

Complete & Return To:
 Indiana Tech
 Attn: Athletic Trainer
 1600 E. Washington Blvd.
 Fort Wayne, IN 46803

INDIANA TECH

Pre-Participation Physical Examination

Student's Name (Print) _____ Sport _____ Date _____

Soc. Sec. # ____ / ____ / ____ Date of Birth _____ Gender M / F Year of Eligibility 1 2 3 4 5

School Address _____ School Phone _____
 Dorm or Street City State Zip Code

Parent/Guardian Name _____ Parent/Guardian Phone _____

Parent/Guardian Address _____ Emergency Contact _____
 Street City State Zip Code

Emergency Contact Phone _____ Relationship to You (Circle One) Friend / Relative

Medical History Questionnaire:
Please check yes or no for ALL Questions. Comment on all YES answers with as much detail as possible.

Have you ever had or do you now have:	Y	N	Comments (please include dates)
Dizziness during or after exercise?	()	()	_____
Chest Pain during or after exercise?	()	()	_____
Wheezing or coughing with exercise?	()	()	_____
Passed out due to exercise?	()	()	_____
Weakness or fatigue?	()	()	_____
Headaches or migraines?	()	()	_____
Frequent anxiety, depression, insomnia?	()	()	_____
Loss of function or absence of kidney, testicle, eye?	()	()	_____
Have you ever?			
Broken a bone?	()	()	_____
Been hospitalized for illness or injury?	()	()	_____
Had surgery?	()	()	_____
Had heat exhaustion?	()	()	_____
Lost consciousness or been "knocked -out"?	()	()	_____
Had a concussion?	()	()	_____
Had convulsions (seizures)?	()	()	_____
Had a "stinger" or "burner"?	()	()	_____
Has a Physician ever diagnosed you with?			
Heart murmur or irregular heart beat?	()	()	_____
Fast heart rate?	()	()	_____
High blood pressure?	()	()	_____
Diabetes?	()	()	_____
Asthma?	()	()	_____
Hernia?	()	()	_____
Anemia?	()	()	_____
Hearing loss?	()	()	_____
Impaired vision?	()	()	_____
Mental condition?	()	()	_____
Do you currently use?			
Chewing tobacco or cigarettes?	()	()	_____
Marijuana?	()	()	_____
Alcohol?	()	()	_____

Have you ever used?	Y	N	Comments
Steroids?	()	()	_____
Recreational drugs?	()	()	_____
Have you ever used?			
Weight loss pills?	()	()	_____
Energy pills?	()	()	_____
Creatine?	()	()	_____
Other nutritional supplements?	()	()	_____

List any current medications (include birth control pills, inhalers, supplements, vitamins, and over-the-counter meds)

List any allergies: _____

When was your last tetanus shot? _____ Within 5 years? Yes No Within 10 years? Yes No

Orthopaedic Questionnaire	Y	N	Comments
Have you ever had a neck injury?	()	()	_____
If yes, provide dates and details.			_____
Have you ever had back pain?	()	()	_____
If yes, provide dates and details.			_____
Have you ever had a knee injury?	()	()	R L _____
If yes, did you have surgery?	()	()	_____
Provide dates and details.			_____
Have you ever had a shoulder injury?	()	()	R L _____
If yes, did you have surgery?	()	()	_____
Provide dates and details.			_____
Have you ever had an ankle injury?	()	()	R L _____
If yes, provide dates and details.			_____
Have you ever had an elbow injury?	()	()	R L _____
If yes, provide dates and details.			_____
Have you ever worn a special brace, Orthotics, or needed padding for an injury?	()	()	_____

Females ONLY: Have you had or do you currently have irregularities or absence of menses? () () _____

Physical Examination
(To be completed by physician)

Name _____ Date _____ Sport _____

Height _____ Weight _____ Blood Pressure _____ Pulse Rate _____ b.p.m.

Vision	R 20/_____	L 20/_____	Corrected? Yes No	Comments
	Normal	Abnormal		
HEENT	()	()		_____
Cardiac	()	()		_____
Respiratory	()	()		_____
Skin	()	()		_____
Liver	()	()		_____
Spleen	()	()		_____
Genitalia	()	()		_____
Musculo-skel.	()	()		_____

Other: _____

I certify that on this date, with the medical history furnished to me, I found no reason to deny this student participation in intercollegiate athletics at Indiana Tech.

Date: _____ Name of physician: _____ Signature: _____

Phone: _____

SPORT ONE

ORTHO NORTHEAST

Consent to Treat

I hereby authorize medical treatment for said athlete at _____ (School Name) by the athletic trainers, physicians, and staff of Orthopaedics Northeast, P.C. A family member can be reached at _____ in the case that additional treatment or information is required. I understand that if the said athlete is seen by a physician at Orthopaedics Northeast, P.C. and my insurance requires prior approval, I will be responsible for notifying my family physician.

Student Name _____

Student Signature _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Student Date of Birth _____

Authorization for Release of Medical Information

I also hereby authorize the release of any and all information regarding any medical treatment received by me for injury or illness while participating in athletics at said educational institution to that institution' Athletic Training staff, which consist of employees of Orthopaedics Northeast. I expressly authorize communications between the athletic trainer(s), or any designated member of the athletic training staff, and physicians at Orthopaedics Northeast, or any other physician or health care professional regarding my physical condition as it relates to my participation in athletics at said institution. I also authorize the athletic training staff to release said information to said institution's administration and to my current coaching staff for the purpose of informing them of my playing status.

If I am over 18: I authorize the athletic training staff to release my medical information to my parent(s)/guardian(s).

If I am younger than 18: As the parent/legal guardian, I authorize the athletic training staff to release my minor athlete's medical information to my minor athlete.

Orthopaedics NorthEast employees may disclose information to the aforementioned individuals; however, this does not prevent those individuals from disclosing the information further, and Orthopaedics NorthEast will not be held responsible for such further disclosure of information.

This authorization is valid until and unless revoked by me in writing. A photocopy of this authorization shall be considered as valid as the original.

Student Name _____

Student Signature _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Orthopaedics NorthEast HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Orthopaedics Northeast ("ONE") Notice of Privacy Practices has been provided to me, or I have accessed it electronically. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge **only** that I have received ONE Notice of Privacy Practices. The Notice of Privacy Practices for ONE is also provided at the front desk at all of our offices and on the ONE web site at www.Orthone.com.

ONE reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the ONE web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Student Name _____

Student Signature _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Student-Athlete Acknowledgement Form

The undersigned herewith formally acknowledges and declares the following:

I understand that participation in Intercollegiate Athletics at Indiana Tech may result in injury/illness, permanent physical or mental impairment or even death. I understand that Indiana Tech cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that participation in athletics require a personal acceptance of risk of injury. I acknowledge the fact that these risks exist and I am willing to assume responsibility for any and all such risks while participating in Intercollegiate Athletics at Indiana Tech. I also agree to the following:

- A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics at Indiana Tech.
- B. I accept that Indiana Tech and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have.
- C. I understand that having passed a physician's physical examination does not necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at Indiana Tech, but only that the evaluator(s) did not find a medical reason to **disqualify** me at the time of examination.
- D. I understand that I must refrain from practice while injured or ill, whether or not receiving medical care. When under medical care, I may not return to participation until I have been given permission, based on independent exercise of professional judgment, by the attending Team Physician(s) or his/her designate after review of my condition and fitness for the rigors of my sport.
- E. I understand and agree that if I experience an injury/illness or change in my health status it is **my** responsibility to inform my Head Coach and the Certified Athletic Trainer and adhere to the established injury management guidelines, which include rehabilitation and reassessments before I am released to return to full participation. I also understand that if the Certified Athletic Trainer does not receive timely notification (30 days) of my injury/illness I may lose the ability to utilize Indiana Tech's excess athletic insurance coverage. Failure to notify the Certified Athletic Trainer will jeopardize my ability to have medical care claims covered by Indiana Tech's athletic insurance coverage. The remaining balance may/will be the responsibility of the student-athlete or their legal guardian if timely notification followed.
- F. By signing below, I authorize the team physician, athletic trainer, an/or other medical personnel at Indiana Tech to release information on medical history, records of injury, surgery, illness, and results of rehabilitation as requested by the schools insurance carrier and/or by authorized Indiana Tech staff. I understand this information is confidential and will not be released to individuals other than the fore mentioned without my prior consent.

I HAVE READ, UNDERSTAND, AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS

Student-Athlete's Printed Name

Sport

Signature

Date

Parent/Guardian Signature (if under 18 years of age)