PHYSICAL EXAMINATION CLEARANCE FORM
2015-16

Physical Examination

(Please Type or Print)

Student's Name ______________________________ Date of Birth ______________
(Last) (First) (Middle)

Sport ______________________ Height ________ Weight ________ Pulse ________ BP ______/______

Vision R 20/________ L 20/________ Corrected: Y N Pupils: Equal ______ Unequal ______

	Normal	Abnormal Findings	Initials
MEDICAL			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:** ______________________________

____

____

____

☐ **Not cleared for:** ______________________ **Reason:** ______________________

Recommendations: ____

____

____

____

____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

______________________________ ______________________________ ______________
Physician's Name and Address (stamp or print) **Examiner's Signature** **Date**

____
Examiner's Telephone Number

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State University of New York
College of Environmental Science and Forestry

ASSUMPTION OF RISK AND RELEASE OF CLAIMS FOR PARTICIPATION IN INTERCOLLEGIATE ATHLETIC ACTIVITIES AT SUNY-ESF

In consideration of being permitted to participate in the Intercollegiate Athletics Program ("the Program") by the State University of New York College of Environmental Science and Forestry ("the College"), I agree, on behalf of myself, my family, heirs, and personal representatives, to assume all the risks and responsibilities of my participation in the Program. I have been fully and completely apprised of the actual and potential risks inherent in this activity. These include the risk of property damage or loss, personal injury or death. By signing below, I am asserting that I am knowingly and voluntarily assuming such risks.

Furthermore, I do hereby acknowledge complete responsibility for all doctor, hospital, dental, first aid and other medical expenses, which I may incur while participating in the Program.

To the maximum extent permitted by law, I release and indemnify the State of New York, the State University of New York, the College, and their officers, employees, agents and volunteers, from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, during or as a result of my participation in the Program, including periods of travel.

In signing this Assumption of Risk and Release, I acknowledge and represent that I have read the foregoing, understand it, and sign it voluntarily, that no oral representations, statements or inducements, apart from this written agreement, have been made, that I am at least 18 years of age and fully competent (or if not, my parent or guardian is also signing), and I am executing this Assumption of Risk and Release for full, adequate and complete consideration, fully intending to be bound by the same.

Dated:

____
Name of Student

____
Signature

Dated:

____
Parent/Guardian if Student under 18

____
Signature

SUNY-ESF INTERCOLLEGIATE ATHLETICS
STATEMENT OF INSURANCE AND EMERGENCY AUTHORIZATION

Name____ Date of Birth_____________________

Sport____

SUNY-ESF does not provide basic insurance coverage for the damages and costs associated with athletic injuries. The College Athletics Office requires that you complete and sign this statement to show proof of your insurance coverage and provide authorization for emergency medical treatment if needed. Participation will not be allowed until this statement is signed and on file with the College Athletics Office.

STATEMENT OF INSURANCE

I understand that as a student athlete at SUNY-ESF, I am required to have and maintain current individual medical/health insurance coverage, before and while participating in any strength and conditioning session, practice, game, competition, and/or team travel that is supervised by approved SUNY-ESF coaching staff, and I affirm that I have such coverage.

I understand that, since participation in SUNY-ESF athletic programs is voluntary, SUNY-ESF shall not be responsible for medical bills, including deductibles, not covered by my medical/health insurance policy. I understand that coverage or reimbursement for costs associated with hospital emergency room visits, hospitalization, and other health care, shall be determined solely by my health insurance policy.

Please indicate below the type of health/accident insurance coverage you have to ensure that you are in compliance with SUNY-ESF requirements for participation in intercollegiate athletics:

______ I am covered by my parent's health/accident insurance plan with:
Insurance Company: ____ Policy #:__________________

______ I am covered by my own personal health/accident insurance plan with:
Insurance Company :____ Policy#:___________________

EMERGENCY AUTHORIZATION

I hereby authorize emergency medical treatment that may be deemed necessary by SUNY-ESF Athletics staff during my participation. (Efforts will be made to contact the emergency contact person listed below prior to treatment.)

______________________________ ____

Emergency Contact Person Address and Telephone Number

I hereby authorize the release of all health information contained in my student records maintained in the Syracuse University Health Center or the College Athletics Office to any parties deemed necessary by SUNY-ESF Athletics staff.

REQUIRED SIGNATURE(S

I have carefully read this statement before signing it. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made.

____ ____________________

Signature of Student Athlete Date

If Student Athlete is under 18 years of age, a parent or legal guardian must also read and sign this form.

I (A) am the parent or legal guardian of the above student, (B) have read the foregoing statement (including such parts as may subject me to the personal financial responsibility), (C) am and will be legally responsible for the obligations of the student as described in this statement.

____ ____________________

Signature of Parent/Guardian Date

State University of New York
College of Environmental Science and Forestry

Athletic Pre-Participation Medical History

Office of Athletics
10 Bray Hall – SUNY ESF
1 Forestry Drive
Syracuse, NY 13210

Please return by August 7
**ALL potential student-athletes MUST complete and return before you are allowed to participate in any athletic activity*

General Contact Information

____ College Graduation Year:__________
Last Name First Name Middle Name

____
Home Address City State Zip Country (if not US)

Sports Participating In:_________________________ Male:____ Female:____ Date of Birth___/____/______

____
Mother's Name Father's Name Parent Cell Phone

____
Home Address

____
Student Cell Phone Student E-Mail Address College Address

Emergency Contact Information

____
Emergency Contact Name Relationship

Home Phone: (___)__________ Work Phone: (___)__________ Cell Phone: (___)__________

Insurance Information

If there are any changes in your insurance information or coverage during the year, please update your information on file in the Office of Athletics.

Insurance Co.____________________________________ Phone#____________________________________

Policy Subscribers Name____

Identification #__________________________________ Group#____________________________________

Referral Required for Specialist? Yes_____ No_____

Primary Care Physician____ Phone#________________________

***Please mail front/back copy of insurance card with form**

Medical Information: Part 1

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 been told that you have a heart murmur?
YES NO
Please describe:____

Has any family member or relative died of heart problems and/or sudden death before age 50?
YES NO
Please describe:____

Have you or anyone in your family been told you/they have High Blood Pressure?
YES NO
Please describe:____

II. Allergies:

Have you ever been diagnosed with Season Allergies? What meds do you take?
YES NO
Please describe:____

Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications/food?
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
Please describe:____

How often do you use your rescue inhaler/per week?_______________________

How many acute asthma attacks have you had in the past 12 months?______________

Have you been hospitalized as a result of an attack?
YES NO
Date(s):____

Medical Information: Part 2

Mark "Yes" if you have had any of the following

General Medical

____Chronic or recurrent illness?
____Tire quickly?
____Had/have trouble with cough or breathing after exercise?
____Heat exhaustion or heat stroke?
____Pinched nerve or "stinger"?
____Hospitalization and/or surgery?
____Missing organs?
____Have you ever been diagnosed with an eating disorder?
Explain any Yes answers:____

____

Orthopedic History

____Broken bones or fractures?
____Stress fractures?
____Injuries that require recurrent/ongoing treatment?

Any of the following injuries in the past year:

____Head, neck or spinal injuries?
____Chest, back, or pelvic injuries?
____Arm injuries (shoulder/elbow/wrist)?
____Leg injuries (hip/knee/ankle)?
Explain any Yes answers:____

____

Head Injuries

____Have you ever had a concussion? Date(s) of concussion(s)____________________________
____Have you ever had prolonged concussion symptoms (lasting more than 1 week)?
____Have you ever been knocked unconscious? When:__________________________________

Female History

Are you currently pregnant?:____________

Other Medical History

____Have you ever been diagnosed with ADHD? (Refer to www.ncaa.org/health-safety)
____Have any trouble with your eyes or vision?
____Wear glasses or contact lenses?
____Wear any special equipment?
If you have any other medical history not covered by this form, please explain:

____

____

Current medications and reason for taking the medication:

____

____

Please list all dietary and performance enhancing supplements you are currently taking:

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and authorize the staff of Syracuse University Health Services to release any pertinent health information to the SUNY-ESF Athletic Staff and Coaches as it pertains to my participation in athletics.

Athlete Signature____ Date___________________________