



UNIVERSITY OF THE DISTRICT OF COLUMBIA

SPORTS MEDICINE

Student-Athlete Physical Examination

(to be completed by a physician prior to participation in the first year & every other year thereafter)

Name _____ UID: _____ Sport(s) _____

Sex	Age	Date of Birth	Race	Height	Weight (current)	Weight (1 yr. ago)
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Vision Screen R 20 / L 20 /	Corrected Y N	Colortest	Blood Pressure /	Pulse	Allergies
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ORTHOPEDIC EXAMINATION (to be completed by the physician):

	NORMAL	ABNORMAL FINDINGS (use black and/or additional sheets if necessary)
SHOULDER / UPPER ARM		
ELBOW / FOREARM		
WRIST / HAND / FINGERS		
LUMBAR SPINE		
HIP / THIGH		
KNEE		
LOWER LEG		
ANKLE / FOOT		
FLEXIBILITY		

Examiner Signature	Date	Examiner Print Name
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CLINICAL EXAMINATION (to be completed by the physician):

HEAD, FACE, NECK, & SCALP		
NOSE / SINUSES		
MOUTH / THROAT		
EARS		
EYES		
LUNGS / CHEST		
HEART / CARDIOVASCULAR		
ABDOMEN / GI		
GENITOURINARY SYSTEM		
SKIN / LYMPHATICS		
NEUROLOGICAL		

The NCAA recommends that all student athletes be aware of their sickle cell status. If the student athlete does not know whether they are positive for sickle cell trait, the NCAA recommends that student athletes undergo testing to determine their status.

Status:

- Pass without restrictions
- Pass with restrictions _____
- Further Evaluation Needed- _____

Referred to _____ For _____

Examiner Signature	Date	Examiner Print Name
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Student-Athlete Signature	Date
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UNIVERSITY OF THE DISTRICT OF COLUMBIA

SPORTS MEDICINE STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

I, _____, acknowledge that I am currently taking and/or have (*within the past 6 months*)

Student-Athlete Name

taken the following ergogenic aids, creatine powder, amino acids, protein supplements, or other similar substances, hereinafter referred to as "Supplements." (*Use the back of this form if necessary.*)

NAME	DOSAGE	MAIN INGREDIENTS	COMMENTS

I understand and agree:

- a) University of the District of Columbia Department of Intercollegiate Athletics neither approves of nor condones the use of Supplements;
- b) University of the District of Columbia does its best to ensure that all supplements distributed comply with NCAA recommendations. However, I understand that I voluntarily consume these beverages and understand the risks associated with taking them;
- c) I have been informed of the University of the District of Columbia Department of Intercollegiate Athletics, National Collegiate Athletic Association (NCAA), and United States Olympic Committee (USOC) policies with regards to the use of Supplements, and have had any questions about these policies answered;
- d) ***The use of Supplements may result in serious harm to me, possible permanent injury to my health, and even death.***
- e) I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance;
- f) I must list all Supplements on the Chain of Custody Forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at anytime in the future any form of Supplements.

I further understand and agree University of the District of Columbia, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, and/or future use of Supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release, University of the District of Columbia, and its officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of Supplements.

I understand the statements in this form, and have had all questions about the information in this form answered to my satisfaction.

Student-Athlete's Signature

Date

Parent / Guardian's Signature (*if under 18 years old*)

Date



UNIVERSITY OF THE DISTRICT OF COLUMBIA

SPORTS MEDICINE Health Insurance Information / Authorization

Student-Athlete's Name _____ Social Security No. _____ Date of Birth _____
 Permanent Address _____
 City _____ State _____ Zip _____
 Phone # _____ Sex Male Female Sport _____

FATHER'S / GUARDIAN'S INFORMATION	MOTHER'S / GUARDIAN'S INFORMATION
Name _____	Name _____
DOB _____	DOB _____
Home Address _____	Home Address _____
Home Phone _____	Home Phone _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____
Insurance Company _____	Insurance Company _____
Address _____	Address _____
Policy / ID # _____	Policy / ID # _____
Group # _____	Group # _____
Insurance Company Phone # _____	Insurance Company Phone # _____
Type of Insurance- HMO PPO Indemnity Other _____	Type of Insurance- HMO PPO Indemnity Other _____
Student Athletes Primary Care Physician _____	Student Athletes Primary Care Physician _____
Physician Phone # _____	Physician Phone # _____
Is preauthorization necessary for medical/diagnostic services? Yes No Phone # _____	Is preauthorization necessary for medical/diagnostic services? Yes No Phone # _____
Is your son / daughter covered under this policy? Yes No	Is your son / daughter covered under this policy? Yes No

University of the District of Columbia requires all students to purchase a basic accident and sickness hospitalization insurance plan, or be covered under the policy of their parent / guardian. If you are looking at purchasing insurance, we recommend a plan that gives you maximum medical coverage in the Washington, DC area. The Athletics Department maintains an excess coverage blanket sports basic accident insurance policy. It covers only injuries or accidents that occur while participating in organized intercollegiate practices or events; or which occur during travel to and from the location of an organized intercollegiate practice or event. Injuries that qualify for coverage by the University's sport insurance policy must be submitted to the individual's comprehensive hospitalization/accident insurance first.

I hereby authorize University of the District of Columbia and Conner Strong Insurance Company to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

Student-Athlete Consent to Parental Notification of Athletic Injury

If the policy holder of my primary insurance company is my parent/ guardian, I give University of the District of Columbia permission to notify my parent / guardian if I sustain an athletic injury for which I seek medical treatment. In such cases, I understand that the University will inform my parent / guardian of the fact and date of my injury and the process for seeking insurance coverage / reimbursement.

Signature of student-athlete: _____ Date: _____

Authorization of Payment

I authorize Georgetown University or its insurance company to pay medical vendors directly for any bills incurred from an intercollegiate athletic injury.

Signature of policy holder: _____ Policy holder DOB: _____ Policy Holder SS#: _____

****Please provide a photocopy of both sides of your primary, dental and prescription insurance card. ****



UNIVERSITY OF THE DISTRICT OF COLUMBIA

SPORTS MEDICINE Student-Athlete Medical Update

Name _____ Year in School _____

Date of Birth _____ Sport(s) _____

Since your last physical examination on _____, have you?

		DATE			
Yes	No	Had a serious injury / been hospitalized	Yes	No	Had an unfavorable / allergic reaction to a drug, antibiotic, and/or medicine?
Yes	No	Had a sprain / strain and/or fracture	Yes	No	Had a dental injury?
Yes	No	Had a concussion and/or head injury?	Yes	No	Do you have any allergies?
Yes	No	Been unconscious for any other reason other than anesthesia?	Yes	No	Do you take any medications for pain or a medical condition on a regular basis (> 3 days a week)?
Yes	No	Had a neck injury?	Yes	No	Do you have any ongoing or chronic illnesses?
Yes	No	Had a back injury or suffered from back pain?	Yes	No	Had frequent headaches?
Yes	No	Had any of burners, stingers, numbness in neck, shoulder, and/or hand?	Yes	No	Experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise?
Yes	No	Had a shoulder, elbow, and/or hand / wrist injury?	Yes	No	Do you have any ongoing or chronic illnesses?
Yes	No	Had a hip and/or knee injury?	Yes	No	Had an operation?
Yes	No	Had a lower leg, ankle, and/or foot injury?	Yes	No	Do you wear contact lenses, glasses, and/or safety glasses?
Yes	No	Missed a practice and/or game due to an injury and/or illness?	Yes	No	Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
Yes	No	Are you currently undergoing physical therapy or rehabilitation for an injury?	Yes	No	Do you require any special equipment to participate in athletics?
Yes	No	Had a staph infection / MRSA infection on any part of your body?	Yes	No	Have you been told by a physician to restrict your activity or not to participate in sport?
Yes	No	While exercising, has your heart ever "skipped" a beat, have you suffered from a "racing heart", severe chest pain, lightheadedness, or fainted?	Yes	No	Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time / received special attention (IV fluids, etc.) for a heat related problem?
Yes	No	Been diagnosed with any NEW injuries and/or medical problems?	Yes	No	Do you take vitamins, amino acids, creatine, and/or any other dietary supplement on a daily basis and/or as needed?
Yes	No	Been evaluated by a Georgetown University Team Physician, Georgetown University Health Center Physician, and/or other physician?	Yes	No	Been recently diagnosed with infectious mononucleosis ("mono"), hepatitis B or C, HIV/AIDS, and/or any other severe infectious disease / viral infection?
Yes	No	Have you ever felt dizzy, passed out, or "blacked out" during or after exercise?	Yes	No	Been denied clearance by a medical professional to participate in any athletic activity?

FEMALES ONLY!

When did your last menstrual period begin? _____

How long does your menstrual period usually last? _____

How many menstrual periods have you had in the last 12 months? _____

Do you take birth control pills? If so, which one(s)? _____

Do you take pain medication? If so, which one(s)? _____

If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail below (use additional sheet(s) if necessary)-

The NCAA recommends that all student athletes be aware of their sickle cell status. If the student athlete does not know whether they are positive for sickle cell trait, the NCAA recommends that student athletes undergo testing to determine their status. Please see the Sickle Cell Information Sheet / Waiver.

I verify that all the information is accurate and complete. Further, I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that University of the District of Columbia is not responsible for expenses related to any previously existing conditions.

Student-athlete signature: _____ Date: _____

Athletic Trainer signature: _____ Date: _____