



Tom Oxley Athletic Center
777 Glades Rd. Boca Raton, FL 33431

Florida Atlantic University Sports Medicine Department Interim Physical Policy

According to NCAA by law 17.1.5 student athletes returning to school must fill out an updated medical history 6 months prior to participating in any off-season conditioning session, practice, or game for the applicable academic year.

Once an updated medical history is obtained, student athletes will have their medical history reviewed by a member of the sports medicine staff (team physician, staff athletic trainer) to determine if additional examination is required.

Student athletes are also required to show proof of primary insurance prior to the first practice or game for the applicable academic year.

It is required that all student-athletes eligible for student aid (Pell grant) complete their application if he or she is not covered under their parent / guardian health care plan. If a student-athlete is covered under their parent / guardian health care plan, they must provide student enrollment documentation to their insurance company at the beginning of each coverage period.

All forms (HIPPA, Medical Consent, Assumption of Risk, Prescription Medication Release, and contact information) must be filled out in complete before the first practice or game for the applicable academic year.

Please fill out the forms included in the packet and return to the athletic training room no later than the date of your physical exam. We are available to contact if you have any questions.

Please refer to the sports medicine web-site for any questions regarding our policies and procedures.

Have a great season and let us know if we can assist you in any way!

**John F. Burnside Jr.
Head Athletic Trainer
Florida Atlantic University**

Florida Atlantic University Student – Athlete Interim Physical Examination

Name _____ Year in School _____

Date of Birth _____ Sport _____

Sine your last Physical Exam on _____, have you experienced the following?

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Had a serious injury / been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Had an unfavorable / allergic reaction to a drug, antibiotic, and/or medicine?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Had a sprain / strain and/or fracture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Had a dental injury?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Had a concussion and/or head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Been unconscious for any other reason other than anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Do you take any medications for pain or a medical condition on a regular basis (> 3 days a week)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Had a neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Do you have any ongoing or chronic illnesses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Had a back injury or suffered from back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Had frequent headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Had any of burners, stingers, numbness in neck, shoulder, and/or hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Had a shoulder, elbow, and/or hand / wrist injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Do you have any ongoing or chronic illnesses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Had a hip and/or knee injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Had an operation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Had a lower leg, ankle, and/or foot injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Do you wear contact lenses, glasses, and/or safety glasses?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Missed a practice and/or game due to an injury and/or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Are you currently undergoing physical therapy or rehabilitation for an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Do you require any special equipment to participate in athletics?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Been diagnosed with any new medical or surgical problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Have you been told by a physician to restrict your activity or not to participate in sport?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. While exercising, has your heart ever "skipped" a beat, have you suffered from a "racing heart", severe chest pain, lightheadedness, or fainted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Had a heat related illness, (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time / received special attention (IV fluids, etc.) for a heat related problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Been diagnosed with any NEW injuries and/or medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	32. Do you take vitamins, amino acids, creatine, and/or any other dietary supplement on a daily basis and/or as needed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Been evaluated by a Florida Atlantic University Team Physician, Florida Atlantic University Student Health Center Physician, or a family physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Been recently diagnosed with infectious mononucleosis ("mono"), hepatitis B or C, HIV/AIDS, and/or any other severe infectious disease / viral infection?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever felt dizzy, passed out, or "blacked out" during or after exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Been denied clearance by a medical professional to participate in any athletic activity?

FEMALES ONLY!

When did your last menstrual period begin? _____

How long does your menstrual period usually last? _____

How many menstrual periods have you had in the last 12 months? _____

Do you take birth control pills? If so, which one(s)? _____

If you answered "yes" to any of the above questions and / or have any further information, which is knowledgeable to you and not required on this form, please explain in detail below

Student – Athlete signature _____ **Date** _____

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements 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.

This page is reserved for sports medicine staff only

Vital Information:

Height _____ Weight _____

Blood Pressure _____ / _____ Pulse _____

Does student athlete have ECG on file? Y / N

Physical examination (to be completed by team physician):

I have reviewed the following student-athlete's updated medical history and determined that he / she can continue activity without restrictions

Sports Medicine Staff _____ **Date** _____

I have reviewed the student athlete's updated medical history and determined that he / she needs to be re-evaluated by a team physician prior to any new competition for the upcoming year

	NORMAL	ABNORMAL FINDINGS
Heart / Cardiovascular	<input type="checkbox"/>	
Pulmonary / Lungs	<input type="checkbox"/>	
Abdomen / Gastrointestinal	<input type="checkbox"/>	
Musculoskeletal Review	<input type="checkbox"/>	
Re-evaluation of Medical Problems since the last exam	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Team Physician Signature _____ **Date** _____



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MEDICAL CONSENT

I, _____, hereby grant permission to the Florida Atlantic University team physicians and/or their consulting physicians to render to myself any treatment, medical, or surgical care that they deem reasonably necessary to my health or well-being. In the event that hospitalization is required, I give my permission for hospitalization at an accredited hospital.

I also hereby authorize the athletic trainers at Florida Atlantic University who are under the direct supervision of the team physicians, to render any preventative treatment, first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to my health and well-being.

I also hereby consent to the affiliated hospital providing medical services to myself through a licensed physical therapist employed by the affiliated health provider

I also hereby authorized the athletic trainers at Florida Atlantic University to communicate and receive information from my insurance company.

Athlete's Signature

Date

Parent/Guardian (if under 18)

Date



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ASSUMPTION OF RISK

I, _____, verify that I have been informed that I may be injured while participating in intercollegiate athletic practice or competition. I understand that it is possible that I may sustain an injury that may result in permanent disability, paralysis, or possibly death. I understand that paralysis may include loss of movement, feeling, and use of my arms, legs, and trunk. I further understand that paralysis may involve complete loss of sexual function, and/or bowel and bladder control which would require the use of external aids, attached or inserted into my body for the collection and removal of body wastes.

I understand that paralysis and its effects could last my entire lifetime.

In addition, I understand that an injury to any of my body joints (Ankle, knee, hip, spine, shoulder, etc) may result in disfigurement, loss of movement, strength, or feeling which may last my entire lifetime.

I understand that it is my responsibility to adhere to all rules and regulations of my chosen sport. I understand that infraction of the rules may result in injury to my opponent or myself. I also understand that no modification of protective equipment or uniform should be made.

In addition, I understand that it is my responsibility to report faulty or poor fitting equipment immediately to the coach, equipment manager, or athletic trainer.

I understand that all injuries are to be reported to the athletic trainer. I understand that I am responsible for the follow-up care and treatment of my injuries under the supervision of the athletic training staff.

I accept these risks of participation in _____(sport) during the 20__-20__ seasons.

Athlete's signature

Date

Parent/guardian if under 18

Date



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STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that my authorization for the release of my protected health information is a condition for participation as an intercollegiate athlete for the Florida Atlantic University. I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I hereby authorize the Florida Atlantic University Sports Medicine staff and other health care personnel representing the Florida Atlantic University Athletics Department to release information regarding my education records and medical records which includes physical exams, sports medicine staff documentation regarding diagnosis, treatment, prognosis of any and all injuries and illnesses past or present during my training for and participation in intercollegiate athletics. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, sports information staff and members of the media.

I understand that I may revoke this authorization at any time by notifying in writing the Head Athletic Trainer and or the Athletic Director. Such revocation shall not affect release of information prior revocation. This authorization will expire one (1) calendar year from the date it was signed.

Athlete Name (print)

Athlete Signature

Date

Parent/Guardian Name (print) (Athlete under 18)

Parent/Guardian Signature (Athlete under 18)

Date