

University of Wisconsin – Stevens Point Athletics Incoming Freshman/Transfer Student Medical Information

Dear Parent/Guardian:

We are extremely pleased to have your son/daughter as a student athlete at the University of Wisconsin – Stevens Point. This letter will detail the necessary medical/insurance forms your son/daughter must fill out prior to competing (games or practice) in intercollegiate athletics. All forms are included in this packet and must be filled out completely. We wish your son/daughter much success in their academic and athletic endeavors.

UWSP Athletic Training Staff

- **Medical Coverage:** UWSP employs five Certified Athletic Trainers (ATC's) to provide athletic medical coverage for all UWSP home events and practices. The ATC's provide complete athletic injury prevention, assessment, treatment, rehabilitation, and consultation services to all UWSP student-athletes.
- **Team Physicians:** UWSP works with an Orthopedic Physician and medical professionals affiliated with the Klasinski Clinic and Aspirus Hospital and Clinics. The team physician provides event coverage, referral, and evaluation services to the student-athletes. The team physician visits the athletic training facility weekly to evaluate athletic related injuries incurred by the student-athletes. All student-athletes **MUST** be evaluated by an ATC prior to seeing a team physician.

Eligibility for Athletic Participation

- All student-athletes must have the following up-to-date forms on file in the athletic training facility prior to participation in intercollegiate practices or contests:
 - UWSP Physical History and Examination (new/freshmen and transfer student-athletes)
 - UWSP Insurance form
 - UWSP Hold Harmless (to be completed at the sport's eligibility meeting)
 - HIPAA Form (to be completed at the sport's eligibility meeting)
- All student-athletes who report with an existing condition (post-surgery, chronic injury, etc.) must be evaluated by the athletic training staff and/or team physician prior to participation.
- **The UWSP Team Physician has the final say on the participation of an injured/ill student-athlete.**

Medical Forms

- **UWSP Physical History and Examination:**
 - A new (including transfers) or returning student-athlete (after 1 year absence) must complete a Pre-Participation Medical Exam prior to practice and/or contest participation in an intercollegiate sport. Student-athletes will be advised to obtain physical exams on their own.
 - Athletes who are currently enrolled may complete the physical examination at UWSP Health Services Center at a prearranged appointment. Appointments are the responsibility of the student-athlete and are not applicable to student-athletes who participate in fall sports (football, volleyball, women's soccer, M/W cross country, women's tennis, golf).
 - **Any athlete who has not completed a physical examination (to UWSP requirements) will NOT be allowed to engage in contests or practice sessions.**

Appendix K

- **High School Physicals (WIAA, etc.) will not be accepted. All physicals must be completed within 3 months of the student-athlete's first day of classes.**
- The first pages are to be filled out by the student-athlete. Please fill out all information as completely as possible. Please explain all "Yes" answers in the space provided. The last two pages are completed during the pre-participation physical exam. The pre-participation physical exam **MUST** be completed by a Licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Physicians Assistant (PA), or Nurse Practitioner (NP).
*****Physicals will not be accepted by Chiropractors, Physical Therapists, Physical Therapy Assistants, or Massage Therapists.**

ALL SECTIONS OF THE PHYSICAL EXAM FORM MUST BE COMPLETED. ANY BLANK SECTIONS WILL RESULT IN AN INCOMPLETE FORM AND WILL PROHIBIT ANY ATHLETE FROM ENGAGING IN CONTESTS AND/OR PRACTICE.

The lab test (HCT) is important to establish baseline measures and to assist in the future examination of a student-athlete's injury/illness sustained in participation in intercollegiate athletics.

PLEASE INFORM THE MEDICAL PROFESSIONAL COMPLETING THE FORM THAT ALL SECTIONS NEED TO BE COMPLETED.

- **UWSP Insurance Form**
 - All athletes must have their own medical insurance. The University assumes no legal obligation to pay any such medical expenses due to an injury/illness suffered during athletic competition. The athlete must have minimal insurance coverage to compete in intercollegiate athletics. (Must be \$75,000 of coverage including sports related injuries)
 - Each individual is responsible for his/her own medical expenses through his/her own individual or family insurance plan.
 - Athletes will not be allowed to participate without a completed medical insurance form. Returning athletes need to verify the existing information, initial, and date the form. The medical insurance form can be obtained from the athletic training room.
 - Short-term or long-term insurance can be attained from
Community Insurance Store
2625 Church Street
(715)344-2222
Email: cispoint@g2a.net

Contact Information

Head Athletic Trainer

Nathan R. Weiler
University of Wisconsin – Stevens Point
2050 Fourth Ave
Stevens Point, WI 54481
(O) (715)346-4772
(F) (715)295-8938
Email: nweiler@uwsp.edu

UWSP PHYSICAL HISTORY FORM

STUDENT: Complete first 5 pages prior to your appointment with your physician.

STUDENT INFORMATION

DATE _____

NAME _____ SPORT _____

LOCAL ADDRESS _____

AGE _____ Street _____ City _____ State _____ Zip _____
 BIRTHDATE _____ SEX _____

PHONE (Cell) _____

EMERGENCY NOTIFICATION INFORMATION

EMERGENCY CONTACT _____ Relationship _____

ADDRESS _____

PHONE (Home) _____ Street _____ City _____ State _____ Zip _____
 (Work) _____ (Cell) _____

FAMILY HISTORY

	LIVING	DECEASED	AGE (at death)	Illnesses (or cause of death)
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
No. of Brothers	_____	_____	_____	_____
No. of Sisters	_____	_____	_____	_____

Among your blood relatives, is there a history of the following?

	Yes	No
Alcoholism or abuse of alcohol	_____	_____
Allergy	_____	_____
Emotional or psychiatric problems	_____	_____
Recurrent severe headaches	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Stroke	_____	_____
Thyroid disorder	_____	_____
Emphysema	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Tuberculosis	_____	_____
Other serious illness	_____	_____

MEDICAL HISTORY

Please answer the following questions about your medical history. If you answer ‘YES’ to any question, provide the date or dates and provide explanation

General	Yes/No	Date	If yes please explain
Have you ever been hospitalized?	Yes/No		
Have you ever had surgery?	Yes/No		
Are you currently taking any medication? (include ADHD , over the counter meds, birth control pills, etc.)	Yes/No		<p>If taking medication for ADHD, please include the following with your physical forms.</p> <ul style="list-style-type: none"> a. Record of the student-athlete’s evaluation. b. Statement of the Diagnosis, including when it was confirmed. c. History of ADHD treatment (previous/ongoing). d. Copy of the most recent prescription (as documented by the prescribing physician).
Do you have any allergies? (medications, bee stings, food, etc.)	Yes/No		
Do you have any mental or emotional illness?	Yes/No		
Do you have diabetes?	Yes/No		
Have you had recurrent severe headaches?	Yes/No		
Have you ever had eczema?	Yes/No		
Have you had rheumatic fever?	Yes/No		
Have you had tuberculosis?	Yes/No		
Have you had/have hepatitis?	Yes/No		
Do you have (or had) any type of bleeding disorder?	Yes/No		
Do you use tobacco?	Yes/No		Type/How much?/How often?
Do you drink alcohol?	Yes/No		How much per day? Per week?
Any other serious illness not discussed above?	Yes/No		

Appendix K

Cardiac

Date If yes please explain

Have you ever had chest pain during exercise?	Yes/No		
Have you ever passed out or fainted during exercise?	Yes/No		
Have you ever been dizzy during exercise?	Yes/No		
Have you ever had high blood pressure?	Yes/No		
Have you ever been told you have a heart murmur?	Yes/No		
Have you ever had racing of your heart or skipped heartbeats?	Yes/No		
Has <u>anyone</u> in your family died of a heart problem or sudden death before the age of 50?	Yes/No		

Neurological

Date If yes please explain

Have you ever had a head injury/concussion?	Yes/No		Severity? Time Loss? Number of concussions?
Have you ever been knocked out or unconscious?	Yes/No		
Have you ever had a seizure?	Yes/No		
Have you ever had a “stinger”, “burner”, or pinched nerve?	Yes/No		

Pulmonary

Date If yes please explain

Do you have any history of asthma or exercise induced asthma?	Yes/No		If yes, please bring a second inhaler.
Do you have trouble breathing or do you cough during or after activity?	Yes/No		

Orthopedic

Date If yes please explain (R vs. L, severity, etc.)

Have you ever strained/sprained, dislocated, Fractured or had repeated swelling or other injuries to the following joints.	Yes/No		
--	--------	--	--

Appendix K

		Date	If yes, please explain.
Hip	Yes/No		
Knee	Yes/No		
Ankle	Yes/No		
Foot	Yes/No		
Shoulder	Yes/No		
Elbow	Yes/No		
Hand/wrist	Yes/No		
Neck	Yes/No		
Back	Yes/No		
Have you ever had a stress fracture or stress injury	Yes/No		Place of fx and number of fx's

STUDENT PERSONAL HISTORY

Do you have any unusual problems with:		Date	If yes please explain
Head, eyes, ears, nose, throat	Yes/No		
Heart	Yes/No		
Chest & lungs	Yes/No		
Stomach & intestines	Yes/No		
Kidney or bladder	Yes/No		

Appendix K

		Date	If yes, please explain.
Hernia	Yes/No		
Have you ever been diagnosed with an eating disorder?	Yes/No		
Are you concerned with your weight or diet?	Yes/No		
Do you have a loss or seriously impaired function of any organ (eye, kidney, lung, etc)	Yes/No		
FEMALES: How many cycles have you had in the last year?			
Does your menstrual cycle fluctuate with activity?	Yes/No		
MALES: Have you had/have any testicular problems?	Yes/No		

Immunizations:	Yes	No	Initial	First Booster	Second Booster
Measles, mumps, rubella	___	___	Date _____	_____	_____
Varicella	___	___	Date _____	_____	_____
HEP B series	___	___	Date _____	_____	_____
HPV	___	___	Date _____	_____	_____
Tetanus/diphtheria	___	___	Date _____	_____	_____
Others _____					

Have you been advised to restrict activity in the last five years? Yes_____ No_____

Explain:

Are you aware of any reason you should not participate in all athletics? Yes_____ No_____

I, _____ hereby give permission to undergo medical treatment for any injury/illness that I sustain or acquire while engaged in intercollegiate athletics at the University of Wisconsin – Stevens Point (UWSP). I understand that the medical personnel at UWSP, including certified athletic trainers, physicians, physicians assistant, and physical therapists will only perform those procedures that are within their training, scope of professional practice, and the State of Wisconsin Practice Act to prevent, care for, and rehabilitate activity related injuries/illness.

All information provided is accurate to the best of my knowledge and has not been falsified.

Having understood the above statement, I freely sign this Permission to Provide Medical Treatment.

SIGNED _____

DATE _____

UWSP PHYSICAL EXAMINATION FORM

PHYSICIAN: Please complete all sections and review student and family medical history with the athlete.

ALL SECTIONS MUST BE COMPLETED FOR CLEARANCE TO COMPETE IN INTERCOLLEGIATE ATHLETICS

NAME: _____

WEIGHT: _____ (Last) lbs. HEIGHT: _____ (First) ft. _____ (Middle) in.

RESTING PULSE: _____ HCT: _____ BLOOD PRESSURE: _____

VISION EXAM:	RIGHT	LEFT
Normal (EX. 20/20, 20/40)	_____	_____
Glasses	_____	_____
Contacts	_____	_____
Does the athlete wear glasses/contacts (please circle) for competition?		

MEDICAL EXAM

	NORMAL	ABNORMAL	PLEASE EXPLAIN
Eyes	_____	_____	_____
Ears, nose (septum), throat	_____	_____	_____
Neck (thyroid)	_____	_____	_____
Lungs	_____	_____	_____
Breasts	_____	_____	_____
Heart	_____	_____	_____
Gastro-intestinal	_____	_____	_____
Hernia	_____	_____	_____
Genito-urinary	_____	_____	_____
Neuro-psychiatric	_____	_____	_____
Skin	_____	_____	_____
Lymph nodes	_____	_____	_____
Neurologic (reflexes)	_____	_____	_____
Bicep	_____	_____	_____
Brachioradialis	_____	_____	_____
Tricep	_____	_____	_____
Patellar	_____	_____	_____
Achilles	_____	_____	_____

USE THIS AREA TO EXPLAIN ANY ADDITIONAL HISTORY, ABNORMALITIES, AND/OR RECOMMENDATIONS.

Appendix K

TO THE PHYSICIAN: By signing below, I signify that I have reviewed the athlete's medical history. Measles, rubella, polio and tetanus immunization are strongly recommended. Verification of freedom within the last year from active tuberculosis is required (intermediate strength PPD is recommended for the skin test).

DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE CARE OF THIS STUDENT WHILE ATTENDING THE UNIVERSITY? Yes _____ No _____

If yes, explain.

Can this student participate in intercollegiate athletics? Yes _____ No _____

PHYSICIAN NAME _____

SIGNATURE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (include area code) _____

DATE _____