SPORT (s):___ ___________

NAME:____________________
(PRINT) First Last

College M#: ________________

<u>MONTGOMERY COLLEGE</u>

<u>SPORTS MEDICINE PACKET</u>

Montgomery College

<u>INSTRUCTIONS:</u>
- **7/11**
- **<u>DO NOT remove any papers – this includes the four physical exam pages!</u>**
- **If downloading from our website - Print all pages in order and staple together.** **(DO NOT copy pages back to back – print each page)**
- **All pages must be completed before turning this packet in to your coach.**

MONTGOMERY COLLEGE PREPARTICIPATION EXAM

PLEASE PRINT CLEARLY

Name:____________________________________**Sport(s):**____________________________

Age:______________ **Date of Birth:**______________________________**Sex:** ___**M**______**F**_____

Address:____

City:________________________ **State:**____________________ **Zip:**____________________

Home Phone:____________________ **Cell Phone:** ______________

In case of Emergency contact:___________________**(H)**__________________**(C)**________________

Please answer the following for the doctor's review and explain all "YES" answers in the space provided at the end of questions. Circle questions you don't know the answer to.

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	_____	_____
2. Do you have ongoing medical condition (like diabetes or asthma)?	_____	_____
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills?	_____	_____
4. Do you have allergies to medicines, pollens, foods or stinging insects?	_____	_____
5. Have you ever passed out or nearly passed out DURING exercise?	_____	_____
6. Have you ever passed out or nearly passed out AFTER exercise?	_____	_____
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	_____	_____
8. Does your heart race or skip beats during exercise?	_____	_____
9. Has a doctor ever told you that you have (check all that applies): _____ High blood pressure _____A heart murmur _____ High cholesterol _____A heart infection		
10. Has a doctor ever ordered a test for your heart? (example: ECG, Echocardiogram)	_____	_____
11. Has anyone in your family died for no apparent reason?	_____	_____
12. Does anyone in your family have a heart problem?	_____	_____
13. Has any family member or relative died of heart problems or of sudden death before age 50?	_____	_____
14. Does anyone in your family have Mar fan syndrome?	_____	_____
15. Have you ever spent the night in a hospital?	_____	_____
16. Have you ever had surgery?	_____	_____
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	_____	_____
18. Have you had any broken or fractured bones or dislocated joint? If yes, circle below:	_____	_____
19. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	_____	_____

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

yes no

20. Have you ever had a stress fracture? _____ _____
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? _____ _____
24. Do you cough, wheeze, or have difficulty breathing during or after exercise _____ _____
25. Is there anyone in your family who has asthma? _____ _____
26. Have you ever used an inhaler or taken asthma medicine? _____ _____
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? _____ _____
28. Have you had infectious mononucleosis (mono) within the last month? _____ _____
29. Do you have any rashes, pressure sores, or other skin problems? _____ _____
30. Have you had a herpes skin infection? _____ _____
31. Have you ever had a head injury or concussion? _____ _____
32. Have you been hit in the head and been confused or lost your memory? _____ _____
33. Have you ever had a seizure? _____ _____
34. Do you have headaches with exercise? _____ _____
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? _____ _____
36. Have you ever been unable to move your arms or legs after being hit or falling? _____ _____
37. When exercising in the heat, do you have severe muscle cramps or become ill? _____ _____
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? _____ _____
39. Have you had any problems with your eyes or vision? _____ _____
40. Do you wear glasses or contact lenses? _____ _____
41. Do you wear protective eyewear, such as goggles or a face shield? _____ _____
42. Are you happy with your weight? _____ _____
43. Are you trying to gain or lose weight? _____ _____
44. Has anyone recommended you change your weight or eating habits? _____ _____
45. Do you limit or carefully control what you eat? _____ _____
46. Do you have any concerns that you would like to discuss with a doctor? _____ _____

FEMALES ONLY

47. Have you ever had a menstrual period? _____ _____
48. How old were you when you had your first menstrual period? ________________________________
49. How many periods have you had in the last 12 months? ________________________________

EXPLAIN ALL "YES" ANSWERS (Questions #1 – 49) HERE:

QUESTION # EXPLANATION

____
____
____
____
____
____
____

HEATLH HISTORY SHOULD BE REVIEWED BY PHYSICIAN

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

Signature of Athlete ____Date_________________

Signature of Parent/Guardian (under 18yo)__________________________Date_________________

Name ____ Date of Birth ___________________

Height ______ Weight ______ %Body Fat (optional) _____ Pulse ______ BP _____/_____ (/) (/)

Vision R 20/______ L 20/ ______ Corrected Y N Pupils: Equal _______ Unequal _______

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL Appearance			
Eye/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

* Multiple-examiner set-up only
+ Having a third party present is recommended for the genitourinary examination.

NOTES:____

____

____

Name of physician (print/ type) ____________________________________ Date of exam : ______________

Address ____ Phone ____________

Signature of physician ____, MD or DO

PHYSICIAN OFFICE STAMP:

Continue to clearance form ->

PHYSICIAN CLEARANCE FORM

Name ________________________________ Sex _____ Age _____ Date of birth _______________

_______ **CLEARED** without restriction
_______ Cleared, **AFTER** further evaluation or treatment for: ________________________________
____
____
____

_______ **NOT CLEARED** for: _______ All Sports _______Certain sports: ____________ Reason:_________

Recommendations: ____
____

EMERGENCY INFORMATION:
Allergies or Asthma ____
Other information ____

Name of physician (print/type) ____Date ____________

Address ____Phone _________________

PHYSICIAN SIGNATURE: ____, MD or DO

PHYSICIAN OFFICE STAMP:

FOLLOW UP CLEARANCE FORM
Only to be completed if "not cleared" above.

Name ________________________________ Sex _____ Age _____ Date of birth _______________
_______ CLEARED without restriction
_______ Cleared, **AFTER** further evaluation or treatment for: ________________________________
____
____
____

_______ **NOT CLEARED** for _______ All Sports _______Certain sports: ______________ Reason:_______

Recommendations/Allergies/Asthma/ other information: ______________________________________

Name of physician (print/type) ____Date ______________

Address ____Phone ___________________

PHYSICIAN SIGNATURE: ____, MD or DO

PHYSICIAN OFFICE STAMP

MONTGOMERY COLLEGE

Student – Athlete's Name: ____

To all student athletes:
Montgomery College Athletic Department **DOES NOT** provide medical insurance for injuries sustained while participating in athletics. The College also does not pay for any medical expenses incurred when school personnel recommends/requires the athlete to seek medical attention before being allowed to return to play. All medical expenses are the responsibility of the athlete and /or their families. We strongly recommend that athletes carry their own medical insurance policy.

****

I ______________________ understand Montgomery College does not have medical insurance for athletes and that they are not responsible for my medical costs. My signature below indicates that I have read the above, understand, and accept my responsibilities.

NAME ______________________________________ DATE ______________
(Student signature)

PARENT/GUARDIAN ________________________ DATE _______________
(Signature if student under 18yo)

________ I DO NOT CURRENTLY HAVE MEDICAL INSURANCE

_________ I HAVE MEDICAL INSURANCE:

INSURANCE COMPANY: ____

PHONE NUMBER: ____

PRIMARY CARE PHYSICIAN: ____________________________________
PHONE NUMBER: ____

MONTGOMERY COLLEGE

Student – Athlete's name: ______________________________________

Please read the following consent forms carefully. The Student- Athlete's signature, and Parent's signature if student under the age of 18, is required.

Medical Consent

I hereby grant permission to Montgomery College and team physicians and/or their consulting physicians and other medical personnel under their direction to render to my son/daughter/myself any treatment and medical or surgical care that they deem reasonably necessary to the health and well being of the student-athlete. I also hereby authorize the athletic trainers at Montgomery College, who are under the direction and guidance of their team physicians, to render to my son/daughter/myself any preventative, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to the health and well-being of the student-athlete. I also hereby authorize the coaching staff at Montgomery College to render first aid and seek treatment for my son/daughter/myself as deemed necessary. Also, when necessary for executing such case, I grant permission for emergency transportation and hospitalization at an accredited hospital. This consent specifically includes consent to release of all information that may be required for treatment, including, but not limited to, insurance information.

STUDENT ATHLETE'S SIGNATURE_____________________________ DATE _________

PARENT SIGNATURE ____ DATE _________
(If athlete under the age of 18)

Release and Assumption of Risk

Participation in a sport involves inherent risk of bodily harm and requires an acceptance of risk of injury. Student-athletes must assume that their participation can result in injury to them, even serious injury.

I understand that by willingly participating in athletics at the collegiate level, I am knowingly undertaking and assuming a non-controllable risk which may result in an injury that may be severe in nature. Such an injury may result in paralysis or death. I understand these risks and agree to accept full personal responsibility for all risks, foreseen and unforeseen, in connection with my participation in athletics at the collegiate level.

I hereby assume all risks associated with participation in athletics at Montgomery College (including transportation to and from events) and agree to waive from liability and hold harmless Montgomery College, its employees, agents, representatives, coaches, volunteers and athletic trainers from and against any and all claims, demand, losses, or liabilities of any kind or nature which may arise in connection with injuries suffered while participating in, or in any way in connection with, intercollegiate athletics.

STUDENT ATHLETE'S SIGNATURE_____________________________ DATE _________

PARENT SIGNATURE ____ DATE _________
(If athlete under the age of 18)

Authorization for Release of Information

In signing the release of information form, I authorize hospitals, physicians, certified athletic trainers, rehabilitation clinics, and student health services to release medical information to the Montgomery College Athletic Training Staff, team physicians, and coaches concerning my health and welfare. The medical information may relate to my past, present, and future medical conditions, injuries or illnesses that may occur, or already have occurred, in connection with or relevant to intercollegiate athletics at Montgomery College or otherwise.

Also, by giving the authorization for the release of medical information, I permit the representatives of Montgomery College, medical staff and athletic training staff to disclose information concerning my health to parents/guardians, potential professional scouts or four year university coaches interested in recruiting me, if the opportunity arises in the future. I understand that a record and date will be kept of all individuals receiving such information.

STUDENT ATHLETE'S SIGNATURE ______________________________ DATE ________

PARENT SIGNATURE ____ DATE _________
(If athlete under the age of 18)