FIU ATHLETICS
TRY-OUT/WALK-ON CHECKLIST

To try-out for an intercollegiate team at FIU, you must complete the following checklist in its **entirety** and attach all required documentation**. All forms are located at fiusports.com under recruits.** Please follow the steps below. All completed packets/forms must be delivered to FIU Arena 156 no less than 24 hours prior to the try-out date.

_______________________________________ _______________________________
Name *Date*

_______________________________________ _______________________________
Email *Cell #*

_______________________________________ _______________________________
Panther ID *Sport*

Step 1: Verification of 2.5 GPA ________ Confirmation of full-time status (12 credits) ________

Bring this checklist to the Student-Athlete Academic Center (SAAC). Ask for Christina.

_______________________________________ _______________________________
SAAC Director or Assistant Director *Date*

Step 2: Complete internal medical examination from a US licensed physician. (attach completed and physician signed form. If not utilizing campus Health and Wellness center physician must stamp or include business card for office information.

Step 3: Medical insurance that covers participant and does not exclude athletic injuries. Insurance policy must have orthopedic surgeons on plan as participating providers (attach copy of insurance card)

Step 4: Submit signed "Athletics Try-Out Release Form"

Step 5: Sickle cell test result or voluntarily decline test and sign a waiver (attach proof or signed waiver)

_______________________________________ _______________________________
Signature of Student *Date*

_______________________________________ _______________________________
Signature of Certified Athletic Trainer *Date*

_______________________________________ _______________________________
Signature of Athletics Compliance Office *Date (Start of 14 Day grace period)*

_______________ **TRY-OUT APPROVED**

FIU - ATHLETICS
SPORTS MEDICINE DEPARTMENT
WALK-ON PHYSICAL PACKET:

In order to try-out for an intercollegiate sport at FIU, you must successfully pass a physical examination and complete the attached packet in its **entirety.** Please follow the steps below.

STEP 1: Call the Student Health and Wellness Center to make an appointment for a walk-on physical. The telephone number is 305-348-2402. You may make an appt. with your own primary care physician if you prefer.

STEP 2: Complete all of the pages of the physical packet prior to your physical exam appointment. (1st Page: Physician Completes) Your parent or guardians signature is required on the parent information form (Last Page), and all other documents that are specified if you are under the age of 18.

STEP 3: Bring completed packet and a check to the Student Health and Wellness Center for exam. You will be responsible for an associated fee of $118 for the exam. The following is included in this cost: Physical, EKG, Urinalysis, PPD, Vision Screening, and Hearing Test.

STEP 4: After physical examination, bring the completed packet to the athletic training room (PA 156) along with a copy of your insurance card.

STEP 5: Upon receipt of your completed packet the athletic training room staff will arrange for the orthopedic portion of the physical examination. Most ortho exams are conducted at half-time games.

YOU WILL NOT BE CLEARED FOR PARTICIPATION UNTIL ALL OF THE 5 STEPS ARE COMPLETED.

Any questions, please call the training room 305-348-0668.

FIU - ATHLETICS
ATHLETIC TRYOUT RELEASE FORM

In consideration for Florida International University allowing me to tryout on _________________(date(s)) for a position on an Athletic Team for the support of ________________(team) , I, the undersigned, hereby voluntarily release, discharge, waive and relinquish any and all actions or causes of action for personal injury, property damage, or wrongful death occurring to me, arising out of or related to my participation in the said tryouts or any activities incidental hereto, whenever or however the same may occur. I, for myself, my heirs, executors, administrators, and assigns hereby release, waive, discharge and relinquish any action or causes of action, aforesaid, which may hereafter arise for me and for my estate, and agree that under no circumstances will I or my heirs, executors, administrators, and assigns prosecute, present any claim for personal injury, property damage, or wrongful death against the State of Florida, The Florida International University Board of Trustees, FLORIDA INTERNATIONAL UNIVERSITY, FIU Athletics, FIU Athletics Finance Corporation, FIU Foundation, or any of their officers, coaches, instructors, agents or employees for any of said causes of action, whether the same shall arise by the negligence of any said persons, or otherwise. IT IS MY INTENTION BY THIS INSTRUMENT TO EXEMPT AND RELIEVE THE STATE OF FLORIDA, THE FLORIDA INTERNATIONAL UNIVERSITY BOARD OF TRUSTEES AND FLORIDA INTERNATIONAL UNIVERSITY, FIU ATHLETICS, FIU ATHLETICS FINANCE CORPORATION, FIU FOUNDATION, THEIR RESPECTIVE OFFICERS, COACHES, INSTRUCTORS, AGENTS OR EMPLOYEES, FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH ARISING OUT OF OR RELATED TO MY PARTICIPATION IN THE TRYOUTS REFERENCED ABOVE.

I further acknowledge that in the course of the tryouts and any of the activities related thereto which I wish to undertake, I expose myself to risk, known and unknown, of personal injury that could be painful, permanently disfiguring or debilitating and fatal. I, for myself and any other reason or entity claiming through me, accept full responsibility for such athletic activity. I understand and assume the accompanying risk of physical injury or death from such athletic activity.

I have no knowledge of any physical impairment or disability that would be affected by my participation in the above mentioned tryouts.

I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance.

SIGNATURE______________________________

NAME (please print) ______________________

DATE: ________________________________

WITNESS_______________________________

____
Parent/guardian's signature (If under 18 years old)

Insurance Company__________________________

Group/Policy # _____________________________

Insurance Phone #__________________________

HMO: Yes/No PPO: Yes/No

Date of Birth: ____________ SSN# ____________

Phone # ___________________________________

FIU – ATHLETIC TRAINING
Parent Information Form

Athlete's Name: ______________________ Sport: __________ Year: 1st 2nd 3rd 4th 5th

Athlete's Social Security#:__________ Date of Birth: __________ Panther ID# __________.

Dear Guardian:

Our athletic injury policy provides **EXCESS or SECONDARY** insurance coverage for your son/daughter's **injuries** incurred while participating in the play or practice of intercollegiate sports for FIU. This simply means that any claim for benefits must be first filed with the group policy covering your child through your employer, your spouse's employer, or policy purchased for your family. After filing with your insurance policy, our policy will provide coverage for the remaining expenses associated with the injury. WE, AS THE UNIVERSITY DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE. Please note: DO NOT drop dependent coverage while your child is participating in intercollegiate athletics, as our policy only covers injuries and does not cover illnesses and/or conditions.

☐ CHECK HERE ONLY IF your son/daughter **IS NOT** covered under **ANY** health insurance policy (signature is required) __________. If checked, please complete the following demographic section ONLY and leave insurance information blank.

Guardian #1: __________ Relationship: __________ Social Security #:__________ DOB: ______

Address (street, city, state & zip code): ______________________________

Home Phone: __________ Work Phone: __________ Email: __________

Employer's Name: __________ Insurance Company: __________

Group/Policy #:__________ Phone #: __________

Please Circle: This policy is an HMO, Yes / No; This policy is a PPO, Yes / No.

Guardian #2: __________ Relationship: __________ Social Security #:__________ DOB: ______

Address (street, city, state & zip code): ______________________________

Home Phone: __________ Work Phone: __________ Email: __________

Employer's Name: __________ Insurance Company: __________

Group/Policy #:__________ Phone #: __________

Please Circle: This policy is an HMO, Yes / No; This policy is a PPO, Yes / No.

Does either of your group insurance policies provide coverage for prescription medications? Please Circle: Yes / No

Does either of your group insurance policies provide dental coverage? Yes / No; If "Yes", please list: __________

Does either of your group insurance policies provide vision coverage? Yes / No; If "Yes", please list:__________

A FRONT AND BACK COPY OF ALL APPLICABLE HEALTH INSURANCE CARD(S), INCLUDING PRESCRIPTION COVERAGE IS MANDATORY!! (Please include a copy)

I hereby authorize Florida International University and its insurer to secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous injuries or conditions and will sign any authorizations required by healthcare providers in order to release this information to FIU and its insurer. I also hereby certify that the answers provided are true, and complete and correct to the best of my knowledge. A photostatic copy of this authorization shall be considered as effective and valid as the original. I authorize FIU/insurer to file a claim should my son/daughter become injured. **Your signature below also acknowledges receipt of our insurance policy information letter, and understand your responsibility when a claim is submitted to your primary insurance.**

______________________________ Date__________

Signature of Insurance Policy Holder / Parent or Guardian

______________________________ Date__________

Student's Signature

Signature expires 08/31/2015

FIU - ATHLETICS
ATHLETIC TRAINING DEPARTMENT
INSURANCE VERIFICATION FORM

Please use this worksheet designed for you to use when you call your insurance company. Use the blank lines to answer the questions. Please complete and return this form to the FIU Athletic Training Room in the enclosed envelope.

FIU Athletic Training has found athletes with HMO or Managed Health Care Plans will have problems with their insurance coverage while they are in Miami. To maximize your benefits and expedite the care of your child, while he/she is away at school, FIU Athletic Training asks that you please contact your insurance company and/or your employer's benefits office **NOW** to determine eligibility and coverage in the Miami area.

Student-Athlete Name ______________________ **DOB** __________ **SSN:** __________

Insurance Company ______________________ **Phone** ______________________

Policy # ______________________ **Group #** ______________________

Type Name (HMO/PPO) ______________________ **Effective Dates** ______________________

1. Does my insurance cover intercollegiate athletic injuries? Yes No

2. Does my insurance cover my son/daughter in Miami? Yes No

3. Do I need to provide certification that my student-athlete is a full-time college student in order for them to be covered under my insurance plan? Yes No

If **YES**, how often must this be done? ______________________

What is acceptable to prove full-time status? ______________________

4. Do I need a referral for office visits to specialists? Yes No

5. Do I need an authorization or precertification for diagnostic medical testing (i.e. x-rays, MRI, bone scans, CT scans, labs)? Yes No

6. Am I required to assign a primary care physician in Miami? Yes No

If **YES**, is *Dr. Ingrid Carter * (305)669-3320 (NPI 1114981883), Dr. Michael Diamond (305)279-2256 (NPI 1174697569) or Dr. Steve Pabalan (305)665-6926 (NPI 1487692307), a participating provider? Yes No

If **NO**, are there any primary care providers in Miami that are participating providers?

____

(*Dr. Ingrid Carter is our preferred primary care physician)

7. Do I have out-of-network benefits? Yes No

8. Is there a deductible on my insurance plan? Yes No

If **YES,** how much? ______________________

****If for any reason your insurance gets terminated or there are any changes in your coverage you must notify us immediately. Failure to do so may result in you incurring out-of-pocket expenses. If you have any questions, please feel free to contact us at 305-348-2759. ****

Please sign and date that the student-athlete's insurance policy has been verified.

______________________ __________

Signature **Date**

____

Print Name

STAFF USE ONLY

Reviewed By: __________

Date: __________

2014

Florida International University
University Health Services
Medical Health History

Panther I.D. # ________

Please print in black ink.

Social Security # ___-___-____

Name: ____________ (Last, First, Middle) Birthplace: ____________

Sex: Male ☐ Female ☐ Date of Birth ___/___/___ (Month) (Day) (Year) Age: ______ Phone: ( ) ______ - ______

Local Address: ____________ Street Apt. # City State Zip

Cell Phone #: ( ) ______-______ E-Mail Address: ____________

Person to notify in case of emergency: ____________ Relationship to you: ____________

Phone: ( ) ______ - ______ Address: (Street) ____________ (City) ______ (State) ______ (Zip) ______

ALLERGIES/DRUG, OTHER

1 ☐ No known allergies
2 ☐ Aspirin
3 ☐ Penicillin
4 ☐ Sulfa
5 ☐ Codeine
6 ☐ Other drugs______
7 ☐ Food______
8 ☐ Other______

INSURANCE Yes ☐ No ☐ HMO ☐ PPO☐

____
Name of Insurance Company

PERSONAL HISTORY

	Yes	No	Date, if yes		Yes	No	Date, if yes
Anemia	☐	☐		Hepatitis	☐	☐	
Asthma	☐	☐		High blood pressure	☐	☐	
Bleeding disorder	☐	☐		Kidney disease	☐	☐	
Blood clots	☐	☐		Loss of consciousness	☐	☐	
Blood in stool	☐	☐		Ovarian cyst	☐	☐	
Breast mass	☐	☐		PID	☐	☐	
Cancer	☐	☐		Seizures/convulsions/epilepsy	☐	☐	
Depression	☐	☐		Sickle cell disease or Sickle cell trait (circle one)	☐	☐	
Diabetes mellitus	☐	☐		Thyroid disease	☐	☐	
Eating disorder	☐	☐		Tuberculosis or positive PPD	☐	☐	
Fibroid	☐	☐		Ulcer	☐	☐	
Heart murmur	☐	☐		Other			

HOSPITALIZATIONS/SURGERIES____________ Other____________

Family Medical History: Were you adopted? ☐ Yes ☐ No.
If no, complete below. List any **close relatives** who had the following:

☐ Cancer______ ☐ Drinking Problems______
☐ Diabetes______ ☐ High Blood Pressure______
☐ Heart Disease______ ☐ High Cholesterol______
☐ Stroke______ ☐ Depression______

Health Behavior:

	Yes	No
Do you perform regular breast or testicular exams?	☐	☐
Do you smoke? _____cigarettes/day_____years	☐	☐
Do you drink alcohol? ________drinks/week	☐	☐
Are you content with way you handle stress?	☐	☐
Are you content with your current weight?	☐	☐
Are you sexually active?	☐	☐

This history form is confidential and will be kept in your medical record. No information may be released without your written consent, unless required by law.

CONSENT FOR TREATMENT (If under 18 years of age, parental consent is required): I authorize the health care providers of University Health Services and their agents or consultants to perform diagnostic and treatment procedures which are necessary in their judgment. I understand that I am responsible for charges incurred and authorize release of medical information to third party insurers for billing purposes.

____________ Signature of Patient ____________ Date

(MHH-3/12)

FIU - ATHLETICS
FIRST-YEAR STUDENT ATHLETE PHYSICAL FORM

NAME______________________________ SPORT______________________

INTERNAL MEDICINE ASSESSMENT

VISION (RIGHT/LEFT) GLASSES/CONTACTS		URINALYSIS FEMALES ONLY: LMP ________	
HEIGHT/WEIGHT		EKG	
BLOOD PRESSURE		ECHOCARDIOGRAM	
HEART RATE		TETANUS	
HEENT		PPD	
LUNGS		CHEST X-RAY REQUIRED	YES / NO
CARDIAC EXAM		ALLERGIES	
PULSES(CAROTID, FEMORAL)		MEDICATIONS & HERBAL SUPPLEMENTS	
MARFANS SCREEN			
NEUROLOGICAL		ADDITIONAL TESTS ORDERED?	YES / NO
INGUINAL EXAM		SICKLE CELL STATUS	

PHYSICIAN NOTES: ____

INTERNAL MEDICAL CLEARANCE: YES/NO

Physician____
PRINT SIGN DATE

ORTHOPEDIC ASSESSMENT

CERVICAL: WNL/ABN
ROM: WNL/ABN **Tenderness:** Yes/No **Location:** Up/Mid/Low
Axial Load: +/- **Redicular Pain:** (R) +/- (L) +/-

BACK : WNL/ABN
ROM: WNL/ ABN Flexibility: WNL/ ABN **SLR:** (R) +/- (L) +/-
Pain w/ extension: Yes/ No **Tenderness:** Yes/ No
Location: TL/UL/LL/LS **Redicular Pain:** (R) +/- (L) +/-

SHOULDER R/L : WNL/ABN

ROM: WNL/ABN
Instability: WNL/ABN
Anterior: Yes/No
Inferior: Yes/No
Posterior: Yes/No
MDI: Yes/No

MMT: WNL/ABN
Supraspinatus: 5 4 3 2 1
Internal Rotators: 5 4 3 2 1
External Rotators: 5 4 3 2 1
Deltoid: 5 4 3 2 1
Apprehension: Yes/No

Impingement: Hawkins: +/-
Neer's: +/-
SLAP/Biceps: Yergasons: +/-
Speeds: +/-
O'Brien's: +/-
Relocation: Yes/No

ELBOW R/L : WNL/ABN
Pain w/ palpation: Med: +/- Lat:+/- Post: +/- **ROM:** WNL / ABN **Resisted Testing Painful:** Med / Lat Epicondyle +/-
Instability: Stress Test: Med +/- Lat +/- 30° +/- 90° +/- Milking +/- Pivot +/-

WRIST R/L : WNL/ABN
ROM: WNL/ABN Limitation: Flex/Ext.
Tenderness: Y/N Snuff Box/SL/LT/TFCC Masses: Y/N

HAND AND THUMB R/L : WNL/ABN
Thumb: Instability +/- **Ulnar** +/- **Radial** +/-
Deformity: 1st IP 2nd DIP PIP 3rd DIP PIP 4th DIP PIP 5th DIP PIP

HIP R/L : WNL/ABN
ROM: WNL/ABN Restricted: IR/ER/ADD/ABD/Ext/Flex
Tenderness: Yes/No Ant/Post/Greater Trochanter

GROIN R/L/PS : WNL/ABN
ROM:WNL/ABN Abd/Flex/Ext
Tenderness: Yes/No Insertion/Prox.⅓

KNEE R/L : WNL/ABN

ROM: WNL/ABN
Instability: WNL/ABN
Lachman's: +/- Grade 1 2 3
Ant. Drawer: +/- Grade 1 2 3
Post. Drawer: +/- Grade 1 2 3
Varus: 0° +/- Grade 1 2 3 30° +/- Grade 1 2 3
Valgus: 0° +/- Grade 1 2 3 30° +/- Grade 1 2 3

Flexibility: Quads: WNL/ABN
Hams: WNL/ABN
P-F Signs: Crepitus: +/-
Grind : +/-
Apprehension: +/-
Patellar Tendon: +/- Prox./Distal

Meniscus: Jt. Line Tenderness: Yes/No
Medial: A/3 M/3 P/3
Lateral: A/3 M/3 P/3
Swelling: Yes/No
Tibial Tuberosity Tenderness: +/- Enlarged +/-

ANKLE R/L : WNL/ABN
ROM: WNL/ABN **Swelling:** Y/N **Instability:** WNL/ABN Grade 1/2/3
Tenderness: Med/Lat/ syndes./post. tib./Achilles/ peroneal

FOOT R/L: WNL/ABN
Tenderness: YES/ NO Mid/Plantar Fascia/Toes 1 2 3 4 5
ROM: WNL/ABN **ARCH:**WNL/ABN High/Flat (Rigid / Flex)

Additional Testing Required: YES/NO ______________________________
ORTHOPEDIC PHYSICIAN NOTES: ______________________________

ORTHOPEDIC MEDICAL CLEARANCE: YES/NO

Orthopedic Physician____
PRINT SIGN DATE

FLORIDA INTERNATIONAL UNIVERSITY
First Year Student-Athlete Health History Questionnaire

NAME______________________ **SPORT**______________________

CARDIOVASCULAR RISK FACTORS		
Chest pain or shortness of breath during/after exercise?	YES	NO
Dizzy, lightheaded, and/or passed out during/after exercise?	YES	NO
Feeling of your heart racing or skipping beats during/after exercise?	YES	NO
Get more tired than teammates/friends during exercise?	YES	NO
Ever been told you have a heart murmur?	YES	NO
Family member died or heart problems and/or sudden death before age of 50?	YES	NO
Ever been restricted or denied participation due to a heart issue?	YES	NO
Ever had an EKG or echo? Date ___________	YES	NO
Ever been told you have high blood pressure or high cholesterol?	YES	NO
ALLERGIES		
Have you ever had an allergic reaction to food? Explain:___________	YES	NO
Have you ever had an allergic reaction to any medications? Explain:___________	YES	NO
Have you ever had an allergic reaction to an insect or pet? Explain:___________	YES	NO
ASTHMA		
Have you ever been diagnosed with asthma or exercise induced asthma?	YES	NO
Are you taking any medications or an inhaler to control your asthma? Rx:___________	YES	NO
HEAD INJURIES/CONCUSSION		
Have you ever suffered a head injury/concussion (no matter how minor)? When?___________How many?___________	YES	NO
Have you ever been knocked out, hospitalized, or lost your memory due to a head injury/concussion?	YES	NO
Do you suffer from headaches (how often___________)?	YES	NO
Are you taking any medications to control your headaches/migraines? ___________	YES	NO
EYE		
Have you had an eye exam in the past year? Date:___________	YES	NO
Do you suffer from blurred vision, double vision, tunnel vision, and/or any abnormal sight?	YES	NO
Do you wear contacts and/or glasses? (Circle One)	YES	NO
HEAT RELATED PROBLEMS		
Have you ever suffered from a heat related injury? Heat cramps? Heat syncope(fainting)? Heat exhaustion? Heat stroke? (Circle all that apply)	YES	NO
FEMALES ONLY		
At what age was your first period? ___________ Last Menstrual Period:___________		
Do you have heavy or painful menstrual periods?	YES	NO
Do you take any medications for your menstrual periods?	YES	NO
Are you on any type of birth control? (ie. Pill, injection, etc) What type:___________	YES	NO
Have you had a pelvic exam in the last year? Date:___________	YES	NO
MISC. QUESTIONS		
Do you have any ongoing or chronic illnesses? List___________	YES	NO
Have you ever been told by a physician to restrict your sports activity or not participate at all?	YES	NO
Are you currently under a physician's care for any medical conditions? List___________	YES	NO
Have you ever been under or are currently under the care of a psychologist and/or psychiatrist?	YES	NO
Do you cough, wheeze, or have trouble breathing during or after exercise?	YES	NO
Have you ever had a stomach ulcer or chronic stomach pains?	YES	NO
Have you had a viral infection (i.e. mononucleosis, myocarditis, etc) in the past year?	YES	NO
Have you ever had convulsions, seizures, and/or epilepsy?	YES	NO
Do you require any special equipment? (braces, neck rolls, dental, orthotics, hearing aids, etc.)	YES	NO
Have you ever had a tetanus booster within the past (5) five years? When?___________	YES	NO
Do you feel stressed out? If yes, do you feel as though you have the necessary support to deal with your stress?	YES	NO
Are you currently taking any prescription medications?	YES	NO
NUTRITION		
Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?	YES	NO
Do you regularly lose weight to participate in your sport?	YES	NO
Do you want to weight more or less that you currently do?	YES	NO
Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?	YES	NO
Have you had a history of anorexia, bulimia (forced vomiting) and/or any other eating disorders?	YES	NO
Do you take vitamins, amino acids, creatine, and/or any other dietary supplements on a daily basis and/or as needed?	YES	NO

If you answered "yes" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail on the back of this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

___________________________ Student-Athlete Signature

___________________________ Date

PLEASE EXPLAIN ALL OF YOUR YES ANSWERS IN DETAIL BELOW.

CARDIOVASCULAR RISK FACTORS

ALLERGIES

ASTHMA

HEAD INJURIES/CONCUSSIONS

EYE

HEAT RELATED PROBLEMS

FEMALES ONLY

MISC. QUESTIONS

NUTRITION

FLORIDA INTERNATIONAL UNIVERSITY
First Year Student-Athlete Orthopedic History Questionnaire

NAME________________________________ SPORT______________________________

CERVICAL SPINE/NECK		
Have you ever suffered an injury to your cervical spine and/or neck? Date____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had a "Burner", "Stinger", and/or Brachial Plexus injury? (circle all that apply) Date____________	YES	NO
Have you ever experienced numbness or tingling in your arms/fingers? Explain:____________	YES	NO
SHOULDER/UPPER ARM		
Have you ever suffered an injury to your shoulder and/or upper arm (circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery of any kind for a shoulder and/or upper arm? (circle all that apply) Date________	YES	NO
ELBOW/FOREARM		
Have you ever suffered an injury to your elbow and/or forearm? (circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery of any kind for an elbow and/or forearm? (circle all that apply) Date__________	YES	NO
WRIST/HAND/FINGERS		
Have you ever suffered an injury to your wrist/hand, and/or fingers? (circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery of any kind for a wrist/hand, and/or fingers? (circle all that apply) Date________	YES	NO
SPINE/LOW BACK/SACROILIAC JOINT		
Have you ever suffered an injury to your spine/low back/ or sacroiliac joint? (circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery of any kind for a spine/low back/ sacroiliac joint? (Circle all that apply)Date:____________	YES	NO
Have you ever had numbness/tingling down one or both legs? Explain____________	YES	NO
HIP/GROIN/HAMSTING/QUADRICEPS		
Have you ever suffered an injury to your hip/groin/hamstring/quadriceps? (circle all that apply) Date:____________	YES	NO
Have you ever had a hernia or a sports hernia? (Circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery for your hip/groin/hamstring/quadriceps? (circle all that apply) Date:____________	YES	NO
KNEE/PATELLA		
Have you ever suffered an injury to your knee or patella? (circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery for your knee/patella? (circle all that apply) Date:____________	YES	NO
Have you ever/ do you presently wear a knee brace? What type____________ Reason for wearing:____________ Which Knee:____________	YES	NO
ANKLE/LOWER LEG		
Have you ever suffered from an injury to your ankle and/or lower leg? (Circle all that apply) Date:______	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery for your ankle and/or lower leg? (Circle all that apply) Date:____________	YES	NO
Do you presently tape your ankles/ wear ankle braces/ wear orthotics? (circle all that apply) Describe:____________	YES	NO
FOOT/TOES		
Have you ever suffered from an injury to your foot and/or toes? (Circle all that apply) Date:____________	YES	NO
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan (circle all that apply) Date:____________	YES	NO
Have you ever had surgery for your foot and/or toes? (Circle all that apply) Date:____________	YES	NO

If you answered "yes" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail on the back of this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

______________________________ ______________________

Student-Athlete Signature **Date**

PLEASE EXPLAIN ALL OF YOUR YES ANSWERS IN DETAIL BELOW

CERVICAL SPINE/ NECK

SHOULDERS/ UPPER ARM

ELBOW/FOREARM

WRIST/HAND/FINGERS

SPINE/ LOW BACK/ SACROILIAC JOINT

HIP/GROIN/HAMSTRINGS/QUADRICEPS

KNEE/PATELLA

ANKLE/LOWER LEG

FOOT/TOES

FIU Athletics - Athletic Training Department
Sickle Cell Trait Information Sheet/Waiver

About Sickle Cell Trait:

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle cell trait is a common condition affecting approximately three million Americans
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive.
- An undiagnosed trait can be dangerous, even fatal. During intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and block blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood and possible death.
- Those with confirmed sickle cell trait may be at increased risk of sickling when traveling to high altitude with specific concern of splenic infarct.
- Twenty-one college student-athletes with sickle cell trait have collapsed and died over the past decade.
- If an athlete tests positive, he or she will still be able to participate in athletics activities with certain precautions.
- More information on sickle cell trait may be found at the following NCAA website: www.NCAA.org/health-safety

Sickle Cell Trait Testing:

- The *NCAA* mandates that all Division I student-athletes be tested for sickle cell trait, show proof of a prior test, or sign a waiver releasing the school from liability if they decline to be tested before participating in athletic-related activities, including intercollegiate athletics events, strength and conditioning sessions, practices, competitions, etc.
- **Please insert your name, date of birth, and sport below then initial one of the options below and return this form and the supporting documentation to Kari Riddle, FIU - Athletics, Head Athletic Trainer in the enclosed pre-paid envelope prior to your scheduled on campus pre-participation physical*.**

Name: ____

DOB: ______________________ SPORT: ______________________

a._____ A copy of my newborn screening records pertaining to sickle cell trait are attached (this test was mandated for all newborns in the State of Florida after 1988).

b._____ A copy of my sickle cell trait test from a physician or other authorized medical care provider is attached.

c._____ I would like to be tested by the FIU sports medicine staff as part of my pre-participation physical examination. I understand that there may be a delay in my medical clearance and that the results will be shared with the team physician.

d._____ I voluntarily decline to be tested, understand that an undiagnosed trait can be dangerous, even fatal, and agree to sign the waiver below. **IF YOU CHOSE THIS OPTION YOU MUST SIGN THE ATTACHED WAIVER AND RELEASE BELOW.**

***If this form is not returned by the date set forth above or returned incomplete, option "c" will automatically be selected.**

Sickle Cell Testing Waiver (only needed if option "d" is selected above):

WAIVER AND RELEASE

I, ____, understand and acknowledge that the NCAA mandates that all Division I student-athletes be tested for sickle cell trait, show proof of a prior test, or sign a waiver releasing the school from liability if they decline to be tested before participating in athletic-related activities. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or other disabilities experienced. I hereby affirm that I have fully disclosed in writing any knowledge of sickle cell trait status to the FIU Athletic Training Department.

I do not wish to undergo sickle cell testing as part of my pre-participation physical exam and agree to assume all risks and consequences associated with my refusal to be tested, including the risks that my participation in athletic activity may result in bodily injury or death to me.

I voluntarily agree to release, waive, discharge, indemnify and hold harmless the State of Florida, Florida International University Board of Trustees, FIU Athletics and Florida International University, their respective officers, coaches, associated medical staff, instructors, agents or employees from any and all costs, liabilities, expenses, claims, demands, suits or causes of action for any loss, personal injury, or wrongful death occurring to me which may arise out of my participation in any athletic activity or any activity incidental thereto, whenever or however the same may occur. I affirm that I have voluntarily made the decision not to be tested. I specifically understand that I am releasing, discharging and waiving any claims or actions that I may have presently or in the future for the negligent acts or conduct by the State of Florida, Florida International University Board of Trustees, FIU Athletics and Florida International University, their respective officers, coaches, associated medical staff, instructors, agents or employees.

I HAVE READ THE ABOVE RELEASE AND BY SIGNING IT AGREE IT IS MY INTENTION TO EXEMPT AND RELIEVE THE STATE OF FLORIDA, FLORIDA INTERNATIONAL UNIVERSITY BOARD OF TRUSTEES, FIU ATHLETICS AND FLORIDA INTERNATIONAL UNIVERSITY FROM LIABILITY FOR PERSONAL INJURY OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR OTHER CAUSE OF ACTION.

I, the undersigned, have read this release and understand its terms. I execute this document voluntarily and with full knowledge of its significance. If I am under 18 years of age, my parent and/or guardian has also signed below.

____

Student -- Athlete Signature　　　　　　　　Date

____

Parent or Guardian Signature (if under 18)　　　　　　　　Date

rev. 3/1/2011