

# ELIZABETHTOWN COLLEGE ATHLETIC PHYSICAL FORM

## REQUIREMENT FOR PARTICIPATION

PLEASE READ THE FOLLOWING INFORMATION PRIOR TO COMPLETING THE  
ENCLOSED FORMS

All student athletes participating in intercollegiate athletics at Elizabethtown College are required to complete a **health history questionnaire** and have a **complete physical** performed by a licensed physician of their choice within six months of the beginning of participation but dated after June 1<sup>st</sup>. For all incoming freshman and transfer student athletes, the athletic physical form must be completed in addition to the physical form that is required by health services. **Elizabethtown College will not offer any physicals on campus.**

Do not return the health history / physical form with missing information. Make sure that every line has been filled out. **Missing information** will result in **missed practice time** until the forms are completed. All physicals are reviewed with the Athletic Training staff and the students prior to participation.

**Insurance Information:** It is required that ALL student-athletes include a photocopy of their primary insurance card (both front and back) to the Head Athletic Trainer with their physical forms.

All forms to be returned by **August 15<sup>th</sup>** to:

Michael D. Sweger, ATC  
Head Athletic Trainer  
Elizabethtown College  
One Alpha Drive  
Elizabethtown, PA 17022

FORM MUST BE SIGNED AND DATED BY YOUR  
PHYSICIAN AFTER JUNE 1<sup>st</sup> AND WITHIN SIX MONTHS OF  
THE START OF PARTICIPATION

## Attention Deficit Hyperactivity Disorder

If you are currently diagnosed with ADHD and taking medication for this condition please read the following **NEW REQUIREMENTS** from the NCAA. **IF** you do not comply with the new requirements for documentation you will be in violation of the banned substance policy.

### **Student-Athlete Document Responsibility:**

The student-athlete's documentation from the prescribing physician to the athletics departments/sports medicine staff should contain a minimum of the following information to help ensure that ADHD has been diagnosed and is being managed appropriately (see Attachment for Physician Letter criteria):

- A. Description of the evaluation process which identifies the assessment tools and procedures.
- B. Statement of the Diagnosis, including when it was confirmed.
- C. History of ADHD treatment (previous/ongoing).
- D. Statement that a non-banned ADHD alternative has been considered if a stimulant is currently prescribed.
- E. Statement regarding follow-up and monitoring visits.

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**Required Physician Letter:** The NCAA has provided the following guidelines for the criteria for a physician letter. If there are any questions please contact the sports medicine staff at (717) 361- 1564.

**NCAA Attention Deficit Hyperactivity Disorder (ADHD) Guideline Criteria** for a letter from the prescribing Physician to provide documentation to the Athletics Department/Sports Medicine staff regarding assessment of student-athletes taking prescribed stimulants for Attention Deficit Hyperactivity Disorder (ADHD), in support of an NCAA Medical Exception request for the use of a banned substance.

The following must be included in supporting documentation:

- Student-athlete name
- Student-athlete date of birth
- Date of clinical evaluation
- Clinical evaluation components including:
  - ✓ Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) – **attach supporting documentation**
  - ✓ ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary – **attach supporting documentation**
  - ✓ Blood pressure and pulse readings and comments
  - ✓ Note that alternative non-banned medications have been considered, and comments
  - ✓ Diagnosis
  - ✓ Medication(s) and dosage
  - ✓ Follow-up orders
- Documentation from prescribing physician must also include the following:
  - ✓ Physician name (Printed)
  - ✓ Office address and contact information
  - ✓ Specialty
  - ✓ Physician signature and date

Additional ADHD evaluation components if available:

- Report ADHD symptoms by other significant individual(s)
- Psychological testing results
- Physical exam date and results
- Laboratory/testing results
- Summary of previous ADHD diagnosis
- Other comments

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in anyway, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.

# HEALTH RECORD AND QUESTIONNAIRE

## Elizabethtown College Sportsmedicine

**Personal:**

*This form must be **completed** and **signed** by athlete and **reviewed** and **signed** by doctor before performing physical examination*

Name (print) \_\_\_\_\_ Graduation Year \_\_\_\_\_ Date \_\_\_\_\_  
 Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Etown Student Mailbox # \_\_\_\_\_ Etown Room Phone Ext \_\_\_\_\_ Athlete cell phone # \_\_\_\_\_

Primary Emergency Contact(s) Is this the Athlete's home address? Y N

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_

Secondary Emergency Contact(s)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_

**Health Insurance:** A copy of athlete's insurance card **must be attached** for the athlete to be cleared for participation **Front and back**

**Student Athlete Initial Required** \_\_\_\_\_ This indicates presence of insurance card attached.

If student athlete has health insurance through Elizabethtown College, indicate here \_\_\_\_\_

Primary Care Physician: (physician with access to complete records)

Name \_\_\_\_\_ Practice \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Health Waiver: Permission is given to Elizabethtown College or its authorized representatives to furnish medical care, as my son/daughter/self require, including examination and treatment. This permission is based on the understanding that in the even of serious illness, hospitalization and/or major surgery, the college will use all reasonable efforts to contact next of kin. Failure to do so should not prevent the college from providing emergency treatment necessary,

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\* Required if student-athlete is under 18 years of age\*\*

**GENERAL** If you have had, or now have, any of the following, please mark and provide a date with the explanation. Any medication currently being taken should be provided with the reason for and amount of the medication.

	Yes	No	Explain
Allergies			
Medication	_____	_____	_____
Food	_____	_____	_____
Insect sting/bites	_____	_____	_____
Other	_____	_____	_____
Asthma	_____	_____	_____
Cancer	_____	_____	_____
Cysts or Lumps	_____	_____	_____
Diabetes	_____	_____	_____
Drug or Alcohol problems	_____	_____	_____
Eating Disorder	_____	_____	_____

	Yes	No	Explain
Heart Problems			
Dizziness	_____	_____	_____
Chest Pain	_____	_____	_____
Extra Heart Beat	_____	_____	_____
Black Outs	_____	_____	_____
Heart Murmur	_____	_____	_____
Other	_____	_____	_____
Herpes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Infectious Mononucleosis	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Sickle Cell Trait or Sickle Cell Anemia	_____	_____	_____
Have you ever had episodes of unexplained shortness of breath, wheezing, chest pain	_____	_____	_____
Are you HIV Positive?	_____	_____	_____
Have you ever had severe pain in your neck or arms?	_____	_____	_____
Medicine taken routinely	_____	_____	_____

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**ABDOMINAL** Have you ever had, or now have, any of the following?

	Yes	No	Explain
Appendicitis	_____	_____	_____
Stomach Trouble	_____	_____	_____
Bleeding from Rectum	_____	_____	_____
Blood in Urine	_____	_____	_____
Injury to Spleen	_____	_____	_____
Hernia	_____	_____	_____
Injury to Kidney	_____	_____	_____
Bladder or Kidney Problem	_____	_____	_____

Please mark YES if any organs are **NOT** intact.

	Yes	No	Explain
Lungs	_____	_____	_____
Kidney	_____	_____	_____
Testes (ovaries/testicles)	_____	_____	_____
Eyes	_____	_____	_____
Other	_____	_____	_____

**NEUROLOGICAL** Have you had, or now have, any of the following?

	Yes	No	Explain
Head Injury			
Fracture	_____	_____	_____
Concussion	_____	_____	_____
Unconsciousness	_____	_____	_____
Other	_____	_____	_____

	Yes	No	Explain
Neck Injury			
Fracture	_____	_____	_____
Pinched Nerve	_____	_____	_____
Other	_____	_____	_____
Frequent Headaches	_____	_____	_____
Seizure Disorder	_____	_____	_____
Nervous Disorder	_____	_____	_____

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**ORTHOPEDIC** Have you ever had, or now have, an injury to any of the following?

(Please note date and whether injury to right or left side):

	Yes	No	Explain
Neck	_____	_____	_____
Shoulder	_____	_____	_____
Arm/Elbow/Wrist/Hand/Finger	_____	_____	_____
Back/Ribs	_____	_____	_____
Hip/Groin	_____	_____	_____
Thigh	_____	_____	_____
Knee	_____	_____	_____
Lower Leg	_____	_____	_____
Ankle	_____	_____	_____
Foot	_____	_____	_____
Other (Stress Fracture, etc)	_____	_____	_____

Other health problems including hospitalizations or surgical operations?

If there is other medical history important to your safety or to the safety of others, please report it below:

FEMALES ONLY:	Yes	No	Explain
Have you been treated for a female disorder?	_____	_____	_____
Are you pregnant?	_____	_____	_____

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**FAMILY HEALTH HISTORY** Has any member of your family died from, or do they now have any of the following:

	Yes	No	Explain
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Seizure disorder	_____	_____	_____
Has any member of your family died? If yes, give relation, age, and cause of death.	_____	_____	_____

**MEDICAL RELEASE**

I authorize the release of my medical information: (Check one of the following answers)

\_\_\_\_\_ to those the Athletic Trainer’s feel need to be involved in my welfare, including parents.

\_\_\_\_\_ to the people listed below:

(If there is anything you wish kept confidential, indicate below):

STUDENT-ATHLETE SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**\*\* Signature required if student-athlete is under the age of 18\*\***

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**ACKNOWLEDGEMENT OF RISK AND INFORMED CONSENT**

I realize that participation in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**. I understand there are risks including and not limited to death or paralysis, brain damage, cardiac arrest, serious injury to internal organs and to bones, joints, ligaments, muscles, tendons, and other serious injury or impairment to other aspects of my general health and well being. I understand that the dangers and risks of participating in sports also include the potentially high cost of medical care and impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life. Recognizing these risks, I choose to participate in the sport(s) of \_\_\_\_\_ at Elizabethtown College during the \_\_\_\_\_ school year.

STUDENT-ATHLETE SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**\*\* Signature required if student-athlete is under the age of 18\*\***

**Signature of Reviewing Physician** \_\_\_\_\_

# Physical Examination

Elizabethtown College Sportsmedicine

Name \_\_\_\_\_ Date \_\_\_\_\_ Sport(s) \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Nutritional Status \_\_\_\_\_

## Orthopedic

### 1. Postural study including extremities, feet, and scoliosis screen.

### 2. Flexibility including hamstring and quadriceps muscles.

Flexible \_\_\_\_\_ Nonflexible \_\_\_\_\_

### 3. Body Strength

#### a. Upper extremity

Symmetrical \_\_\_\_\_ Asymmetrical \_\_\_\_\_

#### b. Lower extremity

Symmetrical \_\_\_\_\_ Asymmetrical \_\_\_\_\_

### 4. Joint stability and range of motion

a. Knee anterior/ posterior cruciate ligaments \_\_\_\_\_

b. Knee medial/ lateral collateral ligaments \_\_\_\_\_

c. Shoulder/ ankle and other joint instability \_\_\_\_\_

d. Back/ neck \_\_\_\_\_

### Review of School Health Record for Results:

Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Scoliosis \_\_\_\_\_

Growth \_\_\_\_\_ Tuberculosis Test \_\_\_\_\_

Immunizations (NCAA recommends student athletes be immunized for the following):

	Date of Shot	Booster
Measles, Mumps, Rubella (MMR)	_____	_____
Hepatitis B	_____	_____
Diphtheria, Tetanus	_____	_____

### General Examination

Eyes: Is bilateral vision present? \_\_\_\_\_ Contacts? \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat and Mouth \_\_\_\_\_

Neck \_\_\_\_\_

Rib Cage \_\_\_\_\_

Breast Exam \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Genitalia \_\_\_\_\_ : Hernia \_\_\_\_\_ Testicles \_\_\_\_\_

Neurological \_\_\_\_\_

