NAME: ASU ID: SPORT(S):

Health Services
Sports Medicine
Appointments:
480-965-3349

2018-2019 RETURNING ATHLETES WHO HAVE HAD A PHYSICAL AT ASU

This form is only for athletes who have had their sports physical on-campus at ASU previously and are returning to ASU for their physical again. This is NOT for off-campus use. Please bring completed paperwork, with **name and ID on every page**, to your appointment.

What club sport(s) did you participate in last year?_____

Approximate date of last physical_____

Sex (circle one): Male Female Date of birth_____

Please list any pills, supplements, vitamins or medication (including inhalers and birth control pills):

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

Medicine	**Reaction**

Since your last ASU sports physical, have you:		
Had chest pains, chest tightness, chest pressure or chest discomfort?	YES	NO
Felt like your heart is racing or skipping beats?	YES	NO
Been dizzy during or after exercise?	YES	NO
Had any heat related illness?	YES	NO
Had a head injury?	YES	NO
Been hospitalized?	YES	NO
Had surgery?	YES	NO
Please explain any YES answers:		

Any changes or new medical issues in your family? Explain:

FEMALES:

How many periods have you had in the last 12 months?	
Date of last pelvic/pap exam	

NAME: ASU ID:

Please list all injuries since last physical:

Body Part	**Sprain / Strain / Fracture / Other**	**Right / Left / Other**	**Date of Injury**	**Treatment/Management**
Shoulder				
Hip				
Knee				
Ankle				
Foot				
Back/Neck				
Other				

Do you use tobacco? If YES, what type? How much/often?	YES	NO
Did you formerly use tobacco? If YES what type? Quit date:	YES	NO
Do you drink alcohol? If yes, how many drinks? How often?	YES	NO
Did you formerly use alcohol? If YES, quit date:	YES	NO
Do you use any illicit or street drugs?	YES	NO
Are you, or have you ever been, sexually active?	YES	NO

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

Have you been treated for any medical issues or musculoskeletal injuries, not listed above, since your last ASU sports physical?	YES	NO
If YES, explain:		

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

Athlete name_____ Signature _____Date_____

Parent, or legal guardian, (if athlete under 18):

Print Name_____ Signature _____Date_____

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_____