



**Florida International University
ATHLETICS TRY-OUT PACKET**

To try-out for an intercollegiate team at FIU, you must complete the following checklist in its **entirety** and attach all required documentation. Please follow the steps below. All completed packets/forms must be delivered to FIU Arena 156/Football athletic training facility **ONLY** at the designated timeframe posted on the try-out notice.

Name

Date

Email

Cell #

Panther ID

Sport

Step 1: 2.4 GPA _____ Full-time status (12 credits) _____ Degree Seeking Student _____

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

SAAC Director or Associate Director

Date

Find out when the athletic training facility is available for the physical via the head coach then present the following to them on the scheduled date and time. Present steps 2-5 in its entirety to the athletic training staff:

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

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



Florida International University ATHLETICS TRY-OUT PACKET



After receiving proof of your approved academic standing by the Academic Center, you must successfully pass a physical examination and complete the attached packet in its entirety in order to try-out for an intercollegiate sport at FIU. You will not be medically cleared for activity until all of the following steps are completed. ***Read Carefully!!!***

Step 1: Health Insurance

1. You must have an **approved** health insurance policy. The qualifications are:
 - a. Proof of active coverage in Miami.
 - b. Deductible of \$2,500 or less.
 - c. Must cover athletic related injuries.
 - d. Insurance card or copy of the front/back.
 - e. Questions? Ask the athletic training staff as soon as possible!

Step 2: Physical Packet

1. Print and complete the pre-participation packet prior to your physical exam appointment.
2. Must obtain all necessary parent/guardian signatures.

Step 3: Internal Physical

1. *You must show proof of an internal physical completed in the current calendar year.*
2. **Option #1:** Call Student Health Services at **305-348-2401** to make an appointment for an athletics physical.
 - a. Bring completed physical packet to the health center for exam. You will be responsible for an associated fee of \$118 for the exam which includes:

i. internal physical	v. urinalysis
ii. vision screening	vi. EKG (if necessary)
iii. hearing test	1. Please attach a copy
iv. sickle cell screening	vii. PPD (if necessary)
3. **Option #2:** Make an appointment with your primary care physician.
 - a. Bring completed physical packet to physician office for exam. You will be responsible for all associated fees for the exam which should include:

i. internal physical	v. urinalysis
ii. vision screening	vi. EKG (if necessary)
iii. hearing test	1. Please attach a copy
iv. sickle cell screening	vii. PPD (if necessary)
 - b. He/she must stamp the physical with their signature or attach their business card.

Step 4: Turn in completed packet including completed physical exam to athletic training staff (FIU Arena 156 or Kirk Landon Fieldhouse 1160 for football) at the designated time of the try-out notice.

Any questions about the pre-participation physical, please email the athletic training room at:
kgreenwa@fiu.edu (Arena) **OR** **dwest@fiu.edu** (Football)



**Florida International University
ATHLETICS TRY-OUT PACKET
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.

Student's Signature

Date: _____

Name (please print)

SSN: _____

Witness

Cell: _____

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



**Florida International University
ATHLETICS TRY-OUT PACKET
DEMOGRAPHIC INFORMATION FORM**

PLEASE PRINT IN BLACK OR BLUE INK.

Name: _____ Social Security #: _____
(Last) (First) (MI)

Sex: Male ☐ Female ☐ Date of Birth ____/____/____ Sport: _____ PID#: _____

Cell Phone: _____ Email: _____

Home Address: _____
(Address Line 1)

(Address Line 2)

(City) (State) (Zip Code)

Local Address: _____
(Address Line 1/Dorm Building) (Apt. #/Dorm #)

(Address Line 2)

(City) (State) (Zip Code)

Guardian #1: _____ Relationship: _____ Phone: _____

Guardian #2: _____ Relationship: _____ Phone: _____

To whom should we send medical correspondence? ☐ Mother ☐ Father ☐ Guardian ☐ Self ☐ Other

Name: _____

Address: _____
(Address Line 1)

(Address Line 2)

(City) (State) (Zip Code)

Person to notify in case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____



**Florida International University
ATHLETICS TRY-OUT PACKET
INSURANCE INFORMATION FORM**

Student's Name: _____ Date of Birth: _____

Dear Student/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. 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.

INSURANCE POLICY HOLDER INFORMATION

Policy Holder: _____ Relationship: _____ Social Security #: _____ DOB: _____

Home Address: _____

(Address Line 1)

(Address Line 2)

(City)

(State)

(Zip Code)

Home Phone: _____ Work Phone: _____ Email: _____

Employer's Name: _____ Insurance Company: _____

Policy/Member ID #: _____ Group #: _____ Phone #: _____

This policy is an: ☐ HMO ☐ PPO

Does either of your group insurance policies provide coverage for prescription medications? ☐ 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: _____

**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF ALL APPLICABLE HEALTH INSURANCE
CARD(S), INCLUDING PRESCRIPTION MEDICINE COVERAGE.**

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.

Student's Signature

Date:

Signature of Parent/Guardian or Insurance Policy Holder (If under 18 years of age)

Date:



**Florida International University
ATHLETICS TRY-OUT PACKET
SICKLE CELL TRAIT**

Student's Name: _____ Date of Birth: _____

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 or show proof of a prior test 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 then initial one of the options below. Return this form and the appropriate supporting documentation with your pre-participation physical packet via e-mail to your athletic trainer or fax to (305)348-3673.

Student's Signature

Date: _____

Signature of Parent/Guardian or Insurance Policy Holder (If under 18 years of age)

Date: _____

Please initial one of the following options:

- 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.



**Florida International University
ATHLETICS TRY-OUT PACKET
GENERAL MEDICAL HISTORY FORM**

Student's Name: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY			
Have you been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered a head injury/concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been restricted or denied participation by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been knocked out, hospitalized, or lost your memory due to a head injury/concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contacts or glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from blurred vision, double vision, tunnel vision, and/or any abnormal sight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any ongoing or chronic illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a stomach ulcer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
While exercising, have you suffered from a racing heart, chest pain, lightheadedness, fainted, or felt that your heart is skipping a beat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed with infectious mononucleosis, Hepatitis B, HIV/AIDS, and/or any other serious infectious/viral infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cough, wheeze, or have trouble breathing during/after exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever experienced any seizure or convulsions; and/or been diagnosed with epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been tested for sickle cell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a dental injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told you have a heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed with cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an echo or EKG performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed with a blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told you have high blood pressure or cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you require any special equipment to participate in athletics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a heat-related illness (heat cramps, heat exhaustion, and/or heat stroke)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you content with the way you handle stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever tested positive for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
FAMILY MEDICAL HISTORY			
Has any of your family members been diagnosed with cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any family member under the age of 50 died suddenly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any of your family members been diagnosed with diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any of your family members been diagnosed with high blood pressure and/or cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any of your family members been diagnosed with any heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any of your family members suffered from a stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
NUTRITION			
Have you ever been diagnosed with an eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you want to lose weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want to gain weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take vitamins, amino acids, creatine, and/or any other dietary supplement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
FEMALES ONLY			
Are your periods regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have painful or heavy menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any problems with your breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any medications during your menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had a pelvic examination within the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 in the space below.

I, the undersigned, hereby acknowledge, affirm, and represent that all 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's Signature

Date: _____

Signature of Parent/Guardian or Insurance Policy Holder (If under 18 years of age)

Date: _____



Florida International University



ATHLETICS TRY-OUT PACKET ORTHOPEDIC MEDICAL HISTORY FORM

Student's Name: _____ Date of Birth: _____

CERVICAL SPINE/NECK		HIP/GROIN/HAMSTRING/QUADRICEPS	
Have you ever suffered an injury to your cervical spine and/or neck? Date _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered an injury to your hip/groin/hamstring/quadriceps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a hernia or a sports hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a "Burner", "Stinger", and/or Brachial Plexus injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced numbness or tingling in your arms/fingers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery for your hip/groin/hamstring/quadriceps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
SHOULDER/UPPER ARM		KNEE/PATELLA	
Have you ever suffered an injury to your shoulder and/or upper arm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered an injury to your knee or patella?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had surgery of any kind for a shoulder and/or upper arm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery for your knee/patella?	<input type="checkbox"/> Yes <input type="checkbox"/> No
ELBOW/FOREARM		Have you ever/ do you presently wear a knee brace?	
Have you ever suffered an injury to your elbow and/or forearm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ANKLE/LOWER LEG	
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered from an injury to your ankle and/or lower leg?	
Have you ever had surgery of any kind for an elbow and/or forearm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	
Have you ever/ do you presently wear an elbow brace?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery for your ankle and/or lower leg?	
SPINE/LOW BACK/SACROILIAC JOINT		Do you presently tape your ankles/ wear ankle braces/ wear orthotics?	
Have you ever suffered an injury to your spine/low back/ or sacroiliac joint?	<input type="checkbox"/> Yes <input type="checkbox"/> No	FOOT/TOES	
Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered from an injury to your foot and/or toes?	
Have you ever had surgery of any kind for a spine/low back/ sacroiliac joint?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were any diagnostic tests performed? X-Ray, MRI, CT Scan, Bone Scan?	
Have you ever had numbness/tingling down one or both legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery for your foot and/or toes?	

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 in the space below.

I, the undersigned, hereby acknowledge, affirm, and represent that all 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's Signature

Date:

Signature of Parent/Guardian or Insurance Policy Holder (If under 18 years of age)

Date:



**Florida International University
ATHLETICS TRY-OUT PACKET
PHYSICIAN ASSESSMENT**

Student's Name: _____ Date of Birth: _____

INTERNAL MEDICINE ASSESSMENT

VISION	R:	URINALYSIS	
GLASSES/CONTACTS? (circle)	L:	FEMALES ONLY: LMP	/ /
HEIGHT(in)/WEIGHT(lb)	/	EKG (DATE)	/ /
BLOOD PRESSURE	/	CHEST X-RAY REQUIRED	YES/NO
HEART RATE (PPM)		ALLERGIES	
HEENT		NEUROLOGICAL	
LUNGS		SICKLE CELL STATUS (circle)	(+) / (-) / NA
CARDIAC EXAM		MEDICATIONS & HERBAL SUPPLEMENTS	
PULSES (CAROTID, FEMORAL)			
MARFANS SCREEN			

INTERNAL MEDICAL CLEARANCE: YES/NO

NOTES: _____

Physician: Print: _____ Signature: _____ Date: _____

Physician Stamp: _____ (Please attach business card)