# TRYOUT STUDENT-ATHLETE CHECKLIST

**Student-Athlete Name______________________________**

**UID______________________________**

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The following materials must be completed in its entirety and returned to the sport’s staff athletic trainer prior to the walk-on tryout date. **Failure to comply will forfeit the prospective student-athlete’s ability to participate in the tryout.** Forms are to be printed single sided. Forms printed double sided will not be accepted.

<table>
<thead>
<tr>
<th>Hard Copy Forms:</th>
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</thead>
<tbody>
<tr>
<td>1. Initial Health Appraisal Form</td>
</tr>
<tr>
<td>2. Documentation of a physical examination by a licensed physician (MD, DO or NP) within the last six months that clears the prospective tryout student-athlete to participate in intercollegiate athletics (form attached)</td>
</tr>
<tr>
<td>3. Sickle Cell NCAA Fact Sheet &amp; Education Acknowledgement</td>
</tr>
<tr>
<td>4. Documentation of Sickle Cell Solubility Test (SST)</td>
</tr>
<tr>
<td>- Sickle Cell Confirmation Positive (if positive)</td>
</tr>
<tr>
<td>5. Concussion NCAA Fact Sheet &amp; Student-Athlete Statement About Concussion</td>
</tr>
<tr>
<td>- Concussion Baseline Symptom Checklist</td>
</tr>
<tr>
<td>6. ADD/ADHD Fact Sheet &amp; Medical Exception Notification Form</td>
</tr>
<tr>
<td>7. Big Ten Injury and Illness Reporting Acknowledgment Form</td>
</tr>
<tr>
<td>8. Assumption of Risk/Release Form</td>
</tr>
<tr>
<td>9. Release and Waiver of Liability Form</td>
</tr>
<tr>
<td>10. Student-Athlete Insurance Information Sheet</td>
</tr>
<tr>
<td>11. Proof of valid personal/primary health insurance that provides coverage for intercollegiate athletic activities (must attach a photocopy of the front and back of current health insurance card)</td>
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</tbody>
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**NOTES:**

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<tr>
<th>Cleared</th>
<th>Not Cleared</th>
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<tr>
<th>Sports Medicine Signature:</th>
<th>Date:</th>
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</thead>
</table>
Initial Health Appraisal
(Please print clearly in BLUE or BLACK INK ONLY!)

Name __________________________ Date __________________________

Date of Birth __________________________

Race: ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other ______________

Sport(s) __________________________ Position(s) __________________________

Height __________________________ Weight __________________________

☐ Right Handed ☐ Left Handed

Family History (please complete / check appropriate boxes):

<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
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<tbody>
<tr>
<td>Current Age</td>
<td></td>
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<tr>
<td>If Deceased, Cause of Death</td>
<td></td>
</tr>
<tr>
<td>Age @ Death</td>
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<tr>
<td>History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)</td>
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<tr>
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<tr>
<td>History of heart disease, high blood pressure, and/or high cholesterol</td>
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<tr>
<td>History of stroke</td>
<td></td>
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<tr>
<td>History of tuberculosis</td>
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</tr>
<tr>
<td>History of Cancer</td>
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<tr>
<th>SIBLING 1</th>
<th>SIBLING 2</th>
<th>SIBLING 3</th>
<th>SIBLING 4</th>
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<tr>
<td>History of Cancer</td>
<td></td>
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</tbody>
</table>
Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice?  
☐ YES  ☐ NO

- Please Describe ____________________________

Do you cough, wheeze, and/or have trouble breathing during or after exercise / practice?  
☐ YES  ☐ NO

- Please Describe ____________________________

Do you get tired more quickly than your teammates / friends do during exercise / practice?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you ever been told that you have a heart murmur?  
☐ YES  ☐ NO

- Please Describe ____________________________

Has any family member or relative died or heart problems and/or of sudden death before age 50?  
☐ YES  ☐ NO

- Please Describe ____________________________

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?  
☐ YES  ☐ NO

- Dates / Please Describe ______________________

Does anyone in your family have a history of high blood pressure?  
☐ YES  ☐ NO

- Please Describe ____________________________

Are there any known cardiac conditions that run in the family?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you ever been told that you have / had high blood pressure?  
☐ YES  ☐ NO

- Please Describe ____________________________

Does anyone in your family have a history of high blood cholesterol?  
☐ YES  ☐ NO

- Please Describe ____________________________

Have you even been told that you have / had high blood cholesterol?  
☐ YES  ☐ NO

- Please Describe ____________________________
## II. Allergies:

Have you ever been diagnosed with seasonal allergies? □ YES □ NO
- Please describe

Are you presently taking/have you previously taken any allergy medications? □ YES □ NO
- Please describe

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? □ YES □ NO
- Please describe

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? □ YES □ NO
- Please describe

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? □ YES □ NO
- Please describe

## III. Asthma:

Have you ever been diagnosed with asthma and/or exercised induced asthma? □ YES □ NO
- Date(s)?
- Please describe

Are you presently taking / have you previously taken any asthma medications / use an inhaler? □ YES □ NO
- Date(s)?
- Please describe

How many times do you use your rescue inhaler (e.g. Albuterol, Proventil, etc.) during an average week?__

How many acute asthma attacks have you had in the past 12 months? __
- Date(s)?
- Please describe

Have you ever been hospitalized as a result of asthma and/or exercised induced asthma? □ YES □ NO
- Date(s)?
- Please describe

Have you ever been advised not to participate in athletic activities due to asthma or any related condition? □ YES □ NO
- Please describe

## IV. Sickle Cell Trait:

Have you ever been tested for sickle cell anemia and/or sickle cell trait that you are aware of? □ YES □ NO
- Date? ______________________ Result? __________

Does any member of your family carry the sickle cell trait / have sickle cell anemia that you are aware of? □ YES □ NO
- Please describe

Have you ever been advised that you carry the sickle cell trait / have sickle cell anemia? □ YES □ NO
- Please describe

Have you ever restricted, modified, and/or been instructed to restrict or modify your participation in sports due to muscle pain and/or cramping during or after exercise? □ YES □ NO
- Please describe

Student-Athlete’s Initials __________
**V Head Injuries / Concussion:**

Have You Ever Suffered A Head Injury / Concussion *(no matter how minor)*?  
☐ YES  ☐ NO

If YES, please complete the following chart for each head injury / concussion

<table>
<thead>
<tr>
<th>DATE</th>
<th>Signs / Symptoms (please check the appropriate box)</th>
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<tbody>
<tr>
<td></td>
<td>Headache(s) and/or “Pressure in the Head”</td>
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<tr>
<td></td>
<td>Dizziness and/or Balance Problems</td>
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<tr>
<td></td>
<td>Loss of Consciousness / “blacked out”</td>
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<td>Loss of Memory</td>
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<td></td>
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<td></td>
<td>Ringing in the Ears / Hearing Problems</td>
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<tr>
<td></td>
<td>Nausea and/or vomiting</td>
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<tr>
<td></td>
<td>Vision problems (double vision; blurred vision)</td>
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<tr>
<td></td>
<td>Balance problems</td>
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<tr>
<td></td>
<td>Difficulty concentrating / Confusion</td>
<td></td>
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<td></td>
<td>Difficulty sleeping</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Lethargy / Drowsiness / Fatigue</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Irritation / Anxiety / Nervousness</td>
<td></td>
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<td></td>
<td>Sensitivity to Light and/or Noise</td>
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<td></td>
<td>Sadness / Depression / “Feeling in a Fog”</td>
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<td></td>
<td>Other (please describe)</td>
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</tbody>
</table>

| Care / Treatment (please check the appropriate box) | | | |
| Evaluation by a physician | | | |
| Emergency Room / Hospitalization | | | |
| Neuropsychological Testing (e.g. ImPACT, etc.) | | | |
| Balance and/or Vision Testing | | | |
| Diagnostic Testing (e.g. CT Scan, MRI, x-ray, etc.) | | | |
| Other (please describe) | | | |

| Time Missed | | | |
| Days | | | |
| Practices | | | |
| Games | | | |

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion?  
☐ YES  ☐ NO

- Please Describe ____________________________________________

Do You Suffer From Headaches?  
☐ YES  ☐ NO

- When?  
  ☐ Every Day  ☐ 1-2 Times/Week  ☐ 1-2 Times/Month

- Where Are Your Headaches Located?  
  ☐ Left Side of Head  ☐ Right Side of Head
  ☐ Front of Head  ☐ Back of Head  ☐ All Over Your Head

Do You Have A History of Migraine Headaches?  
☐ YES  ☐ NO

- How Often ___________________________  Please Describe ___________________________

- Medications Taken for Migraines?  
  ___________________________

Have You Had Headaches For More Than Three (3) Months?  
☐ YES  ☐ NO

- If yes, please explain ________________________________________

Student-Athlete’s Initials ____________

*Updated 5/2016*
VI. Eye:

When Was Your Last Eye Exam? ________________________________

- Findings: ________________________________

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? YES NO

- List Date(s) / Time (e.g. practices or games) Missed ________________________________

- Please Describe ________________________________

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray
- MRI
- CT-Scan
- Other ________________________________

Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? YES NO

- Please Describe ________________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? YES NO

- Please Describe ________________________________

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? YES NO

- Please Describe ________________________________

Do you routinely wear glasses? YES NO

Do you routinely wear contact lenses? YES NO Type ________________________________

Do you require any special devices / equipment? YES NO Type ________________________________

VII. Ear / Nose / Throat:

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? YES NO

- List Date(s) / Time (e.g. practices or games) Missed ________________________________

- Please Describe ________________________________

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray
- MRI
- CT-Scan
- Other ________________________________

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? YES NO

- Please Describe ________________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? YES NO

- Please Describe ________________________________

VIII. Dental:

When Was Your Last Dental Exam? ________________________________

- Findings: ________________________________

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? YES NO

- List Date(s) / Time (e.g. practices or games) Missed ________________________________

- Please Describe ________________________________

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray
- MRI
- CT-Scan
- Other ________________________________

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? YES NO

- Please Describe ________________________________

Student-Athlete’s Initials __________

Updated 5/9/2016
### IX. Cervical Spine / Neck:

**Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck?**

- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

**Were Any Diagnostic Tests Performed?** (check all that apply)
- X-Rays
- MRI
- CT-Scan
- Bone Scan

**Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury?**

- When? Where?
- Please Describe

**Have You Ever Had “Burners”, “Stingers”, or Brachial Plexus Injuries?**

- How Many? Date(s)/Time Missed?

**Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers?**

- Date(s)
- Please Describe?

**Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck?**

- When? Surgeon?
- Please Describe

**Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury?**

- Please Describe

**Do You Presently Wear A Neck Roll / Collar, “Cowboy Collar” or Helmet Restrictor Plate?**

- If yes, please explain

### X. Shoulder / Upper Arm:

**Have You Ever Suffered An Injury To Your Shoulder / Upper Arm?**

- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

**Were Any Diagnostic Tests Performed?** (check all that apply)
- X-Rays
- MRI
- CT-Scan
- Bone Scan

**Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury?**

- When? Where?
- Please Describe

**Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm?**

- When? Surgeon?
- Please Describe

**Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury?**

- Please Describe
Xl. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ________________________________
- Please Describe _______________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? ☐ YES ☐ NO

- When? ______________________ Where? _____________________________________________
- Please Describe _______________________________________________________________

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? ☐ YES ☐ NO

- When? ______________________ Surgeon? __________________________________________
- Please Describe _______________________________________________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Elbow / Forearm Injury? ☐ YES ☐ NO

- Please Describe _______________________________________________________________

XII. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ________________________________
- Please Describe _______________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- When? ______________________ Where? _____________________________________________
- Please Describe _______________________________________________________________

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? ☐ YES ☐ NO

- When? ______________________ Surgeon? __________________________________________
- Please Describe _______________________________________________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? ☐ YES ☐ NO

- Please Describe _______________________________________________________________

Updated 5/9/2016

Student-Athlete’s Initials ________________
**XIII. Spine / Low Back / Sacroiliac Joint:**

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint?  
- YES  NO

- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

Were Any Diagnostic Tests Performed? (check all that apply)  
- X-Rays  MRI  CT-Scan  Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury?  
- YES  NO

- When?  Where?
- Please Describe

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint?  
- YES  NO

- When?  Surgeon?
- Please Describe

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs?  
- YES  NO

- Date(s)/Time Missed?
- Please Describe?

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury?  
- YES  NO

- Please Describe

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**XIV. Hip / Groin:**

Have You Ever Suffered An Injury To Your Hip / Groin (including hemias and/or sports hernias)?  
- YES  NO

- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

Were Any Diagnostic Tests Performed? (check all that apply)  
- X-Rays  MRI  CT-Scan  Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury?  
- YES  NO

- When?  Where?
- Please Describe

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury?  
- YES  NO

- Please Describe

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Student-Athlete’s Initials ____________

Updated 5/92016
XV. Thigh / Hamstring / Quadriceps:
Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? ☐ YES ☐ NO
- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan
Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO
- When? Where?
- Please Describe

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO
- When? Surgeon?
- Please Describe

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? ☐ YES ☐ NO
- Please Describe

XVI. Knee / Patella:
Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? ☐ YES ☐ NO
- List Date(s) / Time (e.g. practices or games) Missed
- Please Describe

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan
Have You Ever Been Hospitalized For A Knee and/or Patella Injury? ☐ YES ☐ NO
- When? Where?
- Please Describe

Have You Ever Had Surgery For A Knee and/or Patella Injury? ☐ YES ☐ NO
- When? Surgeon?
- Please Describe

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? ☐ YES ☐ NO
- Please Describe

Have You Ever/Do You Presently Wear A Knee Brace? ☐ YES ☐ NO
- Which Knee? Brand / Model of Brace?
- Reason for Wearing?
XVII. Ankle / Lower Leg:
Have You Ever Suffered An Injury To Your Ankle / Lower Leg? [ ] YES [ ] NO
- List Date(s) / Time (e.g. practices or games) Missed ____________________________
- Please Describe ____________________________

Were Any Diagnostic Tests Performed? (check all that apply) [ ] X-Rays [ ] MRI [ ] CT-Scan [ ] Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? [ ] YES [ ] NO
- When? ____________________________ Where? ____________________________
- Please Describe ____________________________

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? [ ] YES [ ] NO
- When? ____________________________ Surgeon? ____________________________
- Please Describe ____________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? [ ] YES [ ] NO
- Please Describe ____________________________

Do You Presently [ ] Tape Your Ankle(s) [ ] Use Ankle Brace(s) [ ] Other
- Please Describe ____________________________

XVIII. Foot / Toes:
Have You Ever Suffered An Injury To Your Foot / Toe(s)? [ ] YES [ ] NO
- List Date(s) / Time (e.g. practices or games) Missed ____________________________
- Please Describe ____________________________

Were Any Diagnostic Tests Performed? (check all that apply) [ ] X-Rays [ ] MRI [ ] CT-Scan [ ] Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? [ ] YES [ ] NO
- When? ____________________________ Surgeon? ____________________________
- Please Describe ____________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? [ ] YES [ ] NO
- Please Describe ____________________________

XIX. Ribs / Thorax / Chest:
Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? [ ] YES [ ] NO
- List Date(s) / Time (e.g. practices or games) Missed ____________________________
- Please Describe ____________________________

Were Any Diagnostic Tests Performed? (check all that apply) [ ] X-Rays [ ] MRI [ ] CT-Scan [ ] Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? [ ] YES [ ] NO
- When? ____________________________ Where? ____________________________
- Please Describe ____________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? [ ] YES [ ] NO
- Please Describe ____________________________

Student-Athlete’s Initials ____________

Updated 5/9/2016
XX. Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? □ YES □ NO

- List Date(s) / Time (e.g. practices or games) Missed _______________________________________________________
- Please Describe ________________________________________________________________

Have You Ever Suffered An Injury To Your Abdomen? □ YES □ NO

- List Date(s) / Time (e.g. practices or games) Missed _______________________________________________________
- Please Describe ________________________________________________________________

Were Any Diagnostic Tests Performed? (check all that apply) □ X-Rays □ MRI □ CT-Scan □ Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? □ YES □ NO

- When? __________________ Where? __________________
- Please Describe ________________________________________________________________

Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? □ YES □ NO

- Please Describe ________________________________________________________________

Do you Routinely Suffer From Chronic or Recurrent Diarrhea? □ YES □ NO

- Please Describe ________________________________________________________________

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? □ YES □ NO

- Please Describe ________________________________________________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? □ YES □ NO

- Please Describe ________________________________________________________________

XXI. Medical Testing:

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? □ YES □ NO

- List Dates/Time Missed __________________________________________________________
- Please Describe ________________________________________________________________

XXII. Dermatological (Skin):

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? □ YES □ NO

- Please Describe ________________________________________________________________

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? □ YES □ NO

- Please Describe ________________________________________________________________

Have you ever been diagnosed with ringworm, herpes, impetigo, or other type of bacterial, viral, or fungal skin infection? □ YES □ NO

- Please Describe ________________________________________________________________

Have you ever been under the care of a dermatologist for any condition? □ YES □ NO

- Please Describe ________________________________________________________________

Have you ever been advised not to participate in athletic activities due to a skin condition? □ YES □ NO

- Please Describe ________________________________________________________________

Student-Athlete’s Initials ____________

Updated 5/9/2016
### XXIII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
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</table>

### XXIV. Supplements / Ergogenic Aids:

Please List **ALL** Vitamins, Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<table>
<thead>
<tr>
<th>SUPPLEMENT</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
</tr>
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<tbody>
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### XXV. Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury? **[ ] YES  [ ] NO** (check all that apply):

- Heat Cramps- Date(s)?
- Heat Syncope (Fainting)-Date(s)?
- Heat Exhaustion- Date(s)?
- Heat Stroke- Date(s)?

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? **[ ] YES  [ ] NO**

- Date(s)?

Have You Ever Been Hospitalized For a Heat-Related Problem? **[ ] YES  [ ] NO**

- Date(s)? Where?

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? **[ ] YES  [ ] NO**

- Please Describe

---

Student-Athlete’s Initials ____________

Updated 5/2016
XXVI. Diabetic History:

Have You Ever Been Diagnosed With Diabetes?  □ YES □ NO

- Date: __________________________

Are You Presently Taking or Have You Taken Any Diabetic Medications?  □ YES □ NO

<table>
<thead>
<tr>
<th>Medication</th>
<th>Form</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
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<tbody>
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</table>

Do You Daily Monitor Your Blood Sugar Level?  □ YES □ NO

- How Many Times Per Day? __________________________
  - What Is Your Average Level? __________

Have You Had Your A1C Level Checked Within The Last Three (3) Months?  □ YES □ NO

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months?  □ YES □ NO

- Please Describe ___

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes?  □ YES □ NO

- Please Describe ___

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

________________________________________________________________________

XXVII. For Females Only:

At what age did you have your first menstrual period? __________________________

□ YES □ NO Have you had menstrual periods within the past 12 months?
  - If yes, how many? __________
  - When was your most recent menstrual period? __________________________
  - How much time do you usually have from the start of one period to the start of another? __________________________
  - What was the longest time between menstrual periods within the past year? __________________________

□ YES □ NO Do you have painful or heavy menstrual periods?

□ YES □ NO Do your menstrual periods change with changes in your training regimen? If yes, please explain? ___

□ YES □ NO Do you take any medications during your menstrual periods? If yes, what? ___

□ YES □ NO Do you take birth control pills? If yes, what brand? ___

□ YES □ NO Have you ever had any problems with your breasts?

□ YES □ NO Have you had a pelvic examination within the last year?

□ YES □ NO Do you take a calcium or iron supplement? If yes, what brand / strength? __________________________

________________________________________________________________________
XXVIII. **Please Answer:** (All questions are strictly CONFIDENTIAL & will not be shared with parents or coaches!)

☐ YES  NO  Have you ever had any injury or illness other than those already noted?
☐ YES  NO  Do you have any ongoing or chronic illnesses?
☐ YES  NO  Have you ever been hospitalized overnight?
☐ YES  NO  Have you ever been told by a physician to restrict your sports activity and/or not to participate in a sport?
☐ YES  NO  Are you currently under a physician’s care for any medical conditions?
☐ YES  NO  Have you ever been under the care of a psychiatrist and/or psychologist?
☐ YES  NO  Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
☐ YES  NO  Have you ever had a rash or hives develop during and/or after exercise?
☐ YES  NO  Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise/practice, at night, or after exposure to allergens/pollutants?
☐ YES  NO  Have you ever been told that you have kidney disease?
☐ YES  NO  Have you ever been told that you cannot donate blood?
☐ YES  NO  Have you ever had rubella (“German Measles”) and/or Rubeola (“red measles”)?
☐ YES  NO  Have you ever had a stomach and/or duodenal ulcer?
☐ YES  NO  Have you had a viral infection (i.e., mononucleosis, myocarditis, etc.) within the past twelve (12) months?
☐ YES  NO  Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES  NO  Have you ever had gall bladder disease and/or a urinary problem?
☐ YES  NO  Do you have ringing in your ears or trouble hearing?
☐ YES  NO  Do you have frequent ear infections or nosebleeds?
☐ YES  NO  Have you ever had an abnormal chest X-ray and/or pneumonia?
☐ YES  NO  Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
☐ YES  NO  Have you ever had the chickenpox? If yes, when? ________________________________

☐ YES  NO  Are you aware of any reasons why you should not participate in intercollegiate athletics at the University of Maryland at this time?
☐ YES  NO  Have you had a tetanus booster within the past five (5) years? If yes, when? ________________________________
☐ YES  NO  Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? ________________________________
☐ YES  NO  Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
☐ YES  NO  Do you use alcohol? If yes, how often? ________________________________
☐ YES  NO  Have you ever used/ tried marijuana, cocaine, or any other illicit “street” drugs?
☐ YES  NO  Do you have any questions regarding drugs, tobacco, or alcohol?
☐ YES  NO  Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
☐ YES  NO  Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
☐ YES  NO  Are you a vegetarian? If yes, what type? ________________________________
☐ YES  NO  Do you regularly lose weight to participate in your sport?
☐ YES  NO  Do you want to weigh more or less than you presently do?
☐ YES  NO  Do you experience cramps or upset stomach when drinking milk or eating dairy products (e.g., yogurt, cheese, ice cream)
☐ YES  NO  Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
☐ YES  NO  Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ YES  NO  Would you like to meet with a dietician to discuss your nutritional needs or eating habits?

If you have answered YES to any of the above, please explain: __________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
_____________________________________________________________________________________________________
Sports Nutrition Pre-Participation Screening Questionnaire

Name: ____________________________ Sport: ____________________________

Date: ____________________________ Birthdate: ____________________________ Age: _____ Year: _____ Gender: M  F

Current nutritional supplements:
Please list all the supplements you are currently taking or have taken within the past 6 months. Remember to include: vitamins & minerals, supplemental beverages, sports drinks, supplemental powders (weight gainer, protein, creatine, etc.), herbal supplements, sports bars and any pills, tablets, formulations, teas, etc. If you aren’t sure about something, list it anyway.

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Brand</th>
<th>Current?</th>
<th>Past 6 Mos?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Height: ____________________________ Weight: ____________________________

Have you lost weight in the past year?  Yes  No  If yes, was it intentional?  Yes  No  How much? __________

Have you gained weight in the past year?  Yes  No  If yes, was it intentional?  Yes  No  How much? __________

Have you tried to gain/lose weight with no success in the past year?  Gain  Lose  No

What are your nutrition goals?  (e.g.; enhance performance, Δ body comp, improve energy level, injury recovery, manage health issues, etc.)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Have you ever been told by a medical provider that you have any of the following?:

Iron deficiency anemia  Yes  No  If yes, when? ____________________________
Stress fracture  Yes  No  If yes, when? ____________________________
High blood pressure  Yes  No  If yes, when? ____________________________
High cholesterol  Yes  No  If yes, when? ____________________________
Diabetes/hypoglycemia  Yes  No  If yes, when? ____________________________
Digestive Disorders  Yes  No  If yes, when? ____________________________
Eating Disorder  Yes  No  If yes, when? ____________________________

Have you ever experienced muscle cramping as a result of exercise?  Yes  No
Have you ever experienced symptoms of dehydration (headache, dizziness, light-headedness, nausea?)  Yes  No
Have you ever noticed a salty/crystal-like film on your skin/clothing after exercise?  Yes  No

Please check off how often you eat the following foods:

<table>
<thead>
<tr>
<th>Food</th>
<th>Daily</th>
<th>Weekly</th>
<th>&lt;1x/week</th>
<th>Never</th>
<th>Food</th>
<th>Daily</th>
<th>Weekly</th>
<th>&lt;1x/week</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk (any)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Eggs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other dairy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Green Veggies</td>
<td></td>
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<td></td>
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<tr>
<td>Red Meat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fresh Fruit</td>
<td></td>
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<td></td>
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<tr>
<td>Poultry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Whole Grains</td>
<td></td>
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<tr>
<td>Fish/Seafood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sweets</td>
<td></td>
<td></td>
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<tr>
<td>Other Dairy includes yogurt, cheese, ice cream, cottage cheese</td>
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<td></td>
<td></td>
<td></td>
<td>Caffeine (circle: coffee/soda/energy drink)</td>
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</table>

Do you eat breakfast most days of the week?  Yes  No
How many times/day do you eat on most days?  1  2  3  4  5  6  more

Do you consume a recovery product or eat a meal/snack w/in 30-60 minutes post workout?  Yes  No

Do you follow a special diet?  Vegetarian  Vegan  Gluten-Free  Diabetic  Paleo  Other
Who suggested this diet for you?  Self  Doctor  Dietitian  Friend  Other

Do you have any food allergies or sensitivities?  Yes  No
If yes, please list: _____________________________________________________________

Do you avoid any foods?  Yes  No  If yes, please list: ________________________________

WOMEN ONLY:
How many periods do you have each year? ________ Date of last period? ________ Age when you had your 1st period: ______

Do you take birth control pills?  Yes  No  If yes, what kind? ____________________________
SCOFF Questionnaire:

1. Do you make yourself sick when you feel uncomfortably full?  
   - Yes  - No

2. Do you worry you have lost control over how much you eat?  
   - Yes  - No

3. Have you recently lost more than 14 pounds within three months?  
   - Yes  - No

4. Do you believe you are fat when others say you are too thin?  
   - Yes  - No

5. Would you say that food dominates your life?  
   - Yes  - No

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through sixteen (16) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

________________________________________________________________________

Student-Athlete Signature  
Date

________________________________________________________________________

Student-Athlete Print Name

________________________________________________________________________

Parent/Guardian Signature (if under 18 years of age)  
Date

________________________________________________________________________

Parent/Guardian Print Name

________________________________________________________________________

Witness  
Date

Reviewed By:

________________________________________________________________________

Reviewer’s Signature  
Date

________________________________________________________________________

Reviewer Print Name
SICKLE CELL TRAIT

WHAT IS SICKLE CELL TRAIT?
Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

During intense exercise, red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or “sickle.” Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles.

During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.

Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.

Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

DO YOU KNOW IF YOU HAVE SICKLE CELL TRAIT?
People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

Sickle cell trait occurs in about 8 percent of the U.S. African-American population, and between one in 2,000 to one in 10,000 in the Caucasian population.

Most U.S. states test at birth, but most athletes with sickle cell trait don’t know they have it.

The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.

Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, allowing you to thrive in your sport.

HOW CAN I PREVENT A COLLAPSE?
Know your sickle cell trait status.

Engage in a slow and gradual preseason conditioning regimen.

Build up your intensity slowly while training.

Set your own pace. Use adequate rest and recovery between repetitions, especially during “gassers” and intense station or “mat” drills.

Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.

If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.

Stay well hydrated at all times, especially in hot and humid conditions.

Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.

Maintain proper asthma management.

Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.

Beware when adjusting to a change in altitude, e.g., a rise in altitude of as little as 2,000 feet. Modify your training and request that supplemental oxygen be available to you.

Seek prompt medical care when experiencing unusual physical distress.

For more information and resources, visit www.NCAA.org/health-safety
Sickle Cell Trait Educational Acknowledgement

I, ________________________, understand and acknowledge that the NCAA and the University of Maryland Intercollegiate Athletics mandate that all student-athletes have knowledge of sickle cell trait and how it may affect their well being. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell trait testing. I understand that Sickle Cell Trait test is needed in order to compete in college athletics.

I have read and signed this document with full knowledge of its significance. I have received a Sickle Cell Education Materials Packet provided by the University of Maryland Sports Medicine Staff. I understand the results of this test will not affect my eligibility nor influence depth chart decisions. I further attest that I am at least 18 years of age and competent to sign this waiver.

____________________________________________
Student-Athlete Name

____________________________________________
Student-Athlete Signature

____________________________________________
Date

____________________________________________
Sport

____________________________________________
UID

____________________________________________
Parent/Guardian Signature (If under 18 years of age)

____________________________________________
Date

____________________________________________
Parent/Guardian Print Name

____________________________________________
Date
SICKLE CELL TRAIT TESTING
REQUIREMENTS

In compliance with NCAA Proposal 2009-75-B-1, the University Of Maryland Department Of Intercollegiate Athletics requires all student-athletes, including those participating in walk-on tryout activities, to have documentation of a sickle cell solubility test (SST) as part of his / her pre-participation physical examination. **Documentation must be present BEFORE the student-athlete is permitted to participate in any athletically related activities, including, but not limited to tryout activities, practices, strength and conditioning sessions, and/or compete in any intercollegiate athletic events.**

Tryout Student-athletes can meet this requirement in one of two ways-

1. **University of Maryland Health Center**-
   a. Meet with a physician at the health center to get a prescription for the test. Testing can performed at the health center. (Please note that results may take up to 3 business days to return).

2. **Pediatrician / Primary Care Physician**-
   a. Obtain a copy of appropriate documentation from your pediatrician / primary care physician (PCP)

Appropriate documentation is a copy of laboratory results indicating the student-athlete’s sickle cell status. A statement from a physician on letterhead or a prescription pad will not be accepted.

Please make sure you come with a copy of the laboratory results to the tryout.

If you have any questions or concerns regarding the Sickle Cell Trait testing requirements or process and/or other general questions regarding any aspects of the University of Maryland pre-participation physical exam process, please do not hesitate to contact University of Maryland Sports Medicine personnel at mdsportsmedicine@umd.edu.

Thank you

Updated: 11/11/16
I, ____________________________, affirm that I have been informed by University of Maryland Sports Medicine personnel on __________________ that I have tested positive for the following condition:

1. **Sickle Cell Trait Positive**

**About Sickle Cell Trait**-
- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.
- Likely sickling settings include timed runs, all out exertion of any type for 2 – 3 continuous minutes without a rest period, intense drills and other spurts of exercise after prolonged conditioning exercises, and other extreme conditioning sessions.
- Common signs and symptoms of a sickle cell emergency include, but are not limited to: increased pain and weakness in the working muscles (especially the legs, buttocks, and/or low back); cramping type pain of muscles; soft, flaccid muscle tone; and/or immediate symptoms with no early warning signs.

I, the undersigned, do hereby affirm that I have been informed that I am sickle cell trait positive. I further attest that the physical findings and recommendations have been discussed with me by a member of the University of Maryland Sports Medicine Department; and that I fully understand the recommendations and have had any and all questions answered to my satisfaction. I have been told to notify my private physician as soon as possible that I am sickle cell trait positive, and I agree to do so. I also have been advised to share this information with my parent or guardian. I further attest that I will notify a member of the University of Maryland Sports Medicine Department immediately should I begin to feel weakness, cramping sensations, difficulty breathing and/or catching my breath, and/or any other signs or symptoms of distress during or after exercise without fear of repercussion.

Student-Athlete Signature (If under 18, include parent/guardian signature)   Date

Examining Physician Signature   Date

Examining Physician Print Name

Athletic Trainer Signature   Date

Athletic Trainer Print Name

Gossett Football Team House ♦ 4068 Field House Drive ♦ College Park, MD 20742
(301) 314-7340 ♦ fax- (301) 314-6549

Updated 5.9.16
What is a CONCUSSION?
A concussion is a brain injury caused by a blow to the head, face or elsewhere on the body with a force transmitted to the head. Concussions can result from hitting a hard surface such as the ground or floor, from players colliding with each other or from being hit by a ball, bat, stick, puck or other sporting equipment.

Facts about CONCUSSION
1. A concussion is a serious brain injury
2. Concussions can occur without loss of consciousness or other obvious signs
3. Concussions can occur from blows to the body as well as to the head
4. Concussions can occur in any sport
5. Athletes can still get a concussion even if they are wearing a helmet
6. Recognition and proper response to concussions when they first occur can help prevent further injury or even death
7. No helmet can prevent concussion, serious head injuries, or neck injuries.
8. Do not use your head to impact an opposing player and do not intentionally strike another player in the head (such as with your helmet, stick, ball, elbow, knee, forearm or foot).

Signs and Symptoms of Concussion

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Headache</td>
<td>• Feeling mentally “foggy”</td>
<td>• Irritable</td>
<td>• Drowsiness</td>
</tr>
<tr>
<td>• Nausea</td>
<td>• Feeling slowed down</td>
<td>• Sad</td>
<td>• Sleeping more than usual</td>
</tr>
<tr>
<td>• Vomiting</td>
<td>• Difficulty concentrating</td>
<td>• More emotional</td>
<td>• Sleeping less than usual</td>
</tr>
<tr>
<td>• Balance problems</td>
<td>• Difficulty remembering</td>
<td>• Nervous</td>
<td>• Difficulty falling asleep</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Forgetful of recent information and</td>
<td></td>
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<tr>
<td>• Sensitivity to light</td>
<td>conversations</td>
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<td></td>
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<tr>
<td>• Numbness/tingling</td>
<td>• Confused about recent events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dazed</td>
<td>• Answer questions slowly</td>
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<td></td>
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<tr>
<td>• Stunned</td>
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</table>

IT IS BETTER TO MISS ONE GAME THAN THE WHOLE SEASON!
WHEN IN DOUBT, GET CHECKED OUT!

What should I do if I think I have a CONCUSSION?
• Don’t hide it. Report it to your athletic trainer and/or team physician
• All signs and symptoms should resolve BEFORE returning to practice or a game
• Take the appropriate time to recover. While your brain is healing, you are much more likely to have a repeat concussion which can cause severe and permanent brain damage
• You will complete a graduated return-to-play before resuming practice and competition

Why knowing you have a CONCUSSION is important
Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer. Some concussions can even lead to chronic symptoms such as headache, decreased memory, sleeping problems, depression or personality change. Rest, avoiding another blow to the head and following the advice of your medical staff are critical in helping you recover as fast and as safely as possible. Sustaining another concussion prior to recovery from the first increases your chance of long term symptoms. There have been reports of death with a second concussion in younger athletes that incur a head impact while experiencing concussion symptoms from a previous injury. It is very important for you to report any concussion symptoms as described above to your athletic trainer or team physicians at the time of injury. This includes alerting the medical staff to symptoms in your teammates if you notice these. Often times delaying the report of symptoms can lead to longer recovery time.

Statement of Student-Athlete Responsibility
I accept responsibility for reporting all injuries and illnesses to the University of Maryland Sports Medicine Staff (athletic trainers and team physicians) including any signs and symptoms of CONCUSSION. I have read and understand the above information on concussion. I will inform the supervising athletic trainer or team physician immediately if I experience any of these symptoms or witness a teammate with these symptoms. I will also sign and complete the attached baseline concussion symptom checklist.

Signature of Student Athlete: ___________________________ Date: ________________
Printed Name: ___________________________
**UNIVERSITY OF MARYLAND SPORTS MEDICINE DEPARTMENT**
**BASELINE CONCUSSION SYMPTOM CHECKLIST**

Name__________________________________  Date ______________________  Time _________

Sport ______________________________________

Instructions: Please Check the **Yes** or **No** box to indicate any symptoms the patient is experiencing.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Problems (e.g. ringing in the ears)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Pressure in head”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck pain</td>
<td></td>
<td></td>
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<tr>
<td>Nausea or vomiting</td>
<td></td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Blurred vision</td>
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<tr>
<td>Balance problems</td>
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<tr>
<td>Sensitivity to light</td>
<td></td>
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<tr>
<td>Sensitivity to noise</td>
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<tr>
<td>Feeling slowed down</td>
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<tr>
<td>Feeling like “in a fog”</td>
<td></td>
<td></td>
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<tr>
<td>“Don’t feel right”</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty concentrating</td>
<td></td>
<td></td>
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<tr>
<td>Difficulty remembering</td>
<td></td>
<td></td>
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<tr>
<td>Fatigue or low energy</td>
<td></td>
<td></td>
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<tr>
<td>Confusion</td>
<td></td>
<td></td>
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<tr>
<td>Drowsiness</td>
<td></td>
<td></td>
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<tr>
<td>Trouble falling asleep</td>
<td></td>
<td></td>
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<tr>
<td>More emotional</td>
<td></td>
<td></td>
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<tr>
<td>Irritability</td>
<td></td>
<td></td>
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<tr>
<td>Sadness</td>
<td></td>
<td></td>
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<tr>
<td>Nervous or anxious</td>
<td></td>
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</tr>
<tr>
<td>Anterograde amnesia (loss of memory of events after concussion)</td>
<td></td>
<td></td>
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<tr>
<td>Retrograde amnesia (loss of memory of events prior to concussion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

I confirm that the information provided on this document is accurate.

Student-Athlete Signature: ___________________________________________ Date: ____________

Healthcare Provider Signature: ______________________________________ Date: ____________
Information regarding the use of stimulants for treatment of ADHD, ADD, and/or similar conditions

Background-
The NCAA bans classes of drugs that can be harmful to student-athletes and that can create unfair advantages during competition (NCAA Bylaw 31.2.3). Some medications that student-athletes are prescribed for legitimate medical reasons contain NCAA banned substances. The NCAA, through the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) has a Medical Exceptions Procedure to review and approve the use of medications that contain NCAA banned substances. Effective August 1, 2009, with respect to the use of banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and/or like conditions, (e.g. Ritalin, Stattera, Adderall, Concerta, etc.), the NCAA now requires documentation of a comprehensive clinical evaluation to support treatment with NCAA banned stimulants and a current prescription.

What should student-athletes who are prescribed stimulant medications for ADHD, ADD, and/or like conditions do?
Student-athletes who have been prescribed stimulant medications for the treatment of ADHD, ADD, and/or like conditions should immediately notify a member of the Sports Medicine Department to ensure that they have the necessary documentation on file.

What documentation must the student-athlete obtain from his/her prescribing physician?
At a minimum, student-athletes prescribed NCAA banned stimulants for the treatment of ADHD, ADD, and/or like conditions must have their prescribing physician complete the University of Maryland ADHD / ADD Medical Exceptions packet. The prescribing physician must provide the following documentation:
1. Evidence of comprehensive clinical evaluation (recording observations and results from standardized rating scales and/or neuropsychological testing), a physical exam and any lab work (attaching all documentation);
   - A simple statement from a prescribing physician that he/she is treating the student-athlete for ADHD, ADD, and/or like conditions with the prescribed stimulant IS NOT adequate documentation
2. Statement of diagnosis, including when diagnosis was confirmed;
3. History of ADHD, ADD, and/or like conditions treatment (previous and ongoing);
4. Recommended treatment (attaching current prescription);
5. Statement that a non-banned ADHD alternative has been considered and why banned stimulant was prescribed; and
6. Annual follow-up with prescribing physician and updated letter or copy of medical record is required in each year of eligibility.

When and where should documentation be sent?
- The aforementioned documentation must be on file with the University of Maryland Sports Medicine Department in order for the student-athlete to participate in intercollegiate athletics at the University of Maryland.

- All documentation should be sent to the following address-
  University of Maryland Sports Medicine
  Attn: Steve Nordwall
  Gossett Football Team House
  379 Field House Drive College Park, MD 20742
  Fax: 877-863-2802 {secure fax}
  Email: snordwal@umd.edu

Who can student-athletes, parents, coaches, etc. contact with questions regarding issues surrounding ADHD medications and the NCAA Medical Exceptions Policy?
Student-athletes and/or parents with questions regarding the use of prescribed stimulants to treat ADHD, ADD, and/or like conditions should start by directing questions to the physician who initially conducted the evaluation and diagnosis.

Individuals with specific questions regarding the NCAA Bylaw related to banned substances, drug testing, and/or medical exceptions can view the NCAA website (www.ncaa.org/health-safety) and/or contact Steve Nordwall (301-314-2663; snordwal@umd.edu)
ADHD MEDICAL EXCEPTIONS NOTIFICATION FORM

I, _______________________________ affirm that I have been informed by University of Maryland Sports Medicine personnel on ________________________ about NCAA Medical Exceptions Policy as it specifically pertains to the use of banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. I attest that:

ONLY INITIAL ONE SECTION

| Initial ___________ | I AM NOT presently taking and/or have taken within the last 12 months any banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. |
| Initial ___________ | I AM presently taking and/or have taken within the last 12 months banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. |

Medication: ____________________________

I, the undersigned, do hereby affirm that I understand that I am to immediately notify a member of the University of Maryland Sports Medicine Department should I ever be prescribed the aforementioned stimulant medications and that I must obtain and submit appropriate documentation from the prescribing physician.

I further attest that I have had any and all questions regarding the NCAA ADHD Medical Exceptions Policy answered to my satisfaction.

_________________________________________ Date
Student-Athlete Signature

_________________________________________ Date
Athletic Trainer Signature

_________________________________________
Athletic Trainer Print Name
I, ______________________, acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physician, athletic training staff). I recognize that my true physical condition is dependent upon my accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that my institution has provided me with educational materials on what a concussion is and given me an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, ______________________ have read the above and agree that the statements are accurate.

________________________________________  __________________________
Student-athlete’s name

Signature of student-athlete                   Date

________________________________________  __________________________
Name of person obtaining consent             Signature of person consenting
ASSUMPTION OF RISK/RELEASE FORM

In consideration of being allowed to participate in any way in the Intercollegiate Athletics program at the University of Maryland, College Park and/or related events and activities of the Intercollegiate Athletics program at the University of Maryland, College Park, I:

a. Acknowledge and fully understand that I will be engaging in activities that involve risk or potentially serious injury including permanent disability and death, and severe social and economic losses which might result not only from my actions, inactions or negligence, but the actions, inactions or negligence of others, the rules of play or the condition of the premises or of any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.

b. Knowingly and freely assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death.

c. Understand that the University of Maryland and the Department of Intercollegiate Athletics has no appropriation for other funds which may be used to pay claims against the University of Maryland or the Department of Intercollegiate Athletics and their officers, agents and employees of any individual who may be injured in an accident while participating in a University of Maryland athletic program.

d. Understand that I have been advised by the University of Maryland and the Department of Intercollegiate Athletics to obtain a physical examination to determine that I am fit to participate in Athletic Department activities and to procure health and accident insurance to cover the cost incurred from injuries I may sustain as a result of my participation in Athletic Department activities.

e. Voluntarily assume all risks of loss, damage, illness, injury or death that I may sustain while participating in University or Athletic Department activities and in consideration of the right to participate in such programs, I covenant to refrain from instituting any claim, demand or cause of action for damages, costs or compensation against the University of Maryland or the Department of Intercollegiate Athletics or their officers, agents or employees for any injury or loss which may occur as a result of participation in University or Athletic Department activities.

f. Release, waive, discharge and covenant not to sue the University of Maryland, College Park, its officers, agents and employees all of which are hereinafter referred to as “releases,” from any and all liability to me, my heirs, or next of kin for any and all claims, demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releases or otherwise.

g. Have read and understand the content of the waiver and release and sign voluntarily.

______________________________
Signature

______________________________
Date

______________________________
Parent / Guardian Signature (if under 18 years old)

______________________________
Date

The University of Maryland and the Department of Intercollegiate Athletics are not authorized to provide medical, accident or health insurance. You are advised to obtain appropriate insurance on an individual basis. If you are presently insured, you should check your policy to assure yourself of sufficient and appropriate coverage.

Updated 2/16/2015
RELEASE & WAIVER OF LIABILITY

I, __________________________, acknowledge that I am completely aware of the inherent risks associated with __________________________ and with participation in a try-out for that sport. I understand that, in addition to the risks of injury, which may include death, my participation in that sport may cause aggravation of pre-existing injuries. Knowing this, I take full responsibility for any injury that may occur as a result of my participation in the try-out. Further, in consideration of the University of Maryland granting me permission to participate in this tryout, I hereby agree to irrevocably and unconditionally release, hold harmless, and indemnify the State of Maryland, the University System of Maryland, the University of Maryland College Park, and their officers, employees and agents (hereinafter referred to as the "University") from any and all liability, demands, claims, and causes of action in the event that I become injured in any way as a result of my participation in the tryout period. I warrant that I am in adequate physical condition, and physically able to perform this tryout, and that I have no known physical conditions, which could be materially worsened or aggravated by my participation, unless stated below:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

I also have accurately and completely filled out the attached Health History Questionnaire. It is my understanding that the University of Maryland Sports Medicine Department may deny my participation in a tryout due to a medical condition found in my health history. I understand that any pre-existing medical condition may have to be corrected prior to the try-out and/or acceptance to the team. In addition, all costs associated with any tests, consultations, and/or medical procedures needed to gain approval/certification for participation are the responsibility of myself, and/or my parent(s) / guardian(s). I further acknowledge that I am signing this waiver voluntarily, with complete understanding of the terms and conditions herein, and that, as applicable, I have discussed my participation and the related risks with my parents and/or guardians.

______________________________                            ________________
Student-Athlete Signature              Date

______________________________
Student Identification Number

______________________________                            ________________
Parent / Guardian Signature (if under 18 years of age)              Date

______________________________
Parent / Guardian Printed Name

______________________________                            ________________
Witness Signature              Date
UNIVERSITY OF MARYLAND SPORTS MEDICINE
Student-Athlete Insurance Information Sheet

Last Name __________________________________ First Name________________________ UMID#    ________________________________

Date of Birth________________________________ Gender:    Male     Female    Sport______________________________________________________

Cell Number________________________________ Home Number ________________________________ Email __________________________________

Permanent Address_____________________________________________City______________________________State_________ Zip_________________

Campus Address_________________________________________________________________________________________________________________

Current Medications:_______________________________________________________________________________________________________________

EMERGENCY CONTACT INFORMATION

Name ____________________________ Relationship ___________________________________________

Phone 1 ___________________________ Phone 2 ___________________________ Home Address ___________________________

Email ____________________________

SECONDARY EMERGENCY CONTACT INFORMATION

Name ____________________________ Relationship ___________________________________________

Phone 1 ___________________________ Phone 2 ___________________________ Home Address ___________________________

Email ____________________________

STUDENT-ATHLETE INSURANCE INFORMATION

Coverage-

MEDICAL

DENTAL

PRESCRIPTION

VISION

Insurance Company __________________________________________ Policy / ID #____________________________

Address __________________________________________ City State Zip __________________________ Phone # ________________

Group Name __________________ Group # __________________

Policy Owner __________________ DOB __________________

Prescription Medication Coverage Information

Rx Bin # ________________ Rx GRP # ________________ PCN # ________________

Is preauthorization necessary for medical/diagnostic services?

Yes    No   Phone # ________________

Type of Insurance-

HMO   PPO   POS   Military

Other __________________________________________

Primary Care Physician __________________

Physician Phone # __________________

PLEASE READ CAREFULLY

• The University of Maryland Department of Intercollegiate Athletics’ accident policy provides insurance for student-athletes with injuries occurring only when participating in the play or practice of intercollegiate athletics. This accident policy is considered “EXCESS” or “SECONDARY” to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will the University of Maryland’s Department of Intercollegiate Athletics’ insurance carrier consider payment for any remaining balances.

• I hereby authorize the University of Maryland Department of Intercollegiate Athletics, hospitals, & physicians connected with or provided, to furnish information to insurers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.

• I agree to supply any & all information requested by my primary insurance, the University of Maryland Department of Intercollegiate Athletics & their excess insurance company in a timely manner.

• I hereby authorize the University of Maryland Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.

• I hereby authorize the University of Maryland Sports Medicine Unit and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.

• A photocopy of this authorization shall be deemed as effective & valid as the original.

• I agree to notify the University of Maryland Sports Medicine Unit immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.

• I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

Policy Holder’s Signature ____________________________ Date ________________

Student-Athlete’s Signature ____________________________ Date ________________

MD Sports Medicine
1/12/2016
PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: __________________________  Date of Exam: __________________________
Address: __________________________  Date of Birth: __________________________
Sex:  □ Male  □ Female

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

CURRENT MEDICATIONS  (Attach a second page if needed):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Diagnosis</th>
<th>Prescribing Physician Specialty</th>
<th>Date Medication Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Allergies/Sensitivities: ________________________________________________
Contraindicated Medication: ____________________________________________

Please list any previous injuries (with dates) that required surgery or overnight hospitalization

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**Part Two: GENERAL PHYSICAL EXAMINATION**

Blood Pressure: ____/____  Pulse:  Respiration:  Temp:  Height:  Weight: 

### EVALUATION OF SYSTEMS

<table>
<thead>
<tr>
<th>System Name</th>
<th>Normal findings?</th>
<th>Comments/Description</th>
<th>Is further evaluation recommended by specialist?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
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<tr>
<td>Nose</td>
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<tr>
<td>Mouth/Throat</td>
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<tr>
<td>Head/Face/Neck</td>
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<tr>
<td>Breasts</td>
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<tr>
<td>Lungs</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Extremities</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Gastrointestinal</td>
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<td>Endocrine</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Integumentary</td>
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<tr>
<td>Renal/Urinary</td>
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<tr>
<td>Reproductive</td>
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<tr>
<td>Lymphatic</td>
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<tr>
<td>Nervous System</td>
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<td></td>
</tr>
</tbody>
</table>

#### VISION SCREENING

- Yes  No

- Is further evaluation recommended by specialist?  Yes 

#### HEARING SCREENING

- Yes  No

- Is further evaluation recommended by specialist?  Yes

### Additional Comments:

- Previous medical history reviewed?  Yes  No

- Recommendations for health maintenance: *(including need for lab work at regular intervals, exercise, hygiene, weight control, etc.)*

- Recommended diet and special instructions: 

- Limitations or restrictions for activities *(including work day, lifting, standing, and bending)*  No  Yes (specify): 

- Change in health status from previous year?  No  Yes (specify): 

- Specialty consults recommended?  No  Yes (specify) 

- The Patient is fit for varsity collegiate sports?  No  Yes If no, please explain:

---

**Name of physician (please print)_________________**  
**Physician’s Signature_________________**  
**Date_________________**

**Physician Address:_________________**  
**Physician Phone Number:_________________**