MARYLAND SPORTS MEDICINE

TRYOUT STUDENT-ATHLETE CHECKLIST

Student-Athlete Name _____ **UID** _____

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.

Hard Copy Forms:		
1.	☐	Initial Health Appraisal Form
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)
3.	☐	Sickle Cell NCAA Fact Sheet & Education Acknowledgement
4.	☐	Documentation of Sickle Cell Solubility Test (SST) ☐ Sickle Cell Confirmation Positive (if positive)
5.	☐	Concussion NCAA Fact Sheet & Student-Athlete Statement About Concussion ☐ Concussion Baseline Symptom Checklist
6.	☐	ADD/ADHD Fact Sheet & Medical Exception Notification Form
7.	☐	Big Ten Injury and Illness Reporting Acknowledgment Form
8.	☐	Assumption of Risk/Release Form
9.	☐	Release and Waiver of Liability Form
10.	☐	Student-Athlete Insurance Information Sheet
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)

NOTES:	
Cleared	Not Cleared
Sports Medicine Signature:	Date:

MARYLAND SPORTS MEDICINE

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):*

	FATHER	MOTHER
Current Age		
If Deceased, Cause of Death		
Age @ Death		
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)		
History of Diabetes		
History of heart disease, high blood pressure, and/or high cholesterol		
History of stroke		
History of tuberculosis		
History of Cancer		

	SIBLING 1	SIBLING 2	SIBLING 3	SIBLING 4
Current Age				
If Deceased, Cause of Death				
Age @ Death				
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)				
History of Diabetes				
History of heart disease, high blood pressure, and/or high cholesterol				
History of stroke				
History of tuberculosis				
History of Cancer				

Student-Athlete's Initials _____

I. **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

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

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 _____

IX. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? ☐ 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 Cervical Spine / Neck Injury? ☐ YES ☐ NO

- When?_____ Where? _____
- Please Describe _____

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? ☐ YES ☐ NO

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

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ☐ YES ☐ NO

- Date(s)? _____
- Please Describe? _____

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? ☐ YES ☐ NO

- When?_____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- Please Describe _____

Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? ☐ YES ☐ NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

☐ YES ☐ NO If yes, please explain _____

X. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? ☐ 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 Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- When?_____ Where? _____
- Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ☐ YES ☐ NO

- When?_____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- Please Describe _____

XI. 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 A 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 _____

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 _____

XIV. Hip / Groin:

Have You Ever Suffered An Injury To Your Hip / Groin *(including hernias 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 _____

Student-Athlete's Initials _____

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 _____

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, Syphyllis, 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 _____

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:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

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:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

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 _____

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

Medication	Form	Dosage	Frequency

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 Level _____

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 dietitian to discuss your nutritional needs or eating habits?

If you have answered YES to any of the above, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Student-Athlete's Initials _____

Sports Nutrition Pre-Participation Screening Questionnaire

Name: _____ **Sport:** _____
LAST, FIRST

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.*

Supplement	Brand	Current?	Past 6 Mos?

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, Δbody 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:

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

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? Yes No
Vegetarian *Vegan* *Gluten-Free* *Diabetic* *Paleo* *Other*
Who suggested this diet for you? *Self* *Doctor* *Dietitian* *Friend* *Family Member*
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 _____

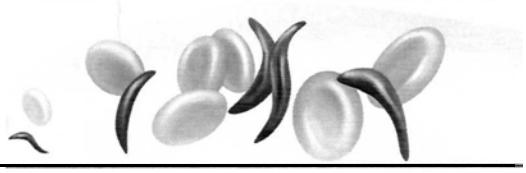
Witness _____ Date _____

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?

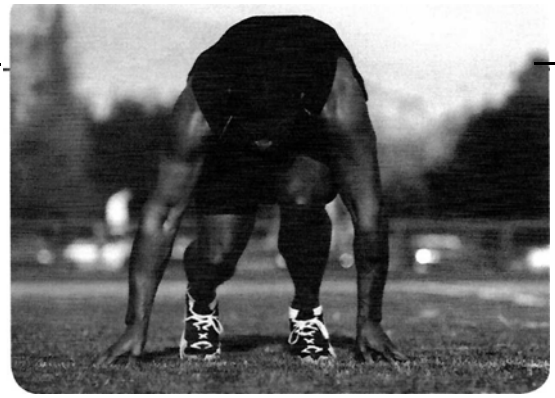
People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

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
Student-Athlete Name

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 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
Student-Athlete Print Name

Maryland Sports Medicine personnel on_____that I have tested positive for
Date

the following condition:

1. **Sickle Cell Trait Positive** Initial _____

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

MARYLAND SPORTS MEDICINE

Student-Athlete Statement About Concussions

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

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

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
Student-Athlete Print Name

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.

_____ _____
Student-Athlete Signature Date

_____ _____
Athletic Trainer Signature Date

_____
Athletic Trainer Print Name

Big Ten Injury and Illness Reporting
Acknowledgement Form

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

MARYLAND
SPORTS MEDICINE

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: _____
Print Name

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.

MARYLAND
SPORTS MEDICINE

RELEASE & WAIVER OF LIABILITY

I,_____, acknowledge that I am completely aware of the
Student-Athlete Print Name

inherent risks associated with_____and with participation in a try-out for that
Sport

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

Updated 5/9/2016

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:_____

Allergies / Asthma / Sickle Cell / Medical Conditions? _____

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 insurance carriers 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 _____

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):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

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: ___ Respirations: ___ Temp: _____ Height: ___ Weight: ___

EVALUATION OF SYSTEMS

System Name	Normal findings?	Comments/Description
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Mouth/Throat	☐ Yes ☐ No	
Head/Face/Neck	☐ Yes ☐ No	
Breasts	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Endocrine	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Integumentary	☐ Yes ☐ No	
Renal/Urinary	☐ Yes ☐ No	
Reproductive	☐ Yes ☐ No	
Lymphatic	☐ Yes ☐ No	
Nervous System	☐ Yes ☐ No	
VISION SCREENING	☐ Yes ☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No
HEARING SCREENING	☐ Yes ☐ No	Is further evaluation recommended by specialist? ☐ Yes ☐ No

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:** _____