Thank you for your interest in Texas A&M Athletics. In order to participate in Texas A&M team try-out, Texas A&M Sports Medicine requires the following be submitted and completed prior to the FIRST DAY of tryouts.

1. All candidates must obtain and provide copies of their health insurance card (front and back). Insurance is verified prior to tryouts.

2. **Provide copy of sickle cell trait status.** Most individuals born after the year 2000 were screened at birth. If birth records are accessible and indicate sickle cell trait status a copy of these records is acceptable and additional testing is not needed. However, if birth records are unavailable, new screenings can be obtained at a medical facility of your choice or at AP Beutel Student Health Services Center on campus. Note that requests for birth records can take several weeks to process and new screenings can take a week or more to receive results, so please plan accordingly.

3. Submit completed Sports Physical administered/signed by a licensed physician and dated within the last six months. You may utilize the standard UIL sports physical form. Fees associated with this service will be the responsibility of the try-out participant.

4. Complete the "Participation Release" form attached. If you are under 18, your parents must also sign release. Your parents may scan and email signed form to insurance@athletics.tamu.edu (pictures will not be accepted, must be scanned in pdf format)

You will NOT be allowed to participate in the try-out until ALL information is received in the Sports Medicine Office.

Last Name ______________________________ First Name ________________________________ Middle Initial _____________

UIN #_____-_____-_______ Date of Birth _____/_____/_______ Age __________ Sex __________ Sport _______________________

Local Address ____ Phone # (___)_____________________

City ________________________________ State ________________ County ______________ Zip code ____________________

Cell phone # (___)____________________________ E-Mail Address ____

Permanent Address ____ Phone # (___)_____________________

City ________________________________ State ________________ County ______________ Zip code ____________________

Emergency Contact
Name ______________________________________

Home Phone (___)____________________________

Work Phone (___)____________________________

If you are under 18 this must be completed by a parent/guardian

Catastrophic Injury & Assumption of Risk

The possibility of sustaining a catastrophic injury, which could lead to permanent disability or even death, is inherent in any athletic activity. I understand that the potential of a catastrophic injury does exist, even though the likelihood of such an injury is limited. With this information, I understand the importance of rules and procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though proper rules and techniques of my sport are followed to the fullest.

Date: ________________Signature:____

- -

Release of Liability

Until I am officially on the roster as a Texas A&M University intercollegiate-level athlete, I understand that I am responsible for any and all medical expenses incurred. By signing below, I also certify that I do have medical insurance that covers athletic related injuries.

Date: ________________Signature:____

- -

Consent to Treat

I give authorization to the staff athletic trainer and/or team physician to evaluate and treat any injuries that occur during my athletic participation at Texas A&M University. (This includes immediate first aid and treatments, x-ray, physical exam, follow-up care and rehabilitation.) I understand the team physician has the authority to eliminate me from further participation due to an injury and/or the undue liability risk of Texas A&M University.

Date: ________________Signature:____

- -

**"These authorizations may be withdrawn at any time by a written, dated request of the signee. **

TEXAS A&M SPORTS MEDICINE

TRY-OUT PARTICIPANT MEDICAL HISTORY

General Medical Data

Have you ever been advised by a medical doctor not to participate in sports? Yes No
For what reason?_____

Are you under a physician's care for any reason now or have you been under a physician's care in the past 12 months? Yes No

Have you ever been hospitalized? Yes No
If yes, why?_____

Have you ever had surgery? Yes No
If yes, what?

Are you currently on prescribed medication or drugs? Yes No
If yes, what?_____

Have you ever had heat or muscle cramps? Yes No

Have you ever been dizzy or passed out in the heat? Yes No

Have you had any other medical problems? Yes No
If yes, what?

Disease and Illness

Have you ever been treated for, or informed by a medical doctor that you have had, rheumatic fever? If so, when?_____ Yes No

Have you ever experienced an epileptic seizure or been informed that you might have epilepsy? Yes No

Have you ever been treated for diabetes? Yes No

Have you ever passed out during or after exercise? Yes No

Have you ever had chest pain during or after exercise? Yes No

Have you ever had high blood pressure? Yes No

Have you ever been told that you have a heart murmur? Yes No

Have you ever had racing of your heart or skipped beats? Yes No

Do you have any skin rashes now or within the last six months? Yes No

Please explain any "Yes" answers

_____

_____

_____

_____

_____

Head and Neck Injuries

Do you wear glasses? Yes No

Do you wear contacts? Yes No

If you answered "yes" to either above question do you wear them during competition? If yes, which? Yes No

Have you been "knocked out" or experienced a concussion during the past 3 years? Yes No

If you answered 'yes" to the above, have you been "knocked out" more than once? Yes No
Give dates _____

If you answered, "yes" to the above, did you stay overnight in a hospital? Yes No

Have you ever had a stinger or burner or pinched nerve? Yes No

Musculoskeletal

Have you ever had a fracture? Yes No
If yes, where & when?

Have you ever had an injury to…

your shoulder?	L or R	Yes	No
your elbow?	L or R	Yes	No
your knee?	L or R	Yes	No
your ankle?	L or R	Yes	No
your foot?	L or R	Yes	No

Have any of the above injuries ever caused you to miss more than one week's practice or one game? Yes No
If yes, which injury(ies)?_____

Have you ever been advised to have surgery to correct any of the above injuries? Yes No
If yes, which injury(ies)?_____

Have you ever had an injury to your back? Yes No

Do you experience frequent pain in the back? Yes No

Have you seen a physician or chiropractor for back pain? Yes No
If yes, when?_____

Have you ever missed practice/games due to back pain/injury? Yes No

Please explain any "Yes" answers

_____

_____

_____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

REVISED 1-6-09

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____Sex _____ Age_____Date of Birth_____

Address _____Phone_____

Grade_____ School _____

Personal Physician _____Phone_____

In case of emergency, contact:

Name _____Relationship _____Phone (H) _____(W)_____

Explain "Yes" answers in the box below. Circle questions you don't know the answers to.** ***Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches***

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____ When was the last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below.		
	☐ Head ☐ Neck ☐ Back ☐ Chest ☐ Shoulder ☐ Upper Arm		
	☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger		
	☐ Hip ☐ Thigh ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot		
16.	Do you want to weigh more or less than you do now?	☐	☐
	Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐
	Females Only		
19.	When was your first menstrual period? _____		
	When was your most recent menstrual period? _____		
	How much time do you usually have from the start of one period to the start of another? _____		
	How many periods have you had in the last year? _____		
	What was the longest time between periods in the last year? _____		

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

*****EXPLAIN 'YES' ANSWERS IN THE BOX BELOW*** (attach another sheet if necessary)**:**

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____Parent/Guardian Signature: _____ Date: _____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name_____Date_____ Signature_____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination:_____

Address:_____

Phone Number: _____

Signature:_____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.