UNIVERSITY OF ALBERTA Augustana Athletics

New Male Athlete Medical Form

2018-2019 Athletic Season

Varsity Team:_____

Year of Eligibility: 1 2 3 4 5
(entering into)

Last Name:_____ First Name: _____

Local Address: _____ City: _____ Prov.:_____ Postal Code:_____

Local Phone: ( )_____ E-Mail:_____ Age:_____

D.O.B.: _____ Student No.: _____ Prov. Health Care #: _____ Prov: _____
Day Month Year

Emergency Contact (local):_____ Phone: _____

Emergency Contact (family):_____ Relationship:_____ Phone: _____

Medications: Please list all prescribed and over-the-counter medications and supplements you are currently taking:

_____

_____

Do you have allergies? Yes ☐ No ☐ If yes, please specify your specific allergy:_____

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason? If so, explain why below.		
2. Do you have any ongoing medical conditions? (infectious mononucleosis, diabetes, asthma, etc)		
3. Have you been advised to be on any medication on a regular basis? Identify medications in space below		
4. Do you use or have you ever used an inhaler?		
5. Are you now on, or have you ever been advised to be on any supplements on a regular basis? Identify in space below		
6. Within the last year have you had any illness or medical condition lasting longer than one week?		
7. Do you have, or have you ever had a skin infection? Identify below what infection and when.		
8. Do you have any joint, bone, or muscle pain not associated to injury?		
9. Within the last year have you had an injury requiring you to miss more than one practice or game?		
10. Have you ever had surgery? Identify surgeries below.		
11. What immunizations have you had? (ie meningitis, hepatitis B/C, MMR)		
12. When was your last tetanus shot?		
13. Within the last year, have you been admitted to hospital?		
14. Do you currently have an incompletely healed injury?		
15. Within the last year, have you had an injury requiring treatment/therapy?		
16. Are there any food groups you refuse to eat?		
17. Do you ever experience unexplained weight loss/gain?		
18. Are you satisfied with your current weight? If not, explain		

AS A RESULT OF PHYSICAL ACTIVITY	Yes	No
19. Do you ever experience coughing or wheezing during or after exercise?		
20. Do you ever experience frequent or severe headaches?		
21. Have you ever passed out or nearly passed out during or after exercise?		
22. Do you ever get lightheaded, dizzy or feel more short of breath than expected during exercise?		
23. Have you ever experienced heat exhaustion or heat stroke?		
24. Do you ever experience muscle cramps or abdominal pain with exercise?		
25. Have you ever had any broken/fractured bones, or dislocated joints? Identify below.		
26. Have you ever had a stress fracture?		
27. Have you ever had an injury that required x-rays, MRI, CT scan, injections, or a brace?		
28. Have you ever been tested for a bloodbourne pathogen? (ie HIV, Hep B or C). Please explain test results below.		
29. Have you ever had a concussion, or hit to the head causing confusion, headache, memory problems?		
30. How many? When was the last one?		
31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
32. Do you use any special equipment? (ie brace, pads, orthotics, etc)		
33. Do you have any problems with your eyes or vision?		
34. Do you wear glasses, contacts, or protective eyewear in practices or games?		
35. Do you use any dental equipment?		

EXPLAIN ALL "YES" ANSWERS IN SPACE PROVIDED

_____ _____

_____ _____

_____ _____

_____ _____

HEART HEALTH QUESTIONS	Yes	No
37. Does your heart ever race or skip beats during exercise?		
38. Do you, or have you ever been told you have an irregular heartbeat?		
39. Do you, or have you ever been told you have a heart murmur?		
40. Has a doctor ever ordered testing for your heart? (Including ECG, EKG, ultrasound, etc.)		
41. Have you ever experienced heart palpitations (when you heart feels as if it is pounding/racing)		
42. Are you on any medications for a heart condition?		

	Yes	No
Is there anything else you wish to discuss with the U of A medical staff?		

EXPLAIN ALL "YES" ANSWERS IN SPACE PROVIDED

Please list and describe any injuries that you have had in the past

Previous/Current Injury	Treatment	Date of injury	Status: (example – still a problem, active, inactive, ongoing)	What care are you currently receiving?

Your pre-season medical will be collected and stored in a confidential manner at CCTR. Information pertaining to clearance and/or restrictions will be shared only with those in the school administration who need to know. By signing this form, you are giving us permission to share information from the CCTR and information that may arise during the next academic year that could impact sports participation with those essential to the process of evaluation and future participation. This may include your personal physician, team physicians, athletic therapist, physiotherapist, student trainer, and if appropriate, coaches and/or U of A administration. Specific medical information will not be discussed with non-healthcare professionals, but final clearance or disqualification decisions may be reviewed with school officials. We will attempt to maintain your privacy the best that we can during the pre season screening and during the upcoming sports season.

Is there anything else you would like to discuss with the U of A Medical Staff?	Yes	No

Athlete Signature:_____ Date:_____

If under 18 years of age, Parent or Guardian signature: _____

Print Name:_____ Date: _____

PHYSICAL EXAMINATION FORM to be completed by a medical doctor

Name _____ Date of birth _____ Date of exam _____
(mm/dd/year) (mm/dd/year)

EXAMINATION		
Height: **Weight:** **□ Male □ Female**		
BP / Pulse		
Vision R / L / Corrected □Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Eyes/ears/nose/throat -Pupils equal/color blindness		
EENT, Thyroid		
Lymph nodes		
Heart/chest/CV		
Abdomen (including hernias & testicles)		
Genitourinary (males only)		
CNS		
DTR's		
Skin		
Neurologic		
MUSCULOSKELETAL – ***please note any evidence of prior injury, instability or loss of flexibility of:***		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh/pelvis		
Knee		
Foot/toes		

Recommendations for Participation: (check all that apply)

□ No restrictions (full contact)
□ Limited contact / impact
□ Limited participation
□ Needs further consultation/tests (eg. X-ray, labs, rehabilitation) – please record below
□ Not cleared for participation
Reason_____

Recommendations

_____

I have examined the above-named student and completed the preparticipation physical evaluation. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (print/type)_____Date_____

Address_____Phone _____

Signature of Physician_____MD