

Medical Paperwork for Try-Out Prospective Student-Athletes



All forms in this packet must be filled out completely. Upon completion, please fax (760-750-3660) to Head Athletic Trainer, Brian Smith. All forms must be submitted 48 hours prior to the tryout date.

The CSUSM pre-participatory physical screening form must be thoroughly completed by you, the student-athlete, and the physician. Please pay close attention to the following:

- 🕒 **Date of Exam**
- 🕒 **Name of Student-Athlete, Sport, Campus ID number (if applicable), and Date of Birth**
- 🕒 **Level of Participation box checked indicating clearance**
- 🕒 **Doctor's Name and Signature**
- 🕒 **Doctor's Stamp**

***Please Note:** Only physicals performed by a Medical Doctor, Nurse Practitioner, Physician's Assistant or a Doctor of Osteopathic Medicine will be accepted. A physical performed by a Chiropractor will NOT be accepted. If you have had a physical done within **6 months** of your try-out date you may submit a copy of this physical as long as it was performed by any of the medical personnel listed above. Please fill out the "Previous Physical Confirmation" pages within the try-out paperwork packet if you have had a physical in the last 6 months and plan to submit a copy of this physical.*

If you have any questions about your try-out paperwork packet please feel free to contact the Head Athletic Trainer, Brian Smith @ (760) 750-7111, or via email at bsmith@csusm.edu.

Thank you for your interest in CSUSM Athletics. Go COUGARS!

www.csusmcougars.com

Try-Out Emergency Notification / Health Insurance Form

Please Print

Athlete's Name: _____ Sport: _____ Email: _____

Athlete's Local Phone: _____ Athlete's Cell Phone: _____

Athlete's Address: _____

City _____ State _____ Zip _____

Date of Birth: _____ Soc. Sec. No. _____ Student ID: _____

Everyone must complete this Emergency Notification section

Parent/Guardian or Spouse Name

Address

Phone Numbers (Work) (Cell) (Home)

In an emergency if parents/spouse cannot be reached, contact the following:

Name _____ Relationship _____ Phone Number _____

Medical Information

Contact Lenses? (Y or N) Dental Appliances? (Y or N) Physical Impairments? (Y or N)

Known Allergies _____

Chronic Disabilities _____

Are you covered by your parent's insurance (as a dependent)? If so, complete this section

Name of Parent/Guardian Health Insurance Company

Address of Health Insurance Company

Policy Number Check One: HMO PPO

Name and Address of Employer

Are you self-insured? If so, complete this section

Name of Health Insurance Company

Address of Health Insurance Company

Policy Number Check One: HMO PPO

I release from liability and waive my right to sue the Department of Athletics, the Athletic Medicine Team, State of California, the Trustees of The California State University, California State University San Marcos and their employees, officers, volunteers and agents (collectively "University") from any and all claims, including the Athletic Medicine Team and University's negligence, resulting in any physical injury, illness (including death) or economic loss I may suffer because of my participation in this try-out.

I hereby certify by my signature that the above information is true, accurate and complete to the best of my knowledge.

(Signature of Student)—Try-Out

(Date)



FOR STUDENTS UNDER THE AGE OF 18:

*******NOTE TO ATHLETE AND PARENT/GUARDIAN *******

I understand this insurance information must be COMPLETELY and ACCURATELY provided and on file with the Athletic Medicine Team before my son/daughter will be allowed to tryout with any sports team at CSUSM. I further understand that any medical expenses resulting from an ACCIDENTAL INJURY while participating in a scheduled university athletic activity will not be paid under the accident insurance policy carried by the Department of Athletics secondary insurance until my primary health insurance policy, which covers these expenses, is exhausted. Illnesses, such as appendicitis, and any dental injury sustained are NOT covered by the Athletic Department secondary insurance plan. While it is highly recommended that I carry dental insurance, I MUST carry primary health insurance. In order for coverage by the Athletic Department secondary insurance to be in effect, the athletic injury must have occurred during a designated tryout which is under the supervision of a CSUSM coach. I further understand that failure to report injuries to the Athletic Medicine Team or to meet scheduled medical appointments may void university responsibility for medical expenses resulting from athletic injuries.

Parent/Guardian Signature: _____ Date _____

Athlete Signature: _____ Date _____

I hereby grant permission to the Physicians on the Athletic Medicine Team and Student Health Services at California State University San Marcos and those professional personnel designated by them to treat my son/daughter in the event of any injury or illness. In the event of a serious injury and if unable to contact me, this consent is to include any and all emergency procedures deemed necessary by the attending physician.

Parent/Guardian Signature: _____ Date: _____

Medical History Questionnaire for New Student-Athletes

Name: _____ Age: _____ Year: _____

Address: _____ Sport: _____

Phone: _____ Date: _____

	Yes	No		Yes	No
1. Are you currently under a doctor's care for any reason?			17. Have you had any problems with eyes or vision?		
2. Have you ever been hospitalized?			18. Do you wear glasses or contacts or protective eyewear?		
3. Have you ever had surgery?			19. Do you use any special equipment? (splints, neck rolls, mouth guards, etc.)		
4. Are you currently taking any prescription medications and/or supplements?			20. Has anyone in your family died of a heart problem or sudden death before the age of 50?		
5. Do you have any allergies? (Medications, bee stings, etc.)			21. Do you have only one working organ of usually paired organs? (only one eye, kidney, etc.)		
6. Have you ever been dizzy or fainted during or after exercise?			22. Have you ever sprained, broken, dislocated, or had repeated swelling or pain of any bones or joints?		
7. Have you ever had chest pain during or after exercise?			23. Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.)		
8. Have you ever had high blood pressure?			24. Have you ever used an inhaler or taken any asthma medications?		
9. Have you ever been told you have a heart murmur?			25. Any special instructions or precautions?		
10. Have you ever had a racing heart or skipped heartbeats?			26. When was your last tetanus shot? _____		
11. Have you ever had a head injury?			27. Do you feel your emotional responses to situations have ever interfered with your athletic or competitive performance?		
12. Have you ever been knocked out or unconscious?			28. Have you ever had difficulty balancing the demands on your time?		
13. Have you ever had a seizure?			29. Are you happy with your weight?		
14. Have you ever had a stinger, burner, or pinched nerve?			29. Has anyone recommended to you that you change your weight or eating habits?		
15. Have you ever been dizzy or passed out due to the heat?			30. Has a doctor ever denied or restricted your participation in sports for any reason?		
16. Do you have trouble breathing during or after exercise?					
31. Have you ever had a bone/joint injury that required X-ray <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> Surgery <input type="checkbox"/> Injections <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Brace <input type="checkbox"/> Cast <input type="checkbox"/> Crutches <input type="checkbox"/>					
32. Are any of these bothering you currently? Head <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Back <input type="checkbox"/> Hand <input type="checkbox"/> Wrist <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Shin/Calf <input type="checkbox"/> Foot <input type="checkbox"/>					
33. (Women only) Date of first menstrual period? _____ When was your last menstrual period? _____ When was the longest period of time between your periods during last year? _____					

Explain all "YES" answers by question number and indicate dates for each item (include any special instructions): _____

I, _____, hereby certify that the answers to the above health questionnaire are true.
(print name)

Signature _____ Parent/Guardian Signature (If under 18) _____
(Student Athlete)

The California State University

Pre-Participatory Physical Screening

Name: _____ Sport: _____ Today's Date: _____

Date of Birth: _____ Campus ID: _____

	Satisfactory			Comments
	YES	NO	NE	
Height				
Weight				
BP ____/____				
General				
Head				
Vision				
ENT				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Ortho				
Flex/Strength				

While this does not constitute a complete physical nor replace the need for a periodic health evaluation by a family physician, this individual appears to be physically capable of participation in intercollegiate sports as of this date, except as indicated below.

- Cleared for sport without restrictions
- Cleared with the following restrictions: _____
- Cleared after completing evaluation/rehabilitation for: _____
- Not Cleared Reason: _____

Comments/Recommendations: _____

Physician's Name: _____ Physician's Signature: _____

Physician's Stamp:

Previous Physical Exam Confirmation



I, _____ hereby acknowledge that I have not sustained any new injuries or illnesses since my previous physical exam dated _____ that would hinder my participation in this athletically related tryout for California State University San Marcos.

Tryout Student-Athlete's Signature

Date

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

Date