Try-out Policy

Required Documents:
Prior to any University of Colorado athletics team try-out, each student must provide the following information and documentation to the respective sport's athletic trainer for review. Failure to provide the required information prior to the given **deadline (January 15th Meeting)** will preclude their ability to participate in the try-out. Falsifying or failure to disclose all prior medical history is subject for try-out denial and/or future dismissal.

1) Completed Medical History packet provided by CU Sports Medicine
2) A physical completed by a physician no more than 6 months prior to the tryout date
3) Copy of a current and verified primary insurance card
4) Results of Sickle Cell Trait screen and H&H (Bring with you do not fax them)
5) Completed Try-Out Waiver
6) Any surgical notes including freshman year of high school to present day.

Once reviewed and cleared, these documents will be kept by the athletic trainer for 7-10 years.

Clearance:
Based on review of the required information provided, the University of Colorado possesses the right to approve or deny try-out clearance in the best interest of the student and/or the University of Colorado. If cleared, the athletic trainer will sign the student's compliance form giving them medical clearance to participate. If not cleared, the student will be given an explanation and team's representative and compliance will be notified.

Coverage:
Student participation on the day of the try-out is to be regulated and controlled by the team's representative in charge of the try-out and should be done so through proper clearance and approval from the compliance office.
During all University of Colorado athletics team try-outs, a certified athletic trainer will present for the entirety of the try-out to act a first responder in the event of an injury or illness. Water, first-aid/emergency equipment will be available for all participants.

Assumption of Risk & Treatment:
The student assumes all risks of personal injury (including death) that may result from any try-out activity. However, in the event of an injury or illness, the student gives consent for medical treatment and permission to the covering athletic trainer to administer and/or supervise on-site first-aid for minor injuries and/or to a licensed physician to hospitalize for more severe injuries or illnesses.

Addition to the Roster
Medical clearance for the try-out does not equate medical clearance to be added to the roster. Prior to addition to the roster, the student must first go through medical clearance by University of Colorado sports medicine staff, and must complete pre-participation baseline evaluations. If further tests or imaging is required for clearance, the student will be responsible for scheduling of those appointments as well as all bills incurred.

Sport Specific Restrictions:
Each sport should follow and mirror NCAA acclimation recommendations as well as a joint collaboration agreement with the coaching staff, sports performance staff, and sports medicine staff in the best interest of the student and the University of Colorado.

UNIVERSITY OF COLORADO ATHLETIC INJURY MEDICAL INFORMATION

Athlete's Name ______________________ ______________________ ____________
Last Name First Name Sport

The University of Colorado Department of Intercollegiate Athletics is dedicated to promoting outstanding medical care for our student-athletes including prevention, evaluation, referral, treatment, and rehabilitation of injuries or illnesses sustained during practice or competitions.

ELIGIBILITY FOR ATHLETIC PARTICIPATION

All students who wish to participate in intercollegiate athletic activities including practices, weight training, and conditioning sessions must be medically cleared by the CU Sports Medicine Department before being permitted to begin workouts. The clearance process includes a physical examination conducted by a CU team physician. Medical clearance is in effect as long as the student-athlete is actively competing in intercollegiate athletics; however, the Sports Medicine Department may re-examine and modify the athlete's medical eligibility status at any time.

Students are required to answer truthfully and completely regarding any and all injuries. They are also required to report any and all chronic conditions and/or any episodes of illness due to infectious disease. The student may be asked to supply additional information or documentation prior to being permitted to participate as an athlete at CU.

Failure to report previous injuries, illnesses or conditions relieves the University of Colorado of any and all liability in the event of re-injury or aggravation of the original injury or illness.

Previous loss of one of any paired organs (eye, kidney, testicles, etc.) may disqualify the athlete from participation in an intercollegiate team sponsored by the CU Athletics Department unless the athlete receives written permission to participate from their family (if under 18 years of age) and permission from the CU team physician.

RESPONSIBILITY OF STUDENT-ATHLETES

The following procedures must be followed for an athlete to access medical care through the CU Sports Medicine Department:

1. In the event of an injury during practice or competition, no matter how slight, the athlete **must** report immediately to the athletic trainer of that sport. The athletic trainer will initiate the appropriate care.
2. Referral to specialists will be made **ONLY** by a University of Colorado sports medicine staff member.
   a. **Any individual who seeks medical care without written referral from the team physician or staff athletic trainer will be financially responsible for all bills incurred for that procedure.**
   b. If an individual chooses not to consult his/her athletic trainer to obtain authorization for outside services or surgeries on an athletic-related injury, the initial rehabilitation may not be conducted within the Sports Medicine Department and may be entirely the financial responsibility of the student-athlete.
3. Any conditions identified as pre-existing on the medical history form will be discussed with the student-athlete at the initial physical exam.
   a. The CU Athletics Department may NOT be financially responsible for medical treatments related to pre-existing injuries, surgeries, illnesses or conditions. Each case will be reviewed on an individual basis by CU Sports Medicine staff members, including a CU Team Physician and the Head Athletic Trainer.
   b. Failure to report pre-existing injuries or illnesses relieves the University of Colorado of any and all liability and may result in a medical disqualification of athletic scholarship and/or from intercollegiate athletics.

UNIVERSITY OF COLORADO HEALTH INSURANCE POLICY

The University of Colorado requires all students to carry comprehensive health insurance while attending the University of Colorado Boulder. Athletes must provide proof of health insurance to the Sports Medicine Program. If a student does not have other insurance coverage they can purchase the student health insurance plan offered by Wardenburg Health Center. Students are encouraged to investigate the available options and to ask questions, if necessary. If a student-athlete's insurance changes

during the year, it is his/her responsibility to provide the Sports Medicine Department with current information. Failure to do so may result in denial of payment of medical bills.

Foreign Traveler's Insurance Policy

Although the University of Colorado recognizes a foreign traveler's insurance policy as adequate coverage, international students often have complications with these policies. Many foreign insurance carriers' only cover medical expenses for situations they deem emergent. In addition, many local medical providers do not file claims to insurance companies outside the United States. To expedite payment with a foreign traveler's insurance company, it is necessary for the athlete to obtain a phone number and address within the United States for claims. If a phone number and address for claims in the United States is unattainable, please be aware that it will be the athlete's responsibility to contact the insurance company in order to process payments. If the health care provider is unable to bill the foreign traveler's insurance company, all medical bills will be directed to the student-athlete for payment. They may be expected at this time to pay all medical expenses out of pocket, while seeking reimbursement from their insurance company.

ATHLETIC DEPARTMENT MEDICAL EXPENSE POLICY

Routine medical care for student-athletes is provided by Sports Medicine staff members in athletic training rooms located in the Champions Center, Coors Event Center, and Dal Ward. If an injury requires evaluation or treatment not available in the athletic training room, the student-athlete may be referred to Wardenburg Health Center or an appropriate off-campus provider. A referral form will be given to the student-athlete documenting the reason for the referral, the athlete's demographic information and his/her insurance information. In the event that a student-athlete does not follow the correct procedures to obtain a referral prior to obtaining care, he/she may be financially responsible for the charges. The Athletics Department will not cover any portion of the costs for unauthorized medical care, whether at Wardenburg Health Center or an off-campus facility.

All medical expenses for off-campus providers will be billed by that provider to the athlete's primary insurance company for payment. The Athletics Department will only pay for patient balances related to medical care for injuries after the student's primary insurance plan has processed the bill(s). In order to expedite payment related to an athletic-related injury, all payments and/or denials from an athlete's primary insurance MUST be directly forwarded to:

Attn: Mary Ellen O'Malley
University of Colorado Sports Medicine
UCB 368
Boulder CO 80309-0368
Fax: 303-492-4217
Phone: 303-492-1448

The annual Sports Medicine insurance packet is mailed to each athlete in May or June. Careful review of this packet is strongly suggested. It includes four forms that must be completed and returned to the Sports Medicine Department before participating in any practices or workouts: Health Insurance Information Form, Authorization Form, Checklist, and Wardenburg Acknowledgement Form. Please contact your athletic trainer if you do not receive this packet by July.

UNIVERSITY OF COLORADO SPORTS MEDICINE

I have read the University of Colorado Sports Medicine injury and medical policy, including the pre-existing injury, failure to report pre-existing injury and insurance coverage and claim procedures. I understand that failure to disclose any and all medical problems and/or to provide an accurate medical history may result in forfeiture of athletic aid and compromise my medical eligibility. I understand and agree with the coverage and procedures outlined and have forwarded this information to my parents and/or legal guardian for their awareness. I understand if I do not follow the correct procedure for obtaining medical care, I may be responsible for payment of my medical bills.

______________________ **Date** __________
Athlete's Signature

______________________ **Date** __________
If under 18, Parents or Legal Guardian Signature

UNIVERSITY OF COLORADO INCOMING PRE-PARTICIPATION MEDICAL HISTORY

Please print clearly and complete the following questionnaire to the best of your knowledge.

Today's Date	Academic Year (i.e. 2010-11)	Sport

ATHLETE INFORMATION

Athlete's Name		☐ Freshmen ☐ Sophomore ☐ Junior ☐ Senior ☐ 5th Year	
Student ID Number	Email Address		Birth Date
Boulder Address	City	State	ZIP Code
Permanent Address	City	State	ZIP Code
Home Phone Number ( )	Mobile Phone Number ( )		
Team Status	☐ Scholarship Athlete ☐ Invited Walk-On	☐ Walk-On	☐ Practice Player

EMERGENCY CONTACT

Name	Relationship	Home #	Work #

PERSONAL MEDICAL HISTORY

Medications: Are you currently taking any *PRESCRIBED* or over the counter medications? Please include birth control pills, insulin, allergy shots/pills, asthma inhalers, anti-depressants, anti-inflammatories, medications for ADD/ADHD, etc.

Name	Dose (Strength)	How many times daily &/or weekly	Reason

Do you have ALLERGIES to the following?

Over-the-counter and/or prescription medications	Yes ☐	No ☐	Explain Reaction
Foods	Yes ☐	No ☐	Explain Reaction
Insects or animals	Yes ☐	No ☐	Explain Reaction
Plants, grasses, pollens, dust or environmental factors	Yes ☐	No ☐	Explain Reaction
Latex, iodine, tape or other allergies	Yes ☐	No ☐	Explain Reaction
Other	Yes ☐	No ☐	Please specify

Do you have any *CURRENT* or *CHORNIC* medical conditions for which you have seen a physician for on a regular basis?

Date diagnosis	*Condition*	Physician Name	
Treatment		Contact Number	
Date diagnosis	*Condition*	Physician Name	
Treatment		Contact Number	

Do you wear any special protective or corrective equipment or devices to participate in your sport? (i.e. braces, goggles, etc.)

Device	Please specify
Device	Please specify

Has a physician ever diagnosed with any of the following medical problems, and/or symptoms? If yes, please specify below.

Measles	Yes ☐	No ☐	Neuritis	Yes ☐	No ☐	Blood in urine	Yes ☐	No ☐
Mumps	Yes ☐	No ☐	Stomach or Intestinal Ulcer	Yes ☐	No ☐	Nervousness	Yes ☐	No ☐

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Whooping Cough	Yes ☐	No ☐	Hernia	Yes ☐	No ☐	Hearing loss	Yes ☐	No ☐
Diphtheria	Yes ☐	No ☐	Colitis	Yes ☐	No ☐	Frequent nose bleeds	Yes ☐	No ☐
Typhoid Fever	Yes ☐	No ☐	Bowel Disease	Yes ☐	No ☐	Swollen feet/ankles	Yes ☐	No ☐
Pleurisy	Yes ☐	No ☐	Abnormal Bleeding	Yes ☐	No ☐	Chronic cough	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Kidney Injury/Disease	Yes ☐	No ☐	Unexplained weight loss	Yes ☐	No ☐
Mononucleosis	Yes ☐	No ☐	Blood clot or Embolisms	Yes ☐	No ☐	Frequent headaches	Yes ☐	No ☐
Injury to Spleen	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐	Hoarseness	Yes ☐	No ☐
Meningitis	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐	Poor appetite	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐	Chronic Sinusitis	Yes ☐	No ☐	Dizziness	Yes ☐	No ☐
Jaundice/Hepatitis	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Frequent Heartburn	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Pneumothorax	Yes ☐	No ☐	Frequent diarrhea	Yes ☐	No ☐
Gall Bladder Disease	Yes ☐	No ☐	Paralysis	Yes ☐	No ☐	Frequent indigestion	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Irregular bowels	Yes ☐	No ☐	Memory loss	Yes ☐	No ☐
Hepatitis &/or HIV	Yes ☐	No ☐	Bloody, clay colored stools	Yes ☐	No ☐	Loss of consciousness	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Frequent urination	Yes ☐	No ☐			
Hives	Yes ☐	No ☐	Difficulty swallowing	Yes ☐	No ☐			

Year	Reason

Have you had any previous surgeries? If yes, please specify.

Year	Reason/Procedure	Hospital/Surgeon

Have you ever been hospitalized? If yes, please specify.

Year	Reason	Hospital/Physician

Question	Yes	No	
Have you ever had a blood transfusion?	Yes ☐	No ☐	Please specify
Have you ever had a heat illness?	Yes ☐	No ☐	Please specify
Have you been tested and/or diagnosis for Sickle Cell Trait?	Yes ☐	No ☐	Please specify
Are you missing any paired organs (kidney, ovary)?	Yes ☐	No ☐	Please specify
Have you been anemic?	Yes ☐	No ☐	Please specify

	Question	Yes	No
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No

	Are you prone to "binge" drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you taken or currently use performance-enhancing drugs?	☐ Yes	☐ No

RESPIRATORY MEDICAL HISTORY

Have you ever experienced the following?

Difficulty breathing more than usual	Yes ☐	No ☐	Please specify
Wheezing before, during and after exercise	Yes ☐	No ☐	Please specify

Do you or have you ever used an inhaler? Yes ☐ →please specify No ☐

Name	When	How many times daily &/or weekly
Reason		

Have you had a pulmonary function test? Yes ☐ →please specify No ☐

Year	Reason	Physician

CARDIAC MEDICAL HISTORY

During or after exercise, have you ever experienced the following?

Dizziness	Yes ☐	No ☐	Please specify
Light headedness	Yes ☐	No ☐	Please specify
Passed out or fainted	Yes ☐	No ☐	Please specify
Chest pain, discomfort, or tightness	Yes ☐	No ☐	Please specify

Have you been told by a physician that you or anyone in your family have any of the following?

History of heart disease	Yes ☐	No ☐	Please specify
Heart Murmur	Yes ☐	No ☐	Please specify
Racing, irregular or skipping heartbeat, specialty at rest or with activity	Yes ☐	No ☐	Please specify
High Cholesterol	Yes ☐	No ☐	Please specify
Marfan Syndrome	Yes ☐	No ☐	Please specify
Heart Defect	Yes ☐	No ☐	Please specify
High Blood Pressure	Yes ☐	No ☐	Please specify
Low Blood Pressure	Yes ☐	No ☐	Please specify
Pericarditis, Myocarditis, or Endocarditis	Yes ☐	No ☐	Please specify
Rheumatic Fever	Yes ☐	No ☐	Please specify
Other Heart and/or Vascular problems	Yes ☐	No ☐	Please specify

Have you had any medical tests for your heart?

EKG	Yes ☐	No ☐	Please specify
Echocardiogram	Yes ☐	No ☐	Please specify

Have you ever been restricted from participation? Yes ☐ →please specify No ☐

Date	Please specify

HEAD AND NEUROLOGICAL MEDICAL HISTORY

Head Concussion	Yes ☐ No ☐	If yes, how many times?
Knocked unconscious or "DINGED"	Yes ☐ No ☐	If yes, how many times and for how long?
Long-term problems due to head injury, such as memory loss, headaches, dizziness, and/or nausea?	Yes ☐ No ☐	If yes, specify
Have you had numbness, tingling, or weakness in the following areas: • Shoulder • Buttocks • Legs &/or Feet	Yes ☐ No ☐	If yes, specify
Burner or stinger	Yes ☐ No ☐	Please specify
Seizure or epilepsy	Yes ☐ No ☐	Please specify
Migraine headaches	Yes ☐ No ☐	Please specify

VISION MEDICAL HISTORY

Have you had a serious eye injury?	Yes ☐ No ☐	Please specify
When was your last eye exam?	Date	Results
Do you wear glasses or contacts when you train or compete?	Yes ☐ No ☐	Please specify
Are you legally blind in either eye?	Yes ☐ No ☐	Please specify
Do you wear protective eyewear for your sport?	Yes ☐ No ☐	Please specify
Have you had any other problems with your eyes and/or vision?	Yes ☐ No ☐	Please specify

WOMEN MEDICAL HISTORY

At what age did your menstrual cycle start?	Date	Any problems
When was your most recent menstrual cycle?	Date	Any problems
Are you currently taking any female hormones, such as estrogen, progesterone, or birth control for regulating your period?	Yes ☐ No ☐	If yes, specify
When was your last pelvic exam and pap smear?	Date	Results
Have you ever been diagnosed with stress reaction or stress fracture?	Yes ☐ No ☐	Please specify
Have you had a bone scan or MRI to rule out a stress fracture?	Yes ☐ No ☐	Please specify
Have you ever had a bone density or DEXA scan to check the quality of your bones?	Yes ☐ No ☐	Please specify

In the past 12 months have you had any of the following?

Trouble with heavy menstrual bleeding	Yes ☐ No ☐	Please specify	
Bleeding between periods	Yes ☐ No ☐	Please specify	
Menstrual cramps/pain which affected your school or athletic performance	Yes ☐ No ☐	Please specify	
On an average how long has each period lasted?		Days	Week
How many periods have you had in the past 12 months?		Please specify	
Longest time from one period to the next?		Please specify	
Have you ever gone more than 3 months between periods?	Yes ☐ No ☐	If yes, specify	

MEN MEDICAL HISTORY

Do you feel pain or burning with urination?	Yes ☐ No ☐	Please specify
Any blood in your urine?	Yes ☐ No ☐	Please specify
Have you noted any discharge from penis?	Yes ☐ No ☐	Please specify

Has the force of your urination decreased?	Yes ☐ No ☐	Please specify	
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes ☐ No ☐	Please specify	
Do you have any problems emptying your bladder completely?	Yes ☐ No ☐	Please specify	
Any testicular torsion, pain or swelling?	Yes ☐ No ☐	Please specify	
NUTRITIONAL HISTORY			
Are you satisfied with your body weight?	Yes ☐ No ☐	Please specify	
Do you feel that you need to gain or lose body weight?	Yes ☐ No ☐	Gain lbs	Lose lbs
What was your highest and lowest weight over the past year?		Highest	Lowest
Do you have an "ideal range" competition weight?	Yes ☐ No ☐	If yes, specify	
After the traditional competitive season and your training has reduced, do you lose or gain weight?		Lose Yes ☐ No ☐ lbs	Gain Yes ☐ No ☐ lbs
Do you consciously watch your weight?	Yes ☐ No ☐	Please specify	
Do you restrict your food intake to be at your competitive weight?	Yes ☐ No ☐	Please specify	
Have you ever eaten a large amount of food rapidly and felt that this eating incident was excessive and out of control?	Yes ☐ No ☐	Please specify	
Have you ever purged (vomited, used laxatives and/or diuretics) to control your weight?	Yes ☐ No ☐	Please specify	
Do you think your eating habits are unusual?	Yes ☐ No ☐	Please specify	
Are there certain foods or food groups that you forbid yourself to eat?	Yes ☐ No ☐	Please specify	
Have you ever dieted?	Yes ☐ No ☐	If yes, at what age did you start dieting?	
Are you a vegetarian or vegan?	Yes ☐ No ☐	Please specify	
Do you eat red meat?	Yes ☐ No ☐	Please specify	
Do you take an iron, calcium, vitamin D supplement?	Yes ☐ No ☐	Please specify	
Do you have or have you ever been diagnosed and/or treated with an eating disorder?	Yes ☐ No ☐	Please specify	

Since you've been involved in your sport, have you ever felt encouraged to engage in any of the following behaviors by people you know?

Binge eating	Yes ☐ No ☐	Please specify
Purging	Yes ☐ No ☐	Please specify
Limiting calories	Yes ☐ No ☐	Please specify
BEHAVIORAL HEALTH HISTORY		
Have you ever been diagnosed with a mental health disorder?	Yes ☐ No ☐	Please specify
Is stress a major problem for you?	Yes ☐ No ☐	Please specify
Do you feel depressed?	Yes ☐ No ☐	Please specify
Do you panic when stressed?	Yes ☐ No ☐	Please specify
Do you have problems with eating or your appetite?	Yes ☐ No ☐	Please specify
Do you cry frequently?	Yes ☐ No ☐	Please specify
Have you ever attempted suicide?	Yes ☐ No ☐	Please specify
Have you ever seriously thought about hurting yourself?	Yes ☐ No ☐	Please specify
Do you have trouble sleeping?	Yes ☐ No ☐	Please specify

Have you ever visited with a counselor?	Yes ☐ No ☐	Please specify
Do you have any other mental health issues, which required services of a mental health provider?	Yes ☐ No ☐	Please specify
Would you like to schedule an appointment with a mental health professional?	Yes ☐ No ☐	Please specify

FAMILY MEDICAL HISTORY

For each full-blooded relative listed, please indicate if they have a history of the following (do not include adoptive, step, or foster relatives). If yes, please specify below. **☐ Check if you are adopted.**

High Blood Pressure	Yes ☐ No ☐	Sickle Cell Trait	Yes ☐ No ☐	Blood Clotting Disorder	Yes ☐ No ☐
Heart attack before the age of 50	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Mental Health Illness	Yes ☐ No ☐
Other Heart Problems	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Seizures or Epilepsy	Yes ☐ No ☐
Marfan Syndrome	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Drug and/or Alcohol Dependency	Yes ☐ No ☐
High Cholesterol	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Additional family medical issues	Yes ☐ No ☐
Sudden or unexplained death before the age of 50	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	Stroke before the age of 50	Yes ☐ No ☐

Medical problem selected	Family Member	Medical condition

Do you have any personal beliefs that would prevent you from seeing a physician or taking medication?

Yes ☐ No ☐	Please specify

ORTHOPEDIC MEDICAL HISTORY

Please indicate if you have or had any of the injuries listed below.
If your injury is not listed please indicate in the OTHER box at the end of each section.

NECK AND BACK MEDICAL HISTORY

Facet disorder or disc disease	Yes ☐ No ☐ Date	Please specify
Traumatic or stress fracture	Yes ☐ No ☐ Date	Please specify
Whiplash injury	Yes ☐ No ☐ Date	Please specify
Burner or stinger	Yes ☐ No ☐ Date	Please specify
Congenital deformity	Yes ☐ No ☐ Date	Please specify
Back pain or stiffness	Yes ☐ No ☐ Date	Please specify
Spondyloysis	Yes ☐ No ☐ Date	Please specify
Spondylolisthesis	Yes ☐ No ☐ Date	Please specify
Sacroiliac disorder	Yes ☐ No ☐ Date	Please specify
Sciatica	Yes ☐ No ☐ Date	Please specify
Scoliosis	Yes ☐ No ☐ Date	Please specify
Surgery	Yes ☐ No ☐ Date	Please specify
Other, pain or swelling	Yes ☐ No ☐ Date	Please specify

SHOULDER GIRDLE, CLAVICLE AND UPPER ARM MEDICAL HISTORY

Traumatic or Stress Fracture	Yes ☐ No ☐ Date	Please specify
Subluxation or Dislocation	Yes ☐ No ☐ Date	Please specify
Muscle Strain	Yes ☐ No ☐ Date	Please specify

Ligament Sprain	Yes ☐ No ☐ Date	Please specify
Tendonitis or Bursitis	Yes ☐ No ☐ Date	Please specify
Impingement	Yes ☐ No ☐ Date	Please specify
Rotator Cuff Injury	Yes ☐ No ☐ Date	Please specify
Acromioclavicular (AC) Sprain or Instability	Yes ☐ No ☐ Date	Please specify
Shoulder joint instability	Yes ☐ No ☐ Date	Please specify
Cortisone Injection	Yes ☐ No ☐ Date	Please specify
Surgery	Yes ☐ No ☐ Date	Please specify
Other, pain or swelling	Yes ☐ No ☐ Date	Please specify
ELBOW, FORARM, HAND WRIST AND FINGER MEDICAL HISTORY		
Traumatic or Stress Fracture	Yes ☐ No ☐ Date	Please specify
Subluxation or Dislocation	Yes ☐ No ☐ Date	Please specify
Muscle Strain	Yes ☐ No ☐ Date	Please specify
Ligament Sprain	Yes ☐ No ☐ Date	Please specify
Tendonitis or Bursitis	Yes ☐ No ☐ Date	Please specify
Elbow joint instability	Yes ☐ No ☐ Date	Please specify
Cortisone Injection	Yes ☐ No ☐ Date	Please specify
Surgery	Yes ☐ No ☐ Date	Please specify
Other, pain or swelling	Yes ☐ No ☐ Date	Please specify
PELVIS, HIP AND THIGH MEDICAL HISTORY		
Traumatic or Stress Fracture	Yes ☐ No ☐ Date	Please specify
Subluxation or Dislocation	Yes ☐ No ☐ Date	Please specify
Muscle Strain (Groin, Hamstring, Quad)	Yes ☐ No ☐ Date	Please specify
Tendonitis or Bursitis	Yes ☐ No ☐ Date	Please specify
Severe Contusion or Hip Pointer	Yes ☐ No ☐ Date	Please specify
Cortisone Injection	Yes ☐ No ☐ Date	Please specify
Surgery	Yes ☐ No ☐ Date	Please specify
Other, pain or swelling	Yes ☐ No ☐ Date	Please specify
KNEE MEDICAL HISTORY		
ACL, MCL, PCL, LCL Tear or Repair/Reconstruction	Yes ☐ No ☐ Date	Please specify
Meniscus Injury, Repair, or Menisctomy	Yes ☐ No ☐ Date	Please specify
Patella Dislocation	Yes ☐ No ☐ Date	Please specify
Patella Femoral Syndrome	Yes ☐ No ☐ Date	Please specify
Tendonitis or Bursitis	Yes ☐ No ☐ Date	Please specify
IT Band Syndrome	Yes ☐ No ☐ Date	Please specify
Swelling / Pain	Yes ☐ No ☐ Date	Please specify
Locking or Instability (giving away)	Yes ☐ No ☐ Date	Please specify
Cortisone Injection	Yes ☐ No ☐ Date	Please specify

Surgery	Yes ☐ No ☐	Date	Please specify
Other, pain or swelling	Yes ☐ No ☐	Date	Please specify
LOWER LEG OR ANKLE MEDICAL HISTORY			
Traumatic or Stress Fracture	Yes ☐ No ☐	Date	Please specify
Subluxation or Dislocation	Yes ☐ No ☐	Date	Please specify
Muscle Strain	Yes ☐ No ☐	Date	Please specify
Reoccurring Sprains	Yes ☐ No ☐	Date	Please specify
Tendonitis or Bursitis (Achilles)	Yes ☐ No ☐	Date	Please specify
Chronic Instability	Yes ☐ No ☐	Date	Please specify
Shin Splints	Yes ☐ No ☐	Date	Please specify
Compartment Syndrome	Yes ☐ No ☐	Date	Please specify
Bone chip or bone spur in joint	Yes ☐ No ☐	Date	Please specify
Cortisone Injection	Yes ☐ No ☐	Date	Please specify
Surgery	Yes ☐ No ☐	Date	Please specify
Other, pain or swelling	Yes ☐ No ☐	Date	Please specify
FOOT OR TOE MEDICAL HISTORY			
Traumatic or Stress Fracture	Yes ☐ No ☐	Date	Please specify
Subluxation or Dislocation	Yes ☐ No ☐	Date	Please specify
Muscle Stain	Yes ☐ No ☐	Date	Please specify
Tendonitis	Yes ☐ No ☐	Date	Please specify
Instability or Dislocation	Yes ☐ No ☐	Date	Please specify
Bone chip or bone spur in joint	Yes ☐ No ☐	Date	Please specify
Plantar Fasciitis	Yes ☐ No ☐	Date	Please specify
Sesmoiditis	Yes ☐ No ☐	Date	Please specify
Cortisone Injection	Yes ☐ No ☐	Date	Please specify
Surgery	Yes ☐ No ☐	Date	Please specify
Other, pain or swelling	Yes ☐ No ☐	Date	Please specify

UNIVERSITY OF COLORADO SPORTS MEDICINE

This form will be reviewed by a team physician and athletic training staff member. It will placed in your permanent medical file at the University of Colorado after being reviewed by a CU Team Physician and Athletic Training staff. By signing below, I agree this information is true and accurate to the best of my knowledge. I understand failure to disclose any or all medical problems and/or accurate medical history may result in forfeiture of my athletic aid and relieves the University of Colorado of any and all liability.

_______________________________________ *Signature of Student-Athlete*

_______________ *Date of Signature*

_______________________________________ *Signature of Parent/Legal Guardian (If under 18 years of age)*

_______________ *Date of Signature*

Final Review by Team Physician Initials: ________

UNIVERSITY OF COLORADO ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM

Today's Date		Sport
Athlete's Name		Academic Year
☐ Female ☐ Male	Student ID Number	Date of Birth

PRELIMINARY SCREENING

Height	Weight Lbs	Vision ☐ Corrected ☐ Uncorrected Right 20/		Left 20/
Blood Pressure (sitting)	/ Date	/ Date	/ Date	Pulse bpm

LAB RESULTS

Hgb/Hct	☐ Normal ☐ Abnormal	Findings
Sickle Cell Trait or Disorder	☐ Negative ☐ Positive	Findings
Anemia Profile	☐ Normal ☐ Abnormal	Findings

CLINICAL EVALUATION

Appearance	☐ Normal ☐ Abnormal	Findings
Skin	☐ Normal ☐ Abnormal	Findings
Eyes, Ears, Nose, Throat	☐ Normal ☐ Abnormal	Findings
Hearing	☐ Normal ☐ Abnormal	Findings
Lymph Nodes	☐ Normal ☐ Abnormal	Findings
Heart	☐ Normal ☐ Abnormal	Findings
Murmurs	☐ Negative ☐ Positive	Findings
Pulse incl. femoral	☐ Normal ☐ Abnormal	Findings
Lungs	☐ Normal ☐ Abnormal	Findings
Abdomen	☐ Normal ☐ Abnormal	Findings
Genitourinary (males only)	☐ Normal ☐ Abnormal	Findings
Neurological	☐ Normal ☐ Abnormal	Findings

MUSCULOSKELETAL – SEE ORTHOPEDIC MEDICAL HISTORY

TO BE COMPLETED BY EVALUATING PHYSICIAN

☐ General Medical ☐ Orthopedic	Athlete is **CLEARED** for full athletic participation at the University
☐ General Medical ☐ Orthopedic	Athlete is **NOT CLEARED** for full athletic participation at the University
☐ General Medical ☐ Orthopedic	Athlete is **TEMPORARILY CLEARED** pending further studies as stated below

PENDING ISSUE	RECOMMENDATION OR FURTHER STUDIES

Physician Signature ________________________________ **Date**____________

General Medical Physician

Physician Signature ________________________________ **Date**____________

Orthopedic Physician

Staff ATC Final Review Initial: _______

UNIVERSITY OF COLORADO
SPORTS MEDICINE DEPARTMENT OF INTERCOLLEGIATE ATHLETICS
368 UCB BOULDER, CO 80309-0368
TEL (303) 492-3801 FAX (303) 492-5662

ATHLETIC LAB REQUEST FORM
The following results are ***REQUIRED*** for athletic participation at the University of Colorado.

Athlete's Name:	**Birth Date:**	**Sex:** __ Female __ Male

REQUIRED LAB STUDIES		
Dx Code: Z00.00	**Orders:** Hemoglobin & Hematocrit (H&H) Sickle Cell Screen	**Date Requested:**
Ordering Physicians: Dr Sourav Poddar / Dr. Stephanie Chu		

AUTHORIZATION TO RELEASE OF LAB RESULTS			
Name of clinic providing information to be sent?			
Address	City	State	Zip Code
Phone	Fax		

*PLEASE BRING RESULTS WITH YOU DO NOT HAVE THEM SENT

**Individual is responsible for all charges and fees associated with these exams/labs.*

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire six months from the current date.

____________________ ____________
Signature of Student-Athlete — Date of Signature

____________________ ____________
Signature of Witness — Date of Signature

CU SPORTS MEDICINE
DEPARTMENT OF INTERCOLLEGIATE ATHLETICS
THE UNIVERSITY OF COLORADO AT BOULDER
368 UCB • Boulder, Colorado 80309-0368 • 303-492-3801

Try-Out Consent

Student Name ______________________ **Try-out Date** __________________

SID# ______________________________ **DOB** _______________

In consideration of the University of Colorado at Boulder granting the student permission to participate in the try-out, I hereby assume all risks of personal injury (including death) that may result from any try-out activity. I confirm that my physical has been completed by a physician within the past 6 months, all information on my medical history form, and my lab tests (H&H, Sickle Cell Trait) are current & factual. As a participant, I do identify, defend and hold harmless the University of Colorado at Boulder, Board of Regents, State of Colorado, and the Colorado _*Football*__team, its officers, employees, and agents against all liability; including claims and suits at law or in equity, for injury, fatal or otherwise, which may result from negligence and/or my participation in the try-out activities.

In the event of injury or illness, I hereby give my consent for medical treatment and permission to a certified athletic trainer to supervise on-site first-aid for minor injuries and to a licensed physician to hospitalize and secure proper treatment (including injections, anesthesia, surgery, or other reasonable treatment and necessary procedures) for the student.

____
Student Name (PRINT)

____ ______________________
Signature of Student ***Date of Signature***