2024-2025 Athlete Waiver & Physical Form
Upload to Sport80 membership platform ⇒ Policies & Waivers
or return by email to hannah.beaumont@usabs.com

CURRENT MEDICAL HISTORY SUMMARY

	Yes	No		Yes	No	Cardiac	Yes	No
Bone, joint, or other deformity			Eye trouble			Have you ever passed out during or after exercise?		
Stomach, liver, or intestinal trouble			Severe tooth or gum trouble					
Ear, nose, or throat trouble			Loss of finger or toe			Have you ever been dizzy during or after exercise?		
Gall bladder trouble or gall stones			Jaundice or hepatitis					
Chronic or frequent cold			Hearing loss			Had chest pain during or after exercise?		
Recurrent back pain			Broken bones					
Rupture or hernia			Hay fever			Get tired more quickly than your friends?		
Sinusitis			Neuritis					
Tumor, growth, cyst, or cancer			Frequent or painful urination			Had racing of the heart or skipped heartbeats?		
Head injury			Skin diseases					
Paralysis			Epilepsy			High blood pressure or cholesterol?		
Rectal disease			Kidney stone or blood in urine					
Thyroid trouble			Tuberculosis			Had a heart murmur?		
Car, train, sea or air sickness			Frequent trouble sleeping			Family History	Yes	No
Asthma			Frequent indigestion			Premature death before 50 due to heart disease		
Arthritis, rheumatism or bursitis			Shortness of breath					
Adverse reaction to drug/medicine			Loss of memory or amnesia			Disability from heart disease in close relatives before age 50		
Dizziness or fainting spells			Venereal Disease					
Scarlet fever			Palpitation or pounding heart					
Recent weight gain or loss			Rheumatic fever			Cardiac conditions in family members		
Frequent/severe headache			Leg cramps					
Swollen/painful joints			Chronic cough					

Explain "YES" answers (attach additional page if necessary):

Past surgical procedures (attach additional page if necessary):

1. _____ **Date:** _____
2. _____ **Date:** _____
3. _____ **Date:** _____

Date of most recent concussion: _____ **How many previously diagnosed concussions:** _____

Date of most recent TETANUS TOXOID vaccination: _____

PERSONAL PHYSICIAN'S NAME: _____ **PHONE:** _____

MEDICATIONS/SUPPLEMENTS (please circle): I am NOT taking medications or supplements / I TAKE medications and/or supplements
I am presently taking the following medication(s) and/or supplements: _____
_____
_____

ALLERIGIES (please circle): No Known Allergies / Allergies – see below
I am allergic to the following medicine, bee/insect stings, food, etc. (attach additional page if necessary):

1. _____ **Reaction:** _____
2. _____ **Reaction:** _____

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PHYSICAL EXAMINATION FORM

PLEASE TAKE NOTICE

Physicals cannot be performed by a USABS or USOPC medical provider the first year of the quad. Physicals performed by nurse practitioners or physician assistants must list name, address and phone number of the supervising physician. Physicals performed by chiropractors will not be accepted.
Physicals completed incorrectly will be considered incomplete and returned to the athlete.

Athlete's Name:	Birth Date:
Height:	Weight:
Pulse:	BP:
Vision: R 20/ L 20/	Pupils: Equal Unequal
Glasses or Contacts: Y / N	

Medical	Normal	Abnormal Findings	Initials
Eyes/Ears/Nose/Throat			
Cardiovascular			
Pulmonary			
Abdomen			
Hernia			
Integumentary			
Neurological			

Musculoskeletal

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

A. Cleared for contact sports
B. Cleared after completing evaluation/rehabilitation for:_____
C. Not cleared for:
[ ] Collision
[ ] Contact
[ ] Non-contact __ Strenuous __ Moderately strenuous __ Non strenuous

_____ _____ _____
Examiner's Name (please print) **Examiner's Signature** **Date**

_____ _____
Examiner's Address **Examiner's Phone Number**

_____
If exam performed by NP or PA, name, address and phone number of Supervising Physician

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4 YEAR PHYSICAL EXAMINATION FORM

ITEMS TO BE COMPLETED THE FIRST YEAR OF THE QUAD OR WHEN ATHLETE BEGINS THE SPORT

PLEASE TAKE NOTICE

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Physicals completed incorrectly will be considered incomplete and returned to the athlete.

Athletes Name: _____

Concussion Education	Yes	No
Athlete was educated about the signs and symptoms of concussion and the importance of reporting concussions to their health care providers		
Does the athlete wish to be presented with more information about concussions or have a one-on-one meeting		
Cardiac Evaluation: Personal history	**Yes**	**No**
1. Exertional chest pain/discomfort		
2. Unexplained syncope/near syncope		
3. Excessive exertional and unexplained dyspnea/fatigue, associated with exercise		
4. Prior recognition of a heart murmur		
5. Elevated systemic blood pressure		
6. Family history of premature death (sudden and unexpected, or otherwise) before age 50 due to heart disease		
7. Disability from heart disease in a close relative age 50 or younger		
8. Family history of cardiac conditions including: hypertrophic or dilated cardiomyopathy, long-QT syndrome or other ion channelopathies, Marfan syndrome, or clinically important arrhythmias		

Physical examination	Findings Normal	Findings Abnormal
9. Check for a heart murmur*		
10. Check femoral pulses to exclude aortic coarctation		
11. Check for physical signs of Marfan syndrome		
12. Check brachial artery blood pressure (sitting position)		

*(Auscultation of the heart should be performed initially with the patient in both the standing and supine positions. Auscultation should also occur during various maneuvers (eg, squat to stand, deep inspiration, Valsalva), because these maneuvers can clarify the type of murmur)

Age Appropriate Cancer Screenings and Education	Yes	No
Signs or symptoms of potential cancer		
Patient education about self-exams completed		

Mental Health Survey	Yes	No
I often have trouble sleeping.		
I wish I had more energy most days of the week.		
I think about things over and over.		
I feel anxious and nervous much of the time.		
I often feel sad or depressed.		
I struggle with being confident.		
I don't feel hopeful about the future.		
I have a hard time managing my emotions (frustration, anger, impatience).		
I have feelings of hurting myself or others.		

_____ _____ _____
Examiner's Name (please print) **Examiner's Signature** **Date**

_____ _____
Examiner's Address **Examiner's Phone Number**

_____
If exam performed by NP or PA, name, address and phone number of Supervising Physician