL** prescription and over-the-counter medication, including supplements you are currently taking and have taken in the last two years. Please indicate the dosage and reason for the medication, as well as the dates. (If you need additional space, please attach a separate piece of paper.)

MEDICATION	PURPOSE	DOSAGE	DATES

Cardiovascular/Heart

Have you ever experienced any of the following during or after exercise, a practice, or a game?:

Chest pain or pressure	YES	NO
Dizziness or light headedness	YES	NO
Fainting or passing out	YES	NO
Racing heart	YES	NO
Skipping or irregular heart beats	YES	NO

Do you fatigue or get tired quicker than your teammates and friends during exercise or practice?	YES	NO
Have you ever been told you have a heart murmur?	YES	NO
Has a family member or relative died of heart problems or sudden death before the age of 50?	YES	NO
Has a physician ever denied or restricted you from playing sports due to heart or cardiovascular problem or family history?	YES	NO
Have you ever been examined by a cardiologist?	YES	NO
Have you ever had an electrocardiogram (EKG)?	YES	NO
Have you ever had an echocardiogram (ECHO)?	YES	NO
Does anyone in your family have high blood pressure?	YES	NO
Does anyone in your family have high blood cholesterol?	YES	NO
Have you ever been told you have/had high blood pressure?	YES	NO
Have you ever been told you have/had high cholesterol?	YES	NO
Have you or any family member ever been diagnosed with enlarged heart, hypertrophic cardiomyopathy, Long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	YES	NO

If you answered **YES** to any of the above questions, please expain

_____
_____
_____

Head Injuries/Concussion

Have you ever suffered a head injury/concussion (no matter how minor)?	YES	NO
Have you ever been evaluated by a doctor for a head injury/concussion?	YES	NO
Have you ever had any of the following tests performed on your head/brain?:		
XRAY	YES	NO
MRI	YES	NO
CT Scan	YES	NO
Neuropsychological tests	YES	NO
Other _____	YES	NO
Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to getting hit in the head/concussion/head injury?	YES	NO
Have you been advised not to participate in athletic activities due to a head injury/concussion?	YES	NO
Have you experienced headaches for more than three months?	YES	NO

If you answered **YES** to any of the above, please explain and provide dates

_____
_____
_____

Do you suffer from headaches? YES NO

If yes, when? (circle one)

EVERYDAY 1-2 TIMES A WEEK 1-2 TIMES A MONTH OTHER_____

Do you suffer from migraines? YES NO

How often?_____

Migraine Medication? (please list)_____

Asthma

Have you ever been diagnosed with asthma and/or exercise induced asthma?	YES	NO
Are you presently taking or have taken in the past any asthma medications?	YES	NO
Have you ever been hospitalized as a result of asthma and/or exercised induced asthma?	YES	NO
Have you ever been advised not to participate in athletic activities due to asthma?	YES	NO
Does anyone in your family suffer from asthma?	YES	NO
Do you currently have trouble breathing during exercise or practice?	YES	NO

If you answered **YES** to any of the above, please explain and list all asthma medications.

_____
_____
_____

ASTHMA SUFFERERS ONLY:

How many times do you use your rescue inhaler during an average week? _____

How many asthma attacks have you had in the last month? _____

Allergies

Do you have any allergies to medications?	YES	NO
Do you have any allergies to foods?	YES	NO
Do you have any allergies to insect bites, bee stings, etc.?	YES	NO

If you answered **YES** to any of the above, please list all allergies.

_____
_____

Have you been diagnosed with seasonal allergies?	YES	NO
Are you currently taking/have you previously taken allergy medication?	YES	NO

If you answered **YES**, please list all allergy medication you are currently taken or have taken.

_____
_____

Sickle Cell Anemia/Sickle Cell Trait

Have you ever been told you have Sickle Cell Trait?	YES	NO
If **YES**, do you regularly experience any of the following symptoms during or after exercise?:		
MUSCLE CRAMPING	YES	NO
FATIGUE	YES	NO
DEHYDRATION	YES	NO
FAINTING/PASSING OUT	YES	NO
Does anyone in your family have sickle cell trait?	YES	NO
Have you ever been diagnosed with Sickle Cell Anemia?	YES	NO
Does anyone in your family have Sickle Cell Anemia?	YES	NO

If **YES** to any of the above, please explain:

_____
_____

Heat Related Injury and Illness

Have you ever suffered from heat cramps?	YES	NO
Have you ever fainted from exercising in the heat?	YES	NO
Have you ever suffered from heat exhaustion?	YES	NO
Have you ever suffered from heat stroke?	YES	NO
Have you ever received IV fluids for a heat related injury or illness?	YES	NO
Have you ever been hospitalized for a heat related injury or illness?	YES	NO

If you answered **YES** to any of the above, please explain and provide dates.

_____
_____
_____

Communicable Diseases

Have you ever been diagnosed with a communicable disease (MRSA/Staph infection, Sexually Transmitted Disease, HIV, Hepatitis, Herpes, Syphilis, Tuberculosis, meningitis, etc.)? YES NO

If **YES**, please list and provide dates.

_____

_____

Eyes

Do you wear glasses? YES NO

Do you wear contact lenses? YES NO

When was your last eye exam? _____

Have you ever suffered an injury to your eye(s)? YES NO

If **YES**, please explain and provide dates.

_____

_____

Have ever been diagnosed with an eye disease? YES NO

If **YES**, please explain and provide dates.

_____

_____

Do you regularly suffer from blurred vision, double vision, tunnel vision, and/or other abnormal vision? YES NO

If **YES**, please explain.

_____

_____

Ear/Nose/Throat

Do you have frequent ear infections? YES NO

Do you have difficulty hearing? YES NO

Do you have ringing in your ears? YES NO

Do you have frequent nosebleeds? YES NO

Do you frequently suffer from a sore throat? YES NO

If **YES**, please explain.

_____

_____

Have you had strep throat or tonsillitis in the last 12 months? YES NO

If **YES**, please list how many infections you have had in the last 12 months. _____

Have you been told you should have your tonsils removed? YES NO

If **YES**, please explain. _____

Dental

When was your last dental exam? _____

Were there any significant findings from your last dental exam? YES NO

Have you ever suffered an injury to your mouth, jaw, tooth, or teeth? YES NO

If **YES**, please explain and provide dates.

_____

_____

Do you wear a mouthguard while playing sports? YES NO

Dermatological

Have you experienced any skin problems (rashes, acne, warts, eczema, fungus, etc.)? YES NO
Have you ever experienced a rash or hives during or after exercise? YES NO
Have you ever been under the care of a dermatologist for any condition? YES NO
If **YES**, please explain and provide dates.

_____
_____
_____

Abdomen

Do you regularly experience abdominal or stomach pain? YES NO
If yes, please explain: _____
Have you ever been diagnosed with a problem affecting your stomach, abdomen, intestines, or rectum? YES NO
If yes, please explain: _____
Have you had any diagnostic testing on your abdomen? YES NO
Please circle all that apply: XRAY MRI CT SCAN ENDOSCOPY COLONOSCOPY
OTHER _____
Have you ever had any kind of abdominal surgery? YES NO
If yes, please explain: _____
Do you regularly experience chronic or recurrent diarrhea? YES NO
Have you ever been diagnosed with a stomach ulcer? YES NO
Have you ever been diagnosed with gall bladder disease or gall stones? YES NO
Do you regularly experience urinary tract infections or other urinary problem? YES NO
If yes, how many in the last 12 months: _____
Have you been diagnosed with kidney disease, or other kidney problem? YES NO
If yes, please explain: _____
Have you had an organ removed or are missing any organ (kidney, ovary, testicle, etc.)? YES NO
If yes, please explain: _____
Have you ever suffered an injury to your abdomen? YES NO
If yes, please explain: _____
Have you ever been advised not to participate in athletic activities due to an abdominal injury or condition? YES NO

Additional Health Concerns

Have you had any injury or illness other than those previously noted? YES NO
Do you have any ongoing or chronic illnesses? YES NO
Have you ever been hospitalized overnight? YES NO
Has a physician ever restricted you from athletic activities, practices, or other exercise for any reason? YES NO
Are you currently under a physician's care for any medical condition(s)? YES NO
Do you regularly consult with a holistic medicine practitioner or other non-physician practitioners? YES NO
Do you regularly see a chiropractor? YES NO
Are you happy with your weight? YES NO
Are you currently trying to gain or lose weight? YES NO
Have you experienced any recent weight loss or weight gain in the last 6 months? YES NO
Do you have any dietary restrictions (vegetarian-all types, gluten free, etc.)? YES NO
Have you ever been diagnosed with an eating disorder? YES NO
Have you had a viral infection (mononucleosis, myocarditis, etc.)? YES NO
Have you ever been told you are hypoglycemic, hyperglycemic, or diabetic? YES NO
Have you had a seizure, convulsions, or been diagnosed with epilepsy? YES NO
Have you suffered a tramatic injury or unexpected illness that was not sports-related, but required immediate medical attention? YES NO
Have you ever been restricted from playing sports for a month or more due to a non-orthopaedic injury or illness? YES NO
Do you currently have any health concerns you would like to discuss with a physician? YES NO
Please explain any **YES** answers here:

_____
_____
_____

Mental Health

Have you been under the care of a psychiatrist/psychologist in the last 5 years (including the present time)? YES NO
Have you ever been diagnosed with depression, anxiety/panic disorder, or other mental health condition? YES NO
Are you currently taking any medication for a mental health condition? YES NO
Have you taken any medication for a mental health condition in the last 5 years? YES NO
Have you ever been hospitalized due to a mental health condition? YES NO
Please explain any **YES** answers in detail here:

_____
_____
_____
_____
_____

Women's Health (females only)

Date of your last pap smear? _____
Have you ever had an abnormal pap smear? YES NO
If **YES**, please provide additional details and findings:

_____
_____

Are you currently taking any form of birth control? (pill, patch, NuvaRing, etc.) YES NO
Other than routine exams, are you currently under the care of an OB/GYN for an ongoing problem? YES NO
If **YES**, please explain:

_____
_____

At what age did you begin menstruating? _____
Date of your last menstrual period: _____
How many periods have you had in the last 12 months? _____
Do you frequently skip periods? YES NO
If yes, what is the longest you have gone without having a period (in months)? _____
Do you have heavy periods? YES NO
How many days does your period last on average? _____
Do you experience pain or severe cramping during your period? YES NO

Are you aware of any reason you should not participate in intercollegiate athletics at UTSA? YES NO
If **yes**, please explain

_____
_____

Orthopaedic History

Name:_____

Sport:_____

Grade: FR SO JR SR 5TH

Cervical Spine/Neck

Have you ever suffered an injury to your cervical spine/neck? YES NO
Have you ever had any diagnostic tests performed on your c-spine/neck? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had a "burner", "stinger", or other brachial plexus injury? YES NO
Have you ever experienced numbess and/or tingling in your arms, hands, and/or fingers? YES NO
Have you ever had surgery and/or an injection of any kind to your c-spine/neck? YES NO
Have you ever been advised not to participate in sports due to a c-spine/neck injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Shoulder/Arm

Have you ever suffered an injury to your shoulder/upper arm? YES NO
Have you ever had any diagnostic tests performed on your shoulder/upper arm? YES NO
If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or injection of any kind to your shoulder/upper arm? YES NO
Have you ever been advised not to participate in sports due to a shoulder/upper arm injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Elbow/Forearm

Have you ever suffered an injury to your elbow/forearm? YES NO
Have you ever had any diagnostic tests performed on your elbow/forearm? YES NO
If yes, please circle all that apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or injection of any kind to your elbow/forearm? YES NO
Have you ever been advised not to participate in sports due to an elbow/forearm injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Wrist/Hand/Fingers

Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)? YES NO
Have you ever had any diagnostic tests performed on your wrist/hand/finger? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or injection of any kind to your wrist/hand/fingers? YES NO
Have you ever been advised not to participate in sports due to a wrist/hand/finger injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Spine/Low back/Sacroiliac (SI) joint

Have you ever suffered an injury to your spine, low back, and/or SI joint? YES NO
Have you ever had any diagnostic tests performed on your spine, low back and/or SI joint? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or an injection of any kind to your spine/low back/SI joint? YES NO
Have you ever had numbness/tingling in one or both of your legs andor feet? YES NO
Have you ever been advised not to participate in sports due to a spine/low back/SI joint injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Hip/Groin

Have you ever suffered an injury to your hip/groin? YES NO
Have you ever had any diagnostic tests performed on your hip/groin? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or an injection of any kind on your hip/groin? YES NO
Have you ever been advised not to participate in sports due to a hip/groin injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Thigh/Hamstrings/Quadriceps

Have you ever suffered an injury to your thigh/hamstrings/quadriceps? YES NO
Have you ever had any diagnostic tests performed on your thigh/hamstrings/quadriceps? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or an injection of any kind to your thigh/hamstrings/quadriceps? YES NO
Have you ever been advised not to participate in sports due to a thigh/hamstrings/quadriceps injury? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Knee/Patella

Have you ever suffered an injury to your knee/patella? YES NO
Have you ever had any diagnostic tests performed on your thigh/hamstrings/quadriceps? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or injection of any kind to your knee/patella? YES NO
Have you ever been advised not to participate in sports due to a knee/patella injury? YES NO
Do you wear a knee brace? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Ankle/Lower Leg

Have you ever suffered an injury to your ankle/lower leg? YES NO
Have you ever had any diagnostic tests performed on your ankle/lower leg? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or injection of any kind to your ankle/lower leg? YES NO
Have you ever been advised not to participate in sports due to an ankle/lower leg injury? YES NO
Do you presently tape your ankles regularly? YES NO
Do you presently wear ankle braces? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Foot/Toes

Have you suffered an injury to your foot/toes? YES NO
Have you ever had any diagnostic tests performed on your foot/toes? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or an injection of any kind to your foot/toes? YES NO
Have you ever been advised not to participate in sports due to a foot/toe injury? YES NO
Do you currently wear orthotics? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Ribs/Thorax/Chest

Have you ever suffered an injury to your ribs/thorax/chest? YES NO
Have you ever had any diagnostic tests performed on your ribs/thorax/chest? YES NO
If yes, please circle all the apply: X-RAY MRI CT SCAN BONE SCAN OTHER_____
Have you ever had surgery and/or an injection of any kind to your ribs/thorax/chest? YES NO
Have you ever been advised not to participate in sports due to an injury to the ribs/thorax/chest? YES NO
If **yes** to any of the above, please explain and provide dates.

_____
_____
_____

Additional Orthopaedic Concerns

Have you ever been withheld or restricted from participation in sports due to an orthopaedic injury, other than those listed previously? YES NO
Have you ever been restricted for a month or more from sports activity due to an orthopaedic injury? YES NO
Have you undergone surgery for an orthopaedic injury, other than those listed previously? YES NO
Have you suffered the same injury more than once? YES NO
Do you routinely suffer from over-use injuries that resolve with rest, and recur as you exercise more frequently and/or at a higher intensity? YES NO
Have you ever had a stress fracture anywhere in your body, not previously noted? YES NO
If yes, have you had any recurring stress fractures in the same body part? YES NO
Do you regularly wear any type of brace, sleeve, wrap, or support, other than those previously noted? YES NO
Have you ever suffered a traumatic orthopaedic injury as a result of an accident or other non-sports related activity, that required immediate medical attention?
Do you currently have any orthopaedic concerns you would like to discuss with a physician? YES NO
Please explain any **yes** answers here and provide dates if possible.

_____
_____
_____
_____
_____

I herby state that I have completed the medical history and provided correct and honest answers.

Athlete Name (please print)_____

Athlete Signature_____ Date_____

Parent/Guardian Name (if athlete is a minor)_____

Parent/Guardian Signature_____ Date_____

NAME:_____
SPORT:_____

2011-2012 UTSA Orthopedic Physical Examination

To Be Completed By Medical Personnel:

	Normal	Findings	Initials*
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

Notes/Referrals/Special Tests: _____
_____
_____

To Be Completed By Medical Personnel:

Physician Clearance

I certify that I have examined this student on this date and that, based on the examination required by UTSA and the student's medical history as furnished to me, this student is **cleared to participate with:**

☐ **Cleared to participate in full competition**
☐ **Cleared to participate with restrictions** (please explain)
☐ **Not cleared for participation** (please explain)

Explanation_____
_____
_____

Examiner's Signature:
_____Date: _____
Physician Please Print Name:_____
Address:_____
City: _____ State:_____ Zip Code: _____
Telephone Number: _____

NAME:_____
SPORT:_____

2011-2012 UTSA General Medical Physical Examination

VITAL SIGNS

Height _____Weight _____BMI _____Pulse _____BP___/____ (___/____, ___/___)

Vision R20 /___ L20 / ___ Corrected: Y or N / Pupils: Equal _____Unequal _____

To Be Completed By Medical Personnel:

	Normal	Findings	Initials*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Neurological			

Notes/Referrals/Special Tests: _____
_____
_____
_____

Physician Clearance

I certify that I have examined this student on this date and that, based on the examination required by UTSA and the student's medical history as furnished to me, this student is **cleared to participate with:**

☐ **Cleared to participate in full competition**
☐ **Cleared to participate with restrictions** (please explain)
☐ **Not cleared for participation** (please explain)

Explanation_____
_____
_____
Examiner's Signature: _____Date: _____
Physician Please Print Name:_____
Address:_____
City: _____ State:_____ Zip Code: _____
Telephone Number: _____