

**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 four 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 four Orthopedic and one Doctor of Osteopathy/ATC from Rice Medical Center. The team physicians provide event coverage, referral, and evaluation services to the student-athletes. The team physicians visit the athletic training facility every Monday and Thursday 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)
- 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 Physicians 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 or not applicable to student-athletes who participate in fall sports (football, volleyball, women's soccer, M/W cross country, women's tennis).
  - **Any athlete who has not completed a physical examination (to UWSP requirements) will NOT be allowed to engage in contests or practice sessions.**
  - **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 four 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), or Physicians Assistant (PA). **\*\*\*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 tests (TB, HCT, Urinalysis, etc.) are 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.
- 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](mailto:cispoint@g2a.net)

## **Contact Information**

Head Athletic Trainer

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**UWSP PHYSICAL HISTORY FORM**

STUDENT: Complete first 4 pages prior to your appointment with your physician.

**STUDENT INFORMATION**

NAME \_\_\_\_\_ SPORT \_\_\_\_\_  
S.S.# \_\_\_\_\_ DATE \_\_\_\_\_  
LOCAL ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_  
CURRENT MARITAL STATUS \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
LOCAL PHONE \_\_\_\_\_ SEX \_\_\_\_\_

**EMERGENCY NOTIFICATION INFORMATION**

PARENT \_\_\_\_\_

S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (for Urgent Care registration) DOB \_\_\_\_\_ SEX **M** **F**

ADDRESS \_\_\_\_\_

Street City State Zip  
PHONE Area Code Number

**FAMILY HISTORY**

|                 | LIVING | DECEASED | AGE<br>(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              | _____ | _____ |

**EATING HABITS**

1. I eat a variety of foods each day, including fruits and vegetables, whole grain breads and cereals, lean meats, dairy products, dry peas and beans, and nuts and seeds.  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
2. I limit the amount of fat, saturated fat, and cholesterol I eat (including fat on meats, hot dogs/ bologna, eggs, butter, cream shortenings, and organ meats such as liver).  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
3. I limit the amount of salt I eat by cooking with only small amounts, not adding salt at the table, and avoiding salty snacks.  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
4. I avoid eating too much sugar (especially frequent snacks of stick candy or soft drinks).  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
5. I eat fiber-containing foods daily (bran foods, whole grain breads or cereals, brown rice, fresh fruits and vegetables).  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_

**EXERCISE/FITNESS**

1. I maintain a desired weight, avoiding overweight and underweight.  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
2. I do vigorous exercises for 15-30 minutes at least three times a week (examples include running, swimming, brisk walking).  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_
3. I do exercises that enhance my muscle tone for 15-30 minutes at least three times a week (examples include yoga and calisthenics).  
 Almost always \_\_\_\_\_ Sometimes \_\_\_\_\_ Almost never \_\_\_\_\_

**HABITS**

Cigarettes \_\_\_\_\_ pack/day for \_\_\_\_\_ years.  
 Alcohol \_\_\_\_\_ drink/day \_\_\_\_\_ drink/week.  
 Caffeinated beverages \_\_\_\_\_ #/day.

**MEDICAL HISTORY**

**General**

If yes please explain

|  |     |    |  |
|--|-----|----|--|
| Have you ever been hospitalized?   | YES | NO |  |
| Have you every had surgery?  | YES | NO |  |
| Are you currently taking any medication?<br>(include over the counter meds, birth control pills, etc.) | YES | NO |  |
| Do you have any allergies? (medications, bee stings, food, etc.)                                       | YES | NO |  |
| Do you have (or had) hay fever?  | 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 hepatitis?                             | YES | NO |  |
| Do you have (or had) any type of bleeding disorder? | YES | NO |  |
| Any other serious illness not discussed above?      | YES | NO |  |

### Cardiac

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

If yes please explain

|  |     |    |  |
|--|-----|----|--|
| Have you ever had a head injury?                           | YES | NO |  |
| 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

If yes please explain

|   |     |    |  |
|---|-----|----|--|
| Do you have any history of asthma or exercise induced asthma?           | YES | NO |  |
| Do you have trouble breathing or do you cough during or after activity? | YES | NO |  |

### Orthopedic

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

|  |     |    |  |
|--|-----|----|--|
| Have you ever strained/sprained, dislocated, or had repeated swelling or other injuries to the following joints. |     |    |  |
| Knee   | YES | NO |  |
| Shoulder   | YES | NO |  |
| Ankle  | YES | NO |  |
| Hand/wrist   | YES | NO |  |
| Elbow  | YES | NO |  |
| Foot   | YES | NO |  |
| Hip  | YES | NO |  |
| Back   | YES | NO |  |

|  |     |    |  |
|--|-----|----|--|
| Neck   | YES | NO |  |
| Have you ever fractured or broken any bones or joints? | YES | NO |  |
| Have you ever had a stress fracture or stress injury   | YES | NO |  |

### STUDENT PERSONAL HISTORY

Do you have any unusual problems with:

|  |     |    |  |
|--|-----|----|--|
| Head, eyes, ears, nose, throat                                 | YES | NO |  |
| Heart  | YES | NO |  |
| Chest & lungs  | YES | NO |  |
| Stomach & intestines   | YES | NO |  |
| Kidney or bladder  | YES | NO |  |
| Hernia   | YES | NO |  |
| Menstrual difficulties   | YES | NO |  |
| <b>FEMALES:</b> How many cycles have you had in the last year? |     |    |  |
| Does your menstrual cycle fluxuate with activity?              | YES | NO |  |

| Immunizations:                | Date  | Yes | No  |
|-------------------------------|-------|-----|-----|
| Measles                       |       |     |     |
| After 1 year of age           | _____ | ___ | ___ |
| 1968 or later                 | _____ | ___ | ___ |
| Rubella immunization or titer | _____ | ___ | ___ |
| Polio                         | _____ | ___ | ___ |
| Tetanus/diphtheria            | _____ | ___ | ___ |
| Others _____                  |       |     |     |

Have you been advised to restrict activity in the last five years?    Yes \_\_\_\_\_    No \_\_\_\_\_  
 Explain:

Do you have a loss or seriously impaired function of any organ?    Yes \_\_\_\_\_    No \_\_\_\_\_  
     eye \_\_\_\_\_    lung \_\_\_\_\_    kidney \_\_\_\_\_    testicle \_\_\_\_\_

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?

URINALYSIS:  
(If necessary please explain abnormalities)

|          |       |       |       |
|----------|-------|-------|-------|
| Negative | _____ | Sugar | _____ |
| Protein  | _____ | Blood | _____ |
| Micro    | _____ |       |       |

TB SKIN TEST:  
Date \_\_\_\_\_      Negative \_\_\_\_\_      Positive \_\_\_\_\_

**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.

**TO THE PHYSICIAN: By signing below, I signify that I have reviewed the athlete's medical history. Measles, rubella, polio and tetanus toxoid 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). Adaptive physical education is available for the partially disabled student. Documentation and description of the disability is most helpful to us.**

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: | YES   | NO    |
|----------------------------------|-------|-------|
| Intercollegiate athletics        | _____ | _____ |
| Intramurals                      | _____ | _____ |
| Physical Education               | _____ | _____ |
| ROTC                             | _____ | _____ |

SIGNATURE OF PHYSICIAN \_\_\_\_\_  
PRINT NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE (include area code) \_\_\_\_\_  
DATE \_\_\_\_\_