

Clark University Athletic Physical Exam

Please send completed form to: Clark University Sports Medicine Office, 950 Main St., Worcester, MA 01610

All varsity athletic participants must have a **physician** fill this form out completely to be eligible for play. Examination **must** be completed within 6 months prior to the **first** team practice of the **first** year of participation.

Please print or type Name: _____ Male Female Date of Exam: _____
 Home Address: _____
 Home Phone: _____
 Date of Birth: _____ SS#: _____
 Physician: _____ Physician's Phone #: _____

Varsity Sports Participating In: _____

General Information

BP: ____/____ Pulse: _____ Height: _____ Weight: _____
 Tetanus Booster Date: _____ Allergies: _____ Medications for Allergies: _____
 Medications taken on a regular basis: _____ Reason: _____

Medical History: Please check any conditions that apply to patient. Attach a separate page to explain in further detail if necessary.

	Yes	No		Yes	No		Yes	No
1. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	8. Enlarged Spleen	<input type="checkbox"/>	<input type="checkbox"/>	15. Loss of Paired Organ	<input type="checkbox"/>	<input type="checkbox"/>
2. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	9. Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	16. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Collapsed Lung	<input type="checkbox"/>	<input type="checkbox"/>	10. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	17. Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>
4. Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	11. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	18. Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>
5. Glasses	<input type="checkbox"/>	<input type="checkbox"/>	12. High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	19. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
6. Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	13. Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>	20. Heat Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
7. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	14. Syncope/Near Syncope	<input type="checkbox"/>	<input type="checkbox"/>	21. Heat Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Physician: Please note any abnormalities found in your General Examination on the previous page: _____

Cardiovascular Screening:

Has patient ever had:	Yes	No	<u>Explain</u>
1. Any prior occurrence of exertional chest pain, discomfort or syncope/near syncope?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Excessive, unexpected and unexplained shortness of breath or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Any past detection of Heart Murmur, or an increase in systemic blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Family history of premature death or significant disability from CV disease in any close relatives younger than 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Findings: _____ _____ _____

Musculoskeletal/Orthopedic Evaluation: Please note any joint laxity, tightness or abnormalities and include any previous surgery. Attach a separate page if necessary to explain any of the following.

Shoulders _____ Elbow _____ Hand _____
 Wrist _____ Knee _____ Ankle _____
 Back _____ Hips _____ Feet _____

Other abnormalities? _____

Are there any problems that need referral or follow-up? _____

Recommendations for intercollegiate competition

Limited
 Unlimited Explain: _____

 MD/DO/NP/PA
PHYSICIAN SIGNATURE **DATE**

Student-Athlete Signature Required

Understands that by signing this form that he or she gives permission to Clark University Health Services to release the Athletic Physical to Athletics for the purpose of sports clearance.

STUDENT-ATHLETE SIGNATURE (Parent if under 18) **DATE**

INSURANCE COVERAGE FOR STUDENT-ATHLETES

Students may register for classes at Clark only if they have basic health insurance coverage. This requirement may be met by either electing to take the student health insurance plan offered by the University, or by presenting evidence of coverage through a family plan or other private program.

The Clark University Athletic Insurance is a secondary policy, which pays medical expenses for a covered claim to a maximum of \$75,000 with a \$1,000 deductible per injury. In the event of a covered varsity or designated club sports related injury, the injury must be submitted to the primary insurance policy first. The balances remaining after primary insurance may then be submitted to the Clark University Athletic Insurance. Any payments made by the primary insurance will be applied to satisfy the \$1,000 Clark Athletic policy deductible. The athlete may be responsible for all or part of the \$1,000 deductible if it is not completely satisfied through the primary insurance. The NCAA Catastrophic Injury Insurance will supplement the University's Athletic Insurance Policy after \$75,000. All medical charges must be incurred within 104 weeks from the date of injury.

Please look into your individual health insurance to see what kind of coverage you have for sports injuries.

In the event that you suffer an injury incurred while participating in Clark Athletics, you must report this incident immediately to the Certified Athletic Trainer for documentation and treatment. Any injury that goes unreported may not be covered under the Clark University Athletic Insurance.

This form must be filled out completely and accurately, signed and dated before an athlete can participate.
I have read and understand the above information

STUDENT-ATHLETE SIGNATURE

DATE

PARENT SIGNATURE (Required)

DATE

AUTHORIZATION TO RELEASE MEDICAL AND TREATMENT INFORMATION

The "Health Insurance Portability and Accountability Act of 1996" (HIPAA) was enacted by Congress to protect patients' privacy and confidentiality regarding information pertaining to their medical condition. The law states, in part, that Protected Health Information, referred to as "PHI", may only be released with the consent of the patient.

In the course of providing proper medical care and treatment to injured varsity athletes, the Sports Medicine Department at Clark University often need to share information relating to an injured athlete with the following entities: the athletic director, coaches, parents, doctors, medical personnel, insurance brokers and companies, the Universities Student Health Services Office, University Administrators, the Sports Information office, and on occasion the media. The only information, however, that will be shared is that medical and/or treatment information that relates to injuries incurred by a varsity athlete while participating in varsity sports while playing for Clark University.

Given the need to share medical information pertaining to injured athletes, the University requires that all varsity athletes authorize the University, on an annual basis, to share pertinent medical information, when necessary, with the specific entities and offices listed above. It is therefore necessary, in order to be eligible to participate in varsity sports at Clark University, to provide your signature below.

I have read and understand the above information.

STUDENT-ATHLETE SIGNATURE

DATE

PARENT SIGNATURE (Required if student is under 18y/o)

DATE

***This form must be signed by the student-athlete and parent for him/her to be eligible for varsity athletics.**

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