University of Waterloo
Department of Athletics and Recreation

# VARSITY ATHLETE HEALTH PREPARTICIPATION

Date_____Last Name_____First Name _____
Date of Birth: Day___Month_____Year_____Email_____ Local Address_____
Permanent Address_____ Local phone or cell phone_____
Sport_____Eligibility Year_____Student Number_____Current Height (Ft/In)_____Current Weight (Lbs)_____

## Emergency Contact Info

Name_____Relationship_____
Phone #1_____Phone #2_____
Family physician_____Phone_____

| General Questions | Yes | No | Explain |
|---|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | | |
| 2. Do you have any of the ongoing medical conditions? Asthma, Anemia, Diabetes, Infections, Seizures, Other: | | | |
| 3. Have you ever had surgery or hospitalization? | | | |
| **Heart Health Questions *About You*** | **Yes** | **No** | **Explain** |
| 4. Have **you** had any of the following conditions? | | | |
| a. Heart Murmur | | | |
| b. Heart disease or conditions e.g. Marfans syndrome | | | |
| c. High blood pressure or cholesterol | | | |
| d. Dizziness or fainting before, during or after exercise | | | |
| e. Chest pain, tightness or pressure in your chest during exercise? | | | |
| f. Heart racing or skipping or irregular beats during exercise? | | | |
| g. Medical tests ordered for your heart? E.g. EKG, echocardiogram. | | | |
| **Heart Health Questions *About Your Family*-Parents, Grandparents, Siblings** | **Yes** | **No** | **Explain** |
| 5. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | | |
| 6. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | | |
| 7. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | | |
| 8. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | | |
| 9. Does anyone have blood disorders? | | | |
| 10. Other medical problems e.g. Diabetes, lung or kidney disease? | | | |

| Orthopedic or Musculoskeletal Problems | Yes | No | Explain |
|---|---|---|---|
| 11. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? | | | |
| 12. Have you ever had any broken or fractured bones or dislocated joints? | | | |
| 13. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? List all applicable | | | |
| 14. Have you ever had a stress fracture? Where? | | | |
| 15. Do you have a bone, muscle or joint injury that currently bothers you? | | | |
| 16. Do any of your joints become painful, feel warm, or look red? | | | |
| 17. Do you have a past history of the injury or recurrent pain to any of the following areas? | | | |
| a. Back | | | |
| b. Neck | | | |
| c. Hip or groin | | | |
| d. Knee or thigh | | | |
| e. Ankle or foot | | | |
| f. Shoulder | | | |
| g. Elbow or forearm | | | |
| h. Hand, wrist or thumb | | | |
| i. Head/face/ears/eyes | | | |
| j. Other | | | |
| **General Medical Questions** | **Yes** | **No** | **Explain** |
| 18. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | | |
| 19. Have you ever used an inhaler or taken asthma medication? | | | |
| 20. Is there anyone in your family who has asthma? | | | |
| 21. Were you born without or are you missing any organs? | | | |
| 22. Do you have groin pain or a painful bulge or hernia? | | | |
| 23. Have you had a serious viral infection (e.g. myocarditis or mononucleosis) in the last month? | | | |
| 24. a. Have you tested positive for COVID-19 in the past 12 months? | | | |
| 24. b. If yes, did you get clearance for activity from a physician? | | | |
| 25. Do you have any rashes, sores, or other skin problems or issues? | | | |
| 26. Have you had herpes or MRSA skin infection? | | | |

| General Medical Questions | Yes | No | Explain |
|---|---|---|---|
| 26. Have you ever had a head injury? | | | |
| 27. Have you ever hit your head or had a hit elsewhere on your body and as a result had any of the following symptoms? If so please list the date | | | |
| a. Headache | | | |
| b. Nausea | | | |
| c. Memory loss | | | |
| d. Loss of Balance or unsteadiness | | | |
| e. Vomiting | | | |
| f. Ringing in ears | | | |
| g. Blurry or altered vision | | | |
| h. Incoordination | | | |
| i. Sensitivity to noise or light | | | |
| 28. Have you ever had your "bell rung" or seen stars? | | | |
| 29. Have you ever been "knocked out"? | | | |
| 30. Have you ever seen a physician and been diagnosed with a concussion after a head injury? Number | | | |
| 31. Do you have a history of seizure disorders? | | | |
| 32. Do you have headaches with exercise? | | | |
| 33. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? | | | |
| 34. Have you ever been unable to move your arms or legs after being hit or falling? | | | |
| 35. Do you have any problems with the following: | | | |
| a. Vision? Do you wear contacts or glasses | | | |
| b. Eye injuries? Do you wear protective goggles, glasses or face shield? | | | |
| c. Hearing? Do you have hearing aids | | | |
| d. Dental- False teeth, bridges, veneers, permanent retainer | | | |
| 37. Do you get frequent muscle cramps when exercising? | | | |
| 38. Do you or someone in your family have sickle cell trait or disease? | | | |
| 39. Do you worry about your weight? | | | |
| 40. Have you had a recent large increase or decrease in body weight? Amount (lbs) | | | |

| General Medical Questions | Yes | No | Explain |
|---|---|---|---|
| 41. Are you on a special diet or do you avoid certain types of food? | | | |
| 42. Have you ever had an eating disorder? | | | |
| 43. Do you have **ANY** allergies? Please list | | | |
| 44. Do you have any concerns that you would like to discuss with a healthcare provider? | | | |
| 45. Do you often have trouble sleeping? | | | |
| 46. Do you wish you had more energy most days of the week? | | | |
| 47. Do you think about things over and over? | | | |
| 48. Do you feel nervous and anxious much of the time? | | | |
| 49. Do you often feel sad or depressed? | | | |
| 50. Do you struggle with being confident? | | | |
| 51. Do you feel hopeless about the future? | | | |
| 52. Do you have a hard time managing your emotions (anger, frustration, impatience)? | | | |
| 53. Do you have feelings of hurting yourself or others? | | | |
| **Medications, Supplements** | **Explain/List** | | |
| 54. Please identify any medications, supplements, vitamins, remedies, naturopathic products you currently take regularly. | | | |
| **Lifestyle** | **Yes** | **No** | **Explain** |
| 55. Do you smoke cigarettes, marijuana, cigars, use smokeless tobacco (dip, chew)? If yes, how much/many per week? | | | |
| 56. Do you consume alcohol? If yes, how many drinks per week on average? | | | |
| 57. Do you consume other drugs? | | | |
| **Immunizations (You may choose to NOT answer the following questions)** | **Yes** | **No** | **Date** |
| 58. Measles/mumps/rubella inoculation | | | |
| 59. Tetanus inoculation | | | |
| 60. Hepatitis A/B inoculation | | | |
| 61. COVID-19 inoculation | | | |
| ***Females ONLY*** | **Yes** | **No** | **Explain** |
| 62. Have your periods been regular? If no, please explain | | | |
| 63. How old were you when you had your first menstrual period? | | | |
| 64. How many periods have you had in the past 12 months? | | | |

## CERTIFICATION AND CONSENT FOR DISCLOSURE AND USE OF INFORMATION HEREIN:

I, the undersigned, hereby certify that I have made a full and complete disclosure in answering the questions above. I, the undersigned, will provide UW Athletic Therapy with all documentation pertaining to any prior injuries, illnesses or conditions that have restricted my participation in sport (including physician notes, test reports, specialist reports etc.) and in doing so will prevent any unnecessary delay in medical clearance.

I, the undersigned, hereby give my permission for the information contained on this form, or other information about my health status, to be communicated by the health care staff to the coaching staff of my intercollegiate sport(s) and any other health care professionals managing my care. I hereby give the health care staff permission to communicate my health status to the UW AccessAbility office and thereby providing consent for AccessAbility Services to communicate with your instructor, and in some cases your academic advisor, in order to facilitate the accommodation process. The information that will be shared will include your name and your approved accommodations only. Information related to your condition or disability will not be disclosed. Furthermore, any failure on my part to attend health care appointments scheduled at the UW Therapy Clinic will be communicated to my coach. I am aware that this general permission can be revoked by a specific request to a member of the health care staff to withhold specific information.

I, the undersigned, understand that as an incoming first year student I am not covered by the UW Federation of Student's Extended Health Plan until September 1st. As such I understand that I am solely responsible for attaining my own accident and dental policy during the period between when I commence training at UW and September 1st. **International students** must ensure that they have applied for and received confirmation of UHIP coverage prior to commencing any training at UW. All Canadian residents must also have current valid provincial health cards prior to participation.
I, the undersigned, acknowledge and agree to communicate with the Athletic Therapist or the Athletic Therapist's staff using electronic communications (email, text message, video conferencing) with a full understanding of the risks in doing so.

Signature of Athlete_____ Signature of parent or guardian (if under 19)_____

Date signed_____

Conley, K.M Bolin, D.J et al. National Athletic Trainer's Association Position Statement: Pre-Participation Physical Examinations and Disqualifying Conditions. *Journal of Athletic Training* 2014;49(1):102-120.
http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_patient_screening_guidance.pdf

| MSK EXAM | | | |
|---|---|---|---|
| | | NORMAL | |
| | | L vs R | ABNORMAL FINDINGS/COMMENTS |
| **Spine** *(C/T/L/S)* | | | |
| **Shoulders & Chest** | | | |
| | | | |
| **Hand, Wrist, Elbow** | | | |
| | | | |
| **Pelvis & Hips** | | | |
| *(Hips, SI, Groin, Thigh)* | | | |
| **Knee** | | | |
| | | | |
| **Leg, Ankle, Foot, Toes** | | | |
| | | | |
| ALIGNMENT NOTES: genu varum/valgus/recurvatum, pes planus/cavus, pronation/supination, | | | |
| general ligamentous hyperlaxity, other | | | |
| | | | |
| | | | |

*MSK CLEARANCE – completed by AT or MD*

- Cleared to play – no restrictions
- Cleared to play – with restrictions
- Disqualification _____ Temporary or _____ Season _____
- Clearance deferral pending, following referral/investigation

Signature:_____

Date:_____

**PHYSICAL EXAM FINDINGS – *TO BE COMPLETED BY PHYSICIAN***

| | | | |
|---|---|---|---|
| Height (cm) | | Vision | R / L |
| Weight (lbs) | | Vision corrected? | Y / N |
| Sitting BP | | Pupils Equal? | Y / N |
| HR | | | |

| **MEDICAL EXAM** | | |
|---|---|---|
| | NORMAL | ABNORMAL FINDINGS/COMMENTS |
| **Head & Neck** | | |
| *(Dental, ears, eyes, nose & throat, lymph nodes & thyroid)* | | |
| **Cardiac** | | |
| *Femoral artery pulses* | | |
| *Heart sounds/pulses* | | |
| *Valsalva, (Supine & Upright)* | | |
| *Stigmata of Marfan's* | | |
| **Respiratory -** *breath sounds* | | |
| **Abdomen - GI-GU** | | |
| *GI - pain, masses, organomegaly* | | |
| *GU - testicles, hernias* | | |
| **Dermatologic** - *skin, scalp* | | |
| **Neurologic** | | |

**MEDICAL RECOMMENDATION**

- Cleared to play – no restrictions
- Cleared to play – with restrictions
- Disqualification _____ Temporary or _____ Season _____
- Clearance deferral pending, following referral/investigation

Restricted or Disqualified: Please indicate reasons and conditions of play
Notes:

| |
|---|
| |
| |
| |

*Confidentiality of Information & Release Form*
Personal health information may be used only for the purpose for which it was collected, except with patient consent or as required by law. By signing this form, you agree to allow the sharing of information from this pre-season physical form with the Athletic Therapy department at the University of Waterloo and the appropriate sports medicine physicians. All health information will be kept confidential, stored and secured to protect your privacy.

I acknowledge and consent to the Athletic Therapy department at the University of Waterloo sharing relevant heath information related to this pre-season physical. I certify that the above examination and recommendation is full and complete. I will attach any applicable medical documentation pertaining to any prior injury, illness or condition that restricted sports participation for the above athlete.

Physician Signature: _____
Date: _____