NAME: ASU ID: SPORT(S):

Health Services
Sports Medicine
Appointments:
480-965-3349

2017-2018 SPORTS PHYSICAL

OFF-CAMPUS Primary Care Provider

(Urgent Care Physicals will not be accepted)

Use these forms if you are having your physical performed by a non- ASU physician. Please bring ALL completed paperwork, including **name and ID on each page**, to your appointment. Sickle screening, if required for your sport, may be done off-campus, or at ASU lab. Baseline concussion testing must be done at ASU Health Services.

Sex (circle one) Male Female Date of Birth_____

Do you take any pills, supplements, vitamins or medication (including inhalers and birth control pills)?

Please list:

What medicines are you allergic to? What happens when you take that medicine? Please list:

Medicine	Reaction

ANY Previous Injuries	Sprain / Strain / Fracture / Other	Year	Right / Left	Management / Treatment
Fingers/Wrist/Hand				
Elbow				
Shoulder				
Hip				
Knee				
Ankle				
Foot				
Back/Neck				
Other				

NAME: ASU ID:

What medical problems do you have? What medical problems are in your family? Please specify other family members (i.e. Mother, Paternal Grandfather, etc.):

	You	Specify Family Member(s)	Comments
High Blood Pressure			
Heart Murmur Heart			
Disease/ Heart Attack			
Epilepsy/Seizures			
Asthma/ Exercise Induced Bronchospasm			
Valley Fever			
Mononucleosis			
Headaches			
Hepatitis			
Anemia			
Bleed/Bruise Easily Cancer			
Eating Disorder			
Thalassemia			
Sickle Cell			
Kidney/Bladder Infection or stones			
Thyroid			
Depression/ Bipolar			
ADD/ADHD			
Head injury/ Concussion			
Diabetes			
Other			

Immunization History ***Vaccine***	***Number of shots needed***	***Number of shots received and dates if known***
Chicken Pox	1	
Gardasil(HPV)	3	
Hepatitis A	2	
Hepatitis B	3	
Tetanus	Every 10 years	
Meningitis	1	
Flu Vaccine	Yearly	

Over the past 2 weeks, how often have you been bothered by the following problems?(circle number)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

NAME: ASU ID:

Please answer the following questions honestly and explain any YES answers.

1. Have you recently been thinking about hurting or killing yourself?	YES	NO
2. Have you recently been thinking about hurting or killing someone else?	YES	NO
3. Have you or anyone in your family been treated for alcohol or substance abuse?	YES	NO
4. Are you allergic to any insect bites or stings?	YES	NO
5. Do you need an epi-pen for an allergic reaction?	YES	NO
6. Does anyone in your family have heart disease, a pacemaker, or defibrillator?	YES	NO
7. Have you, or any family member, been diagnosed with: Marfans Syndrome? Hypertrophic Cardiomyopathy? If YES, who:	YES YES	NO NO
8. Has anyone in your family died before the age of 50? If YES, explain:	YES	NO
9. Does anyone in your family have sickle cell disease or sickle cell trait? If YES, who:	YES	NO
10. Have you ever been told you have a heart murmur?	YES	NO
11. Have you ever been told you have a heart problem?	YES	NO
12. Have you ever passed out, or almost passed out, during exercise?	YES	NO
13. Have you ever had chest pain, chest tightness, chest pressure or discomfort during exercise?	YES	NO
14. Have you ever felt your heart racing or skipping beats during exercise?	YES	NO
15. Have you ever been diagnosed with asthma or exercise induced bronchial spasms?	YES	NO
16. Have you ever used an inhaler?	YES	NO
17. After hard work-outs do you experience coughing or wheezing?	YES	NO
18. Have you had a herpes or MRSA skin infection?	YES	NO
19. Have you ever been dizzy, during or after exercise?	YES	NO
20. Have you ever been dizzy or passed out in the heat?	YES	NO
21. Have you ever had a head injury or a concussion? If YES, how many? When was the most recent?	YES	NO
22. Have you ever had a blow, or hit to the head, that caused confusion, prolonged headache or memory problems?	YES	NO
23. Have you ever been knocked unconscious?	YES	NO
24. Have you ever had a stinger or burner?	YES	NO
25. Have you ever had a seizure? If YES, when was the most recent?	YES	NO
26. Do you have any problems with your eyes or with your vision?	YES	NO
27. Do you wear glasses or contacts?	YES	NO
28. Would you like to change your weight?	YES	NO
29. Do you follow any special diet?	YES	NO
30. Do you avoid any certain foods?	YES	NO
31. Have you ever had a stress fracture?	YES	NO
32. Have you been treated by a physician or other health care provider in the last 12 months? If YES, for what?	YES	NO

Physician Notes:	
	Examiner Initials:

NAME: ASU ID:

Please answer the following questions honestly and explain any YES answers.

33. Have you ever fractured (broken) a bone or dislocated a joint? If YES, what?	YES	NO
34. Have you every injured a bone, muscle, ligament or tendon that caused you to miss practice or a game?	YES	NO
35. Do you wear any special or additional bracing/taping etc during sports participation? If YES, what?	YES	NO
36. Has your participation in sports ever been restricted or denied for any reason? If YES, why?	YES	NO
37. Do you use tobacco? If YES, what type? How much/often?	YES	NO
38. Did you formerly use tobacco? If YES what type? Quit date:	YES	NO
39. Do you drink alcohol? If YES, how many drinks? How often?	YES	NO
40. Did you formerly use alcohol? If YES, quit date:	YES	NO
41. Do you use any illicit or street drugs?	YES	NO
42. Are you, or have you ever been, sexually active?	YES	NO

43. Sexual partners (please circle):	Same Sex (male with male, female with female)	Opposite sex (male with female)	Bisexual			
44. Do you use condoms (please circle):	Always	Sometimes	Never			
45. Birth control method (circle all that apply):	Abstinence	Withdrawal	Condoms	Oral Contraceptive Pills	IUD	Other:

FEMALES:

46. How old were you, when you started having periods?	yrs
47. How many periods have you had in the last 12 months?	

I hereby state, that, to the best of my knowledge, my answers to all the above questions are complete and correct.

Athlete name_____ Sport_____

Athlete signature_____ Date_____

If athlete under 18, parent or legal guardian please sign. Name:_____

Signature_____ Date_____

Physician Notes:	
	Examiner Initials:

NAME: ASU ID:

ARIZONA STATE UNIVERSITY

Club Student Athlete Information Release

Sport_____

I, {Athlete Name}_____, give my permission to the following Designated ASU Offices to exchange confidential, personal, mental health and medical information concerning me, *when necessary to coordinate my medical and mental health care:* Campus Health Services, Physiotherapy Physical Therapy, Athletic Training Staff, Coaching Staff, Student Recreation Complex, Counseling and Consultation, Disability Resources and other confidential counseling services provided by or on behalf of ASU. I also give permission for the Designated ASU Offices to receive confidential information from and provide confidential information to any outside health professional directly involved in my care.

I give my permission for the limited release of medical, mental health and related information, including appointment dates and attendance records from designated ASU offices to the following individuals: Coaching Staff, Student Recreation Complex Staff, Sport Club Officers, Athletic Training Staff, Physical Therapists, Team Physician(s). This communication may be done by telephone, e-mail, or text messaging. This limited release allows the release of confidential information only to the extent necessary to determine payment for medical and related services rendered on my behalf, determine compliance with University rules regarding eligibility and medical treatment of the student athlete and to confirm appointment attendance.

I may revoke this release in any time by notifying any one of the designated ASU offices or Team Physician in writing. Revocation will not affect any release made prior to the revocation. This release will expire automatically on August 15th following the end of the Academic Year.

Signature_____ Date_____

If athlete is younger than 18 years of age, parent or legal guardian must sign:

Signature_____ Date_____

Print Name_____

NAME: ASU ID:

CLUB SPORTS PHYSICIAL EXAM

To be filled out by examiner

Date of exam:_____

HT_____ WT_____ B/P_____/_____ HR_____ Vision R: 20/_____ L: 20/_____

Sex: Male Female Peak Flow_____ B: 20/_____ Corrected: Yes No

MEDICAL EXAM	*NORMAL*	*ABNORMAL FINDINGS*
Appearance		
EYES EOMI Pupils		
HEENT		
Neck		
Lymph nodes		
Heart Murmurs Standing/Supine/Valsalva PMI Pulses		
Lungs		
Abdomen		
Genitourinary (males)		
Skin		
Neuro		

Please include copy of sickle cell screening lab test results if participating in: cycling/tri, ultimate frisbee, lacrosse, rowing, rugby, quidditch, or soccer.

Sickle screen testing may be done at ASU Health Services lab. Results are available in less than an hour and should be attached to clearance paperwork.

Examiner Notes:

Examiner Name	*Signature*	*Date*

NAME: ASU ID:

CLUB SPORTS PHYSICAL EXAM

MUSCULOSKELETAL EXAM	*Normal*	*Abnormal Findings*
Neck: ROM Spurlings		
Back: Curve ROM		
Shoulder: ROM Strength and Side Plank If indicated: Tenderness Impingement Speeds O'Briens Laxity Apprehension/Relocation		
Elbow: ROM Strength If indicated: Tenderness Valgus/varus stability		
Wrist/Hand: ROM Strength Opposition/Arachnodactyly Tenderness		
Hip/Pelvis: ROM Flexibility Strength If Indicated : Tenderness FABER Obers		
Knee: ROM Strength Squat and Duck Walk If indicated: Tenderness Apprehension Valgus/varus stability Lachmans Anterior/posterior drawer McMurray		
Ankle: ROM Single leg balance and hop If indicated: Tenderness Ant drawer Talar tilt Klieger		
Foot: Arch, Walk on Toes/Heels If indicated: Tenderness		
Other:		

Examiner Name	*Signature*	*Date*

NAME: ASU ID:

ARIZONA STATE UNIVERSITY SPORTS MEDICINE

Sickle Cell Trait Testing Consent / Refusal and Release

Sickle Cell Trait is a genetically inherited condition that affects red blood cells during intense exercise. NCAA student-athletes with sickle cell trait have experienced significant physical distress during extreme conditioning and some have even died. **Those student-athletes who have Sickle Cell Trait and who participate in football, basketball, track and field, wrestling, lacrosse, rugby, rowing, cycling/triathlon, ultimate frisbee, quidditch, roller hockey and/or soccer are at higher risk of complications during training. Therefore, athletes in those sports are required to present lab test results prior to participation clearance.** Certain student-athletes are at higher risk of having this condition, specifically students who are of African-American and Hispanic descent.

The Arizona State University (ASU) Health Services and/or Sun Devil Athletics (SDA) has provided me with educational materials regarding Sickle Cell Trait (http://fs.ncaa.org/Docs/health_safety/SickleCellTraitforSA.pdf) and the risks associated with that diagnosis. I understand that the NCAA and ASU require that **ALL** incoming Division I student-athletes be tested for Sickle Cell Trait, provide documented results of a prior test to ASU or decline the test and sign a waiver releasing ASU from liability. **I also understand that ASU requires all participants in high risk sports and walk-on sports to undergo testing prior to participation**.

I acknowledge and understand that if I test positive for Sickle Cell Trait, I will **NOT** be restricted from playing my sport. However, for my health and safety, certain precautions will be taken with respect to my training and I will be removed from training if I develop symptoms associated with Sickle Cell Trait. I acknowledge that I have had a full opportunity to ask any questions I have about the diagnosis of Sickle Cell Trait and the ASU Sickle Cell Trait testing program and to discuss the risks associated with participation in intercollegiate athletics at ASU if I have Sickle Cell Trait. Any questions or concerns I had, if any, have been addressed to my satisfaction. I understand the risks involved if I choose NOT to be tested for Sickle Cell Trait, and I knowingly assume such risks.

(Please initial **one line** below)

_____ I have received this information and I AGREE to be tested for Sickle Cell Trait.

_____ I HAVE SHOWN ASU the results of a prior Sickle Cell Trait test.

_____ I have received this information, **do not participate in a high risk sport**, and I DECLINE a blood test for Sickle Cell Trait. I understand that by refusing to undergo screening for Sickle Cell Trait, I assume all risks associated with such refusal and, in consideration for being granted the opportunity to participate in intercollegiate athletics at ASU without agreeing to be tested for Sickle Cell Trait, I (for myself, my executors, administrators and assigns) hereby release and forever discharge Arizona State University, the Arizona Board of Regents and the State of Arizona and their regents, officers, employees, agents, representatives, coaches, physicians, instructors and volunteers from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature directly or indirectly related to any personal injury, including death, bodily injury, mental anguish or emotional distress that I may suffer related in any way to my participation in intercollegiate athletics, whether caused by my negligence or carelessness or the negligence of ASU or otherwise. These risks have been discussed with me and I have made this decision on a fully informed basis. I understand that this release means that, among other things, I am giving up my right to sue Arizona State University for any such losses, damages, injury or costs that I may incur.

I represent and certify that I am at least 18 years old and that I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be legally bound by this document.

Print Name:_____ Signature:_____ Date:_____

If under 18, parent or legal guardian must print and sign below and indicate date signed.

Print Name:_____ Signature:_____ Date:_____

Witness: Print Name:_____ Signature:_____ Date:_____

Arizona State University
Mild Traumatic Brain Injury (MTBI) / Concussion Statement and Acknowledgement Form

I, _____, acknowledge that I have to be an active participant in my own healthcare and have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing to the ASU Sports Medicine staff an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the NCAA Concussion fact sheet (http://fs.ncaa.org/Docs/health_safety/ConFactSheetsa.pdf) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the Sports Medicine staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have been cleared to do so by a team physician.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the NCAA the following sports have been identified as high risk for concussion; baseball, basketball, diving, equestrian, field hockey, football, gymnastics, ice hockey, lacrosse, pole vaulting, rugby, soccer, softball, water polo, and wrestling.

Baseline neuro-cognitive testing using the ImPACT computer program must be done at ASU prior to club sports clearance for: **hockey, lacrosse, rugby, soccer, and, ultimate frisbee.**

I represent and certify that I am at least 18 years old and that I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be legally bound by this document.

Athlete Print Name: _____ Signature: _____ Date: _____

If athlete under 18, parent or legal guardian must print and sign name below and indicate date signed:

Print Name: _____ Signature: _____ Date: _____

NAME: ASU ID:

INITIAL ASU PHYSICAL & ANY PHYSICAL PERFORMED OFF-CAMPUS

2016-2017 CLUB SPORT CLEARANCE FORM

ATHLETE PREFERRED NAME / NICKNAME_____ DOB_____

ADDRESS_____

CLUB SPORT(S)_____ CELL PHONE_____

ALL PHYSICALS WILL BE REVIEWED BY ASU TEAM PHYSICIAN. ADDITIONAL FOLLOW-UP MAY BE INDICATED AT TEAM PHYSICIAN DISCRETION. FORMS MAY TAKE UP TO ONE WEEK TO REVIEW.

----------*Examining Physician to fill out below* ----------

I have thoroughly reviewed pages 1-9 and examined this athlete and he/she:

_____Is cleared for sports participation without restrictions

_____Needs the following work-up before final clearance to participate:

Recommendations:

___ Sickle screen
___ ImPACT baseline concussion test*
___Hepatitis B vaccine series
___Previous records
___ X-rays
___ Other:

Has signed:

__Sickle waiver
__Concussion waiver
__Information release

_____Is **NOT** cleared for sports participation.

Physician Name_____ Date_____

Physician Signature_____

Physician Address _____

_____

Office Phone (_____)_____ Office Fax (_____)_____

**One time ImPACT baselines are done at ASU Health Services, take about 30 minutes, and are required for:* hockey, lacrosse, pankration, rugby, soccer, and ultimate Frisbee. There may be a charge for testing if physical was done off-campus. Low baseline scores may require repeat testing.

Non-ASU providers please fax or return ALL 10 pages to first floor SRC Sports Medicine office.