

PENN STATE ALTOONA SPORTS MEDICINE
PRE-PARTICIPATION PHYSICAL EXAM FORM

Thank you for your interest in becoming an athlete at Penn State Altoona. Intercollegiate athletics strives for excellence by offering you the opportunity to develop meaningful standards of excellence, athletic performance, leadership, community service and sportsmanship within the educational and social environment of Penn State Altoona.

Before students participate in any sport, it is mandatory that you submit the participation form on line through our Penn State Altoona Sports (athletic training/sports medicine) web page (<http://www.altoona.psu.edu/sports/athletictraining.htm>) and also receive a pre-participation sports physical. The physical form is a 6 page download that needs to be completed by you and your practitioner and returned to the Athletic Trainer. These forms are NOT to be submitted to your coach. Whether you elect to have your pre-participation physical completed at the Penn State Altoona Health and Wellness Center or by your own practitioner, please have the health history section of your physical form (the first 5 pages) completed before your appointment. Be sure to have the form with you for your medical appointment. The provider needs to complete the last page (page 6).

Several items that you should know before you begin your participation in athletics:

1. There is an element of danger in all sports. By participating in sports, you assume risk. Injuries do occur.
2. In the event that you sustain an injury during your participation, please report it to your coach and to the athletic trainer immediately.
3. Penn State Altoona offers an excess (secondary) insurance plan. Your parent/guardian's health insurance is still your primary coverage. Our athletic insurance helps to pay reasonable and customary charges after your primary coverage is exhausted.
4. Should you sustain an injury, the athletic trainer will complete the necessary claim forms, but it is your immediate responsibility to report the injury as soon as possible and also to inform the athletic trainer if your primary health insurance information has changed (i.e., your parent changed policies, your parent changed employment, you no longer have insurance). The athletic trainer must report claims within 90 days of your initial injury, but you need to report the injury immediately.
5. DO NOT pay any invoices or balances before proper procedures and claims have been made. Prepayments could cause failures to receive payments in full. Please submit unpaid balances/invoices to the athletic trainer. To insure proper payment, only itemized statements are accepted. The athletic trainer will also need the Explanation of Benefits (EOB's) and any denials from your primary health insurance carrier. Please submit these along with your bills.
6. If you have medical insurance, you must submit your insurance information on line by completing the 'participation form' on our Penn State Altoona sports website (see athletic training/sportsmedicine). If you are not covered by medical insurance, please inform the athletic trainer and complete an affidavit form. Keep in mind that if your insurance status changes, you are obligated to inform the athletic trainer of the change.
7. In cases where the athletic insurance or family insurance does not cover the entire cost of the accident, it is the responsibility of the athlete to pay the additional medical costs.

I have read and understand the information above.

(Print Athlete's full name)

Signature of Athlete (or parent/guardian if under the age of 18)

(Date)

Consent to Treat
Penn State Altoona Sportsmedicine

I have completed the sports participation form on line which includes emergency contacts and insurance information (<http://www.altoona.psu.edu/sports/athletictraining.htm>). I also received my sports physical to participate in intercollegiate athletics at Penn State Altoona. The information that I submitted is for the use of the sports medicine staff, coaching staff, athletic staff and my personal contacts in the event of emergency or injury to me during athletic participation and travel. I assume a risk of injury while participating and traveling with Penn State Altoona athletics. I have provided my health and medical information and it is true to the best of my knowledge.

In the event of an accident requiring medical attention, I hereby grant permission to the sports medicine staff and athletic staff designated by Penn State Altoona to attend to & discuss my condition. In the event of a medical emergency requiring further Emergency Medical Services, I hereby grant permission to appropriate medical staff (EMS personnel, Emergency Room staff, host certified athletic trainer, dentists, medical practitioners, etc.) to attend to me. I expect that every effort will be made to provide information to me and/or to my emergency contact person(s) in order to receive specific directions/authorizations before any such treatment or hospitalization is undertaken.

I authorize Penn State Altoona representatives to release and receive information pertaining to my medical records and to any current course of treatment. This includes, but is not limited to, physicians, hospitals, other medical facilities and insurance companies. I understand that this information may be transferred orally, electronically or written.

(Print Athlete's full name)

Signature of Athlete (or parent/guardian if under the age of 18)

Date

Sport (circle all that apply):

Men's Cross Country

Women's Cross Country

Volleyball

Men's Soccer

Women's Soccer

Golf

Men's Tennis

Women's Tennis

Swimming/Diving

Baseball

Softball

Men's Basketball

Women's Basketball

PENNSYLVANIA STATE UNIVERSITY



PRE-PARTICIPATION PHYSICAL EXAMINATION

Name _____ Date _____ Date of Birth _____ Sex _____
Local Address _____ Sport _____
Phone # () _____
Home Address _____ Phone # () _____
Parent/Guardian _____ Phone # () _____
Emergency Contact _____ Phone # () _____
Family Doctor _____ Phone # () _____
Address _____ Date of Last exam _____
Health Insurance Company _____ Policy # _____

The following questions are to be answered yes or no. Please check the appropriate box. Comment on all "yes" answers.

YES NO

Comments

Has anyone in your immediate family ever had:

() () Diabetes (high blood sugar)?

() () Sudden death (age less than 50)?

() () High blood pressure, high cholesterol?

() () Heart attack (age less than 50)?

() () Asthma, or sickle cell anemia?

() () Convulsions (seizures) or epilepsy?

Have you ever had or do you now have:

() () Chest pain with or after exercise?

() () Dizziness with or after exercise?

() () High blood pressure?

() () Racing of the heart/irregular rhythm?

() () Wheezing/cough with exercise, or asthma?

() () Weakness, fatigue, or anemia?

() () Heart murmur?

Have you ever had:

() () Loss of consciousness?

() () Concussion?

() () Convulsions (seizures) or epilepsy?

() () Neck injury?

() () "Stinger", "burner", or "pinched nerve"?

Have you ever:

() () Been hospitalized for a medical problem?

() () Had infectious mononucleosis? If yes, + blood test? Y / N _____

() () Had heat exhaustion or intolerance?

OVER ->

Have you ever:

- () () Been hospitalized or had surgery? _____
- () () Broken a bone? _____
- () () Had a muscle injury? _____
- () () Had a knee injury? R () L () Ligament () Meniscus () Other ()
- () () If yes, did you have surgery? Result; _____
- () () Had a shoulder injury? R () L ()
- () () If yes, did you have surgery? Result; _____
- () () Had a back injury? _____
- () () If yes, did you have surgery? Result; _____
- () () Had any other joint injuries? _____
- () () Please check appropriate box(es);
() Hip () Elbow () Wrist () Foot () Other

Have you had or do you now have:

- () () Hearing loss or perforated eardrum? _____
- () () Headaches or migraines? _____
- () () Dental plate or orthotic work? _____
- () () Impaired vision, wear glasses/contacts? _____
- () () Hernia? _____
- () () Loss of function or absence of testicle (males)? _____

Have you in the past, or do you currently use, or have concerns about:

- () () Cigarettes, chewing tobacco, or marijuana? _____
- () () Alcohol? _____
- () () Recreational drugs? _____
- () () Steroids? _____
- () () Vitamins or supplements? _____
- () () Wt. loss meds, laxatives, self-induced vomiting? _____

Do you:

- () () Feel out of control when you are stressed? _____
- () () Have a history of depression, or feel depressed? _____
- () () Wear a seat belt at least 90% of the time? _____
- () () Wear a bicycle/motorcycle helmet? _____
- () () Understand and regularly perform a self-breast
exam or self-testicular exam? _____
- () () Practice safe sex? (abstinence, condoms) _____
- () () Have a history of > 2 sexual partners in the last 6 mo.? _____
- () () Have a history of any sexually transmitted disease? _____
- () () Have any additional concerns or questions? _____

OVER →

Nutritional concerns:

What is your present weight? _____

Are you happy with your present weight? _____

If not, what is your desired weight? _____

In the last 2 days, how many servings of each of the following have you eaten? (circle)

Grains (cereal, bread, rice, pasta)	0 1 2 3 4 >4	Fruits	0 1 2 3 4 >4
Dairy products (milk, yogurt, cheese)	0 1 2 3 4 >4	Red meat	0 1 2 3 4 >4
Beans, nuts, tofu	0 1 2 3 4 >4	Vegetables	0 1 2 3 4 >4
Chicken, Fish	0 1 2 3 4 >4	Eggs	0 1 2 3 4 >4

How many meals do you eat each day? _____

Do you diet regularly? _____

Are there certain foods you do not like? _____

Do you ever feel out of control of your eating patterns? _____

Have you ever tried to control your weight by:

Excessive exercise? _____

Vomiting? _____

Diet pills? _____

Laxatives? _____

Diuretics? _____

Have you ever had an eating disorder? _____

List any current medications: (include vitamins, over the counter medications, supplements, and birth control pills,)

List any allergies:
(animals, food, pollen, medications)

I, _____, declare that all of the above information is true to the best of my knowledge.

(Signature) _____

Date _____

(Signature of parent if < 18 yrs. old) _____

Date _____

OVER →

PHYSICAL EXAMINATION: (To be completed by physician)

Blood pressure _____ Pulse _____ Height _____ Weight _____

Vision R 20/ _____ L 20/ _____ corrected Y / N Pupil size; equal / unequal

Normal	Abnormal		Comments
()	()	HEENT	_____
()	()	Thyroid	_____
()	()	Lymphatics	_____
()	()	Cardiac	_____
()	()	Lungs	_____
()	()	Skin	_____
()	()	Abdominal	_____
()	()	Genitalia	Hernia? Y / N _____
()	()	Musculoskeletal:	
()	()	Neck	_____
()	()	Shoulder	_____
()	()	Elbow	_____
()	()	Wrist, hand	_____
()	()	Back	Scoliosis? Y / N _____
()	()	Knee	_____
()	()	Ankle, foot	_____
()	()	Neurologic	_____

Other: _____

I certify that I have reviewed the history and examined the above athlete, and based on this recommend sports activity:

- Clearance with no limitations _____
- Clearance pending further evaluation or testing _____
- Referral to _____ prior to clearance
- Clearance with limitations _____
- Disqualification from competition _____

Signature of Examining Clinician _____ Date _____

PRINT &/OR STAMP CLINICIAN'S ADDRESS AND PHONE NUMBER:

