Dear Student-Athlete:

On behalf of the athletic training staff, we would like to welcome you to San Jose State University. The following physical form, insurance form and waiver must be completed prior to participation in the on-campus evaluation at San Jose State University. The Pre-participation Physical Evaluation must be completed by a physician (MD or DO only) within 6 months of the date of the evaluation. The Student-Athlete Waiver of Liability Form must be signed by a parent or guardian if you are under 18 years of age.

The NCAA has made it mandatory that all Division I student-athletes must be tested for sickle cell trait. The easiest way to fulfill this obligation is to provide proof of a prior test. These tests are routinely done at birth. Parents, family physicians and/or the hospital would have this documentation. A copy of the results of this test is sufficient to meet this requirement. Sickle cell tests can be ordered by a physician when receiving your pre-participation physical evaluation. This documentation should be turned in with the pre-participation physical evaluation and waiver.

Please do not hesitate to call if you have any questions or concerns regarding your pre-participation physical exam and paperwork. We look forward to meeting you.

Sincerely,

Scott Shaw MA, ATC
Director of Sports Medicine
(408) 924-1297
scott.shaw@sjsu.edu
The San Jose State University 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 San Jose State University Department of Intercollegiate Athletics’ insurance carrier consider payment for any remaining balances.

I hereby authorize the San Jose State University Department of Intercollegiate Athletics, affiliated hospitals & physicians, to furnish information to insurance carriers concerning any illness, injury & treatments, and I hereby assign to the party all payments for medical services rendered to the student-athlete.

I agree to supply any and all information requested by my primary insurance, the San Jose State University Department of Intercollegiate Athletics and their excess insurance in a timely manner.

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

I hereby certify that I have read and understand the above statements, that any and all questions have been answered to my satisfaction, and that the answers provided are true, complete and correct to the best of my knowledge.
STUDENT-ATHLETE WAIVER OF LIABILITY FORM
San Jose State University Intercollegiate Athletics, Form SAE-20, Page 1 of 1

Name:________________________________  Sport:__________________________
(Print Clearly)

DISCLAIMER:

I. I realize that there is a risk of injury as a result of athletic practice and competition. Any type of injury can occur. Possible serious injuries include (but are not limited to) the following:
   Brain damage
   Spinal cord injury    Quadriplegia (paralysis of all four limbs)
   Paraplegia (paralysis of two limbs, usually legs)
   Fractured (broken) neck
   Fractured (broken) back
   Other types of less serious injuries that can occur include strains, sprains, contusions and other fractures. Initial ________.

II. I accept the responsibility for reporting any injuries that occur at this evaluation to the San Jose State University Sports Medicine Staff before leaving campus the day of the evaluation, including signs and symptoms of concussions. Initial ________.

__________________  _______________________
Date     Signature of Student-Athlete

__________________  _______________________
Date     Signature of Parent or Guardian if student-athlete is 17 years old or younger
**Preparticipation Physical Evaluation**

**HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

- [ ] Medicines
- [ ] Pollens
- [ ] Food
- [ ] Stinging Insects

Do you have any allergies?  
- [ ] Yes
- [ ] No
  
If yes, please identify specific allergy below.

**GENERAL QUESTIONS**

1. Has a doctor ever denied or restricted your participation in sports for any reason?  
   - [ ] Yes
   - [ ] No

2. Do you have any ongoing medical conditions? If so, please identify below:  
   - [ ] Asthma
   - [ ] Anemia
   - [ ] Diabetes
   - [ ] Infections
   - [ ] Other:

3. Have you ever spent the night in the hospital?  
   - [ ] Yes
   - [ ] No

4. Have you ever had surgery?  
   - [ ] Yes
   - [ ] No

5. Have you ever been out or nearly passed out DURING or AFTER exercise?  
   - [ ] Yes
   - [ ] No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?  
   - [ ] Yes
   - [ ] No

7. Does your heart ever race or skip beats (irregular beats) during exercise?  
   - [ ] Yes
   - [ ] No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  
   - [ ] High blood pressure
   - [ ] A heart murmur
   - [ ] High cholesterol
   - [ ] A heart infection
   - [ ] Kawasaki disease
   - [ ] Other:

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)  
   - [ ] Yes
   - [ ] No

10. Do you get lightheaded or feel more short of breath than expected during exercise?  
    - [ ] Yes
    - [ ] No

11. Have you ever had an unexplained seizure?  
    - [ ] Yes
    - [ ] No

12. Do you get more tired or short of breath more quickly than your friends during exercise?  
    - [ ] Yes
    - [ ] No

**HEART HEALTH QUESTIONS ABOUT YOU**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?  
    - [ ] Yes
    - [ ] No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?  
    - [ ] Yes
    - [ ] No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?  
    - [ ] Yes
    - [ ] No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?  
    - [ ] Yes
    - [ ] No

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  
    - [ ] Yes
    - [ ] No

18. Have you ever had any broken or fractured bones or dislocated joints?  
    - [ ] Yes
    - [ ] No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?  
    - [ ] Yes
    - [ ] No

20. Have you ever had a stress fracture?  
    - [ ] Yes
    - [ ] No

21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantodens instability? (Down syndrome or dwarfism)  
    - [ ] Yes
    - [ ] No

22. Do you regularly use a brace, orthotics, or other assistive device?  
    - [ ] Yes
    - [ ] No

23. Do you have a bone, muscle, or joint injury that bothers you?  
    - [ ] Yes
    - [ ] No

24. Do any of your joints become painful, swollen, feel warm, or look red?  
    - [ ] Yes
    - [ ] No

25. Do you have any history of juvenile arthritis or connective tissue disease?  
    - [ ] Yes
    - [ ] No

**MEDICAL QUESTIONS**

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?  
    - [ ] Yes
    - [ ] No

27. Have you ever used an inhaler or taken asthma medicine?  
    - [ ] Yes
    - [ ] No

28. Is there anyone in your family who has asthma?  
    - [ ] Yes
    - [ ] No

29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?  
    - [ ] Yes
    - [ ] No

30. Do you have groin pain or a painful bulge or hernia in the groin area?  
    - [ ] Yes
    - [ ] No

31. Have you had infectious mononucleosis (mono) within the last month?  
    - [ ] Yes
    - [ ] No

32. Do you have any rashes, pressure sores, or other skin problems?  
    - [ ] Yes
    - [ ] No

33. Have you had a herpes or MRSA skin infection?  
    - [ ] Yes
    - [ ] No

34. Have you ever had a head injury or concussion?  
    - [ ] Yes
    - [ ] No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?  
    - [ ] Yes
    - [ ] No

36. Do you have a history of seizure disorder?  
    - [ ] Yes
    - [ ] No

37. Do you have headaches with exercise?  
    - [ ] Yes
    - [ ] No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?  
    - [ ] Yes
    - [ ] No

39. Have you ever been unable to move your arms or legs after being hit or falling?  
    - [ ] Yes
    - [ ] No

40. Have you ever become ill while exercising in the heat?  
    - [ ] Yes
    - [ ] No

41. Do you get frequent muscle cramps when exercising?  
    - [ ] Yes
    - [ ] No

42. Do you or someone in your family have sickle cell trait or disease?  
    - [ ] Yes
    - [ ] No

43. Have you had any problems with your eyes or vision?  
    - [ ] Yes
    - [ ] No

44. Have you had any eye injuries?  
    - [ ] Yes
    - [ ] No

45. Do you wear glasses or contact lenses?  
    - [ ] Yes
    - [ ] No

46. Do you wear protective eyewear, such as goggles or a face shield?  
    - [ ] Yes
    - [ ] No

47. Do you worry about your weight?  
    - [ ] Yes
    - [ ] No

48. Are you trying to or has anyone recommended that you gain or lose weight?  
    - [ ] Yes
    - [ ] No

49. Are you on a special diet or do you avoid certain types of foods?  
    - [ ] Yes
    - [ ] No

50. Have you ever had an eating disorder?  
    - [ ] Yes
    - [ ] No

51. Do you have any concerns that you would like to discuss with a doctor?  
    - [ ] Yes
    - [ ] No

**FEMALES ONLY**

52. Have you ever had a menstrual period?  
    - [ ] Yes
    - [ ] No

53. How old were you when you had your first menstrual period?  
    - [ ] Yes
    - [ ] No

54. How many periods have you had in the last 12 months?  
    - [ ] Yes
    - [ ] No

**EXPLAIN “YES” ANSWERS BELOW. CIRCLE QUESTIONS YOU DON’T KNOW THE ANSWERS TO.**

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

Signature of athlete  
Signature of parent/guardian  
Date

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   • Do you feel stressed out or under a lot of pressure?
   • Do you feel sad, hopeless, depressed, or anxious?
   • Do you feel safe at your home or residence?
   • Have you tried cigarettes, chewing tobacco, snuff, or dip?
   • During the past 30 days, did you use chewing tobacco, snuff, or dip?
   • Do you drink alcohol or use any other drugs?
   • Have you ever taken anabolic steroids or used any other performance supplement?
   • Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   • Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BP</th>
<th>/</th>
<th>(</th>
<th>)</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

MEDICAL

NORMAL

ABNORMAL FINDINGS

Appearance
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
• Pupils equal
• Hearing

Lymph nodes

Heart
• Murmurs (auscultation standing, supine, +/- Valsalva)
• Location of point of maximal impulse (PMI)

Pulses
• Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only)

Skin
• HSV, lesions suggestive of MRSA, linea corporis

Neurologic

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toes

Functional
• Duck-walk, single leg hop

<Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider (6) exam if in private setting. Having third party present is recommended.

+Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared
☐ Pending further evaluation
☐ For any sports
☐ For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ___________________________ Date ____________

Address ___________________________ Phone ___________________________

Signature of physician ___________________________________________________________________________ MD or DO