IMPORTANT INSTRUCTIONS TO GET CLEARED:
Please keep this sheet for your reference

Club Sports Student Athletes:

**Off-Campus** physical:
Packets need to be turned in, in person, to the Sports Medicine Office at the Sun Devil Fitness Center during regular office hours (8:30-11:30 pm and 1-4:30 pm).

**On-Campus** physical:
Once you have completed your physical and all required testing for your sport you will need to notify the sports medicine team. To do this:

2. Log on to your patient portal at [https://asuportal.pointnclck.com](https://asuportal.pointnclck.com).
3. Click “Message” from the menu on the left.
4. Click “New Message.”
5. Click “I want to communicate with the Club Sports Medical Staff.”
6. In the subject line please type “Completed Physical and Required Testing.”
7. In the body of the email please list which Club Sport you are participating in, the date your physical was completed, and where you completed your physical.
8. Click send.

Please allow 2 business days for us to update your status on Do Sports Easy. If your status does not get updated please resend your email or call 480 965 8908.

**NCAA Division 1 Tryout and Practice/Scout Squad Student Athletes:**

Once you have completed your physical and all required testing for your sport you will need to notify the team Athletic Trainer.

**ROTC Student Cadets:**

Once you have completed your physical please return your completed ROTC forms to your ROTC officer.

**Band Student Performers:**

Once you have completed your physical please follow instructions provided by your band director.
ASU 2019-2020 PRE-PARTICIPATION CLEARANCE FORM

ATHLETE NAME ______________________              DOB               ______________

SPORT/ACTIVITY(S)___________________               CELL PHONE______________

-----------------------------------------

Examining Clinician to fill out below

I have thoroughly reviewed the medical history and examined this student and they:

_________Are cleared for sports/physical activity without restrictions

_________Are NOT cleared for sports/physical activity.

Clinician Name___________________________________________ Date____________

Signature_____________________________________ 

ASU Health Services Tempe
PO Box 872104
Tempe, AZ 85287-2104

Office Phone: 480.965.8908  Office Fax: 480.965.4179

For Club Sports:
All Club Sports physicals will be reviewed by an ASU Team Physician. Additional follow-up may be indicated at the Team Physician’s discretion. Physicals may take up to one week to review.

Sickle Cell Test: Students participating in lacrosse, rugby, ultimate frisbee, soccer, cycling, triathlon, quidditch, rowing, dragon boat, and roller hockey will need to provide results from a sickle cell test. Sickle cell testing may be done on or off-campus.

ImpACT Test: Students participating hockey, rugby, ultimate frisbee, soccer, and lacrosse need to complete a one-time baseline test on-campus.
2019-2020 PRE-PARTICIPATION PHYSICAL

ON-Campus First Physical at ASU Health Services

Use these forms if you have NEVER had a sports/activity physical performed at ASU. Please bring ALL completed paperwork, including name and ID on each page, to your appointment. Sickle screening, if required for your sport, may be done off-campus, or at ASU lab. Baseline concussion testing must be done at ASU Health Services.

Sex (circle one) Male Female    Date of Birth___________________

Do you take any pills, supplements, vitamins or medication (including inhalers and birth control pills)?

Please list:

What medicines are you allergic to? What happens when you take that medicine? Please list:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANY Previous Injuries</th>
<th>Sprain / Strain / Fracture / Other</th>
<th>Year</th>
<th>Right / Left</th>
<th>Management / Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fingers/Wrist/Hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back/Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SDFCSportsMedicine • Phone 480-965-8908 • Fax 480-965-4179
What medical problems do you have? What medical problems are in your family? Please specify other family members (i.e. Mother, Paternal Grandfather, etc.):

<table>
<thead>
<tr>
<th>You</th>
<th>Specify Family Member(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Murmur Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease/ Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/ Exercise Induced Bronchospasm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valley Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleed/Bruiise Easily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thalassemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Bladder Infection or stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/ Bipolar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head injury/ Concussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunization History**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Number of shots needed</th>
<th>Number of shots received and dates if known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gardasil(HPV)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td>Every 10 years</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td>Yearly</td>
<td></td>
</tr>
</tbody>
</table>

Over the past 2 weeks, how often have you been bothered by the following problems? (circle number)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Please answer the following questions honestly and explain any YES answers.

1. Have you recently been thinking about hurting or killing yourself? **YES** **NO**
2. Have you recently been thinking about hurting or killing someone else? **YES** **NO**
3. Have you or anyone in your family been treated for alcohol or substance abuse? **YES** **NO**
4. Are you allergic to any insect bites or stings? **YES** **NO**
5. Do you need an epi-pen for an allergic reaction? **YES** **NO**
6. Does anyone in your family have heart disease, a pacemaker, or defibrillator? **YES** **NO**
7. Have you, or any family member, been diagnosed with:
   - Marfans Syndrome? **YES** **NO**
   - Hypertrophic Cardiomyopathy? **YES** **NO**
   If YES, who:
8. Has anyone in your family died before the age of 50? **YES** **NO**
   If YES, explain:
9. Does anyone in your family have sickle cell disease or sickle cell trait? **YES** **NO**
   If YES, who:
10. Have you ever been told you have a heart murmur? **YES** **NO**
11. Have you ever been told you have a heart problem? **YES** **NO**
12. Have you ever passed out, or almost passed out, during exercise? **YES** **NO**
13. Have you ever had chest pain, chest tightness, chest pressure or discomfort during exercise? **YES** **NO**
14. Have you ever felt your heart racing or skipping beats during exercise? **YES** **NO**
15. Have you ever been diagnosed with asthma or exercise induced bronchial spasms? **YES** **NO**
16. Have you ever used an inhaler? **YES** **NO**
17. After hard work-outs do you experience coughing or wheezing? **YES** **NO**
18. Have you had a herpes or MRSA skin infection? **YES** **NO**
19. Have you ever been dizzy, during or after exercise? **YES** **NO**
20. Have you ever been dizzy or passed out in the heat? **YES** **NO**
21. Have you ever had a head injury or a concussion? **YES** **NO**
   If YES, how many?
   When was the most recent?
22. Have you ever had a blow, or hit to the head, that caused confusion, prolonged headache or memory problems? **YES** **NO**
23. Have you ever been knocked unconscious? **YES** **NO**
24. Have you ever had a stinger or burner? **YES** **NO**
25. Have you ever had a seizure? **YES** **NO**
   If YES, when was the most recent?
26. Do you have any problems with your eyes or with your vision? **YES** **NO**
27. Do you wear glasses or contacts? **YES** **NO**
28. Would you like to change your weight? **YES** **NO**
29. Do you follow any special diet? **YES** **NO**
30. Do you avoid any certain foods? **YES** **NO**
31. Have you ever had a stress fracture? **YES** **NO**
32. Have you been treated by a physician or other health care provider in the last 12 months? **YES** **NO**
   If YES, for what?

**Physician Notes:**

**Examiner Initials:**
Please answer the following questions honestly and explain any YES answers.

33. Have you ever fractured (broken) a bone or dislocated a joint?
   If YES, what?  
   | YES | NO |

34. Have you ever injured a bone, muscle, ligament or tendon that caused you to miss practice or a game?
   If YES, what?  
   | YES | NO |

35. Do you wear any special or additional bracing/taping etc during sports participation?
   If YES, what?  
   | YES | NO |

36. Has your participation in sports ever been restricted or denied for any reason?
   If YES, why?  
   | YES | NO |

37. Do you use tobacco?
   If YES, what type?  
   How much/often?  
   | YES | NO |

38. Did you formerly use tobacco?
   If YES what type?  
   Quit date:  
   | YES | NO |

39. Do you drink alcohol?
   If YES, how many drinks?  
   How often?  
   | YES | NO |

40. Did you formerly use alcohol?
   If YES, quit date:  
   | YES | NO |

41. Do you use any illicit or street drugs?  
   | YES | NO |

42. Are you, or have you ever been, sexually active?  
   | YES | NO |

43. Sexual partners (please circle):
   Same Sex (male with male, female with female)  
   Opposite sex (male with female)  
   Bisexual

44. Do you use condoms (please circle):  
   Always  
   Sometimes  
   Never

45. Birth control method (circle all that apply):  
   Abstinence  
   Withdrawal  
   Condoms  
   Oral Contraceptive  
   Pills  
   IUD  
   Other:

FEMALES:

46. How old were you, when you started having periods?  
   yrs

47. How many periods have you had in the last 12 months?

I hereby state, that, to the best of my knowledge, my answers to all the above questions are complete and correct.

Athlete name__________________________________________ Sport____________________

Athlete signature_______________________________________ Date_____________

If athlete under 18, parent or legal guardian please sign. Name:______________________________

Signature______________________________________________ Date___________________

Physician Notes:

Examiner Initials:
Club Student Athlete Information Release

I, {Athlete Name}_________________________________________, give my permission to the following Designated ASU Offices to exchange confidential, personal, mental health and medical information concerning me, when necessary to coordinate my medical and mental health care: Campus Health Services, Physiotherapy Physical Therapy, Athletic Training Staff, Coaching Staff, Student Recreation Complex, Counseling and Consultation, Disability Resources and other confidential counseling services provided by or on behalf of ASU. I also give permission for the Designated ASU Offices to receive confidential information from and provide confidential information to any outside health professional directly involved in my care.

I give my permission for the limited release of medical, mental health and related information, including appointment dates and attendance records from designated ASU offices to the following individuals: Coaching Staff, Student Recreation Complex Staff, Sport Club Officers, Athletic Training Staff, Physical Therapists, Team Physician(s). This communication may be done by telephone, e-mail, or text messaging. This limited release allows the release of confidential information only to the extent necessary to determine payment for medical and related services rendered on my behalf, determine compliance with University rules regarding eligibility and medical treatment of the student athlete and to confirm appointment attendance.

I may revoke this release in any time by notifying any one of the designated ASU offices or Team Physician in writing. Revocation will not affect any release made prior to the revocation. This release will expire automatically on August 15th following the end of the Academic Year.

Signature___________________________________________________ Date_____________________

If athlete is younger than 18 years of age, parent or legal guardian must sign:

Signature___________________________________________________ Date_____________________

Print Name___________________________________________________________
Sickle Cell Trait is a genetically inherited condition that affects red blood cells during intense exercise. NCAA student-athletes with sickle cell trait have experienced significant physical distress during extreme conditioning and some have even died. Those student-athletes who have Sickle Cell Trait and who participate in football, basketball, track and field, wrestling, lacrosse, rugby, rowing, cycling/triathlon, ultimate frisbee, quidditch, roller hockey and/or soccer are at higher risk of complications during training. Therefore, athletes in those sports are required to present lab test results prior to participation clearance. Certain student-athletes are at higher risk of having this condition, specifically students who are of African-American and Hispanic descent.

The Arizona State University (ASU) Health Services and/or Sun Devil Athletics (SDA) has provided me with educational materials regarding Sickle Cell Trait (http://fs.ncaa.org/Docs/health_safety/SickleCellTraitforSA.pdf) and the risks associated with that diagnosis. I understand that the NCAA and ASU require that ALL incoming Division I student-athletes be tested for Sickle Cell Trait, provide documented results of a prior test to ASU or decline the test and sign a waiver releasing ASU from liability. I also understand that ASU requires all participants in high risk sports and walk-on sports to undergo testing prior to participation.

I acknowledge and understand that if I test positive for Sickle Cell Trait, I will NOT be restricted from playing my sport. However, for my health and safety, certain precautions will be taken with respect to my training and I will be removed from training if I develop symptoms associated with Sickle Cell Trait. I acknowledge that I have had a full opportunity to ask any questions I have about the diagnosis of Sickle Cell Trait and the ASU Sickle Cell Trait testing program and to discuss the risks associated with participation in intercollegiate athletics at ASU if I have Sickle Cell Trait. Any questions or concerns I had, if any, have been addressed to my satisfaction. I understand the risks involved if I choose NOT to be tested for Sickle Cell Trait, and I knowingly assume such risks.

(Please initial one line below)

_____ I have received this information and I AGREE to be tested for Sickle Cell Trait.

_____ I HAVE SHOWN ASU the results of a prior Sickle Cell Trait test.

_____ I have received this information, do not participate in a high risk sport, and I DECLINE a blood test for Sickle Cell Trait.

I understand that by refusing to undergo screening for Sickle Cell Trait, I assume all risks associated with such refusal and, in consideration for being granted the opportunity to participate in intercollegiate athletics at ASU without agreeing to be tested for Sickle Cell Trait, I (for myself, my executors, administrators and assigns) hereby release and forever discharge Arizona State University, the Arizona Board of Regents and the State of Arizona and their regents, officers, employees, agents, representatives, coaches, physicians, instructors and volunteers from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature directly or indirectly related to any personal injury, including death, bodily injury, mental anguish or emotional distress that I may suffer related in any way to my participation in intercollegiate athletics, whether caused by my negligence or carelessness or the negligence of ASU or otherwise. These risks have been discussed with me and I have made this decision on a fully informed basis. I understand that this release means that, among other things, I am giving up my right to sue Arizona State University for any such losses, damages, injury or costs that I may incur.

I represent and certify that I am at least 18 years old and that I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be legally bound by this document.

Print Name:_______________________________ Signature:________________________________ Date:_______________

If under 18, parent or legal guardian must print and sign below and indicate date signed.

Print Name:_______________________________ Signature:________________________________ Date:_______________

Witness: Print Name:_______________________________ Signature:________________________________ Date:_______________
Arizona State University
Mild Traumatic Brain Injury (MTBI) / Concussion
Statement and Acknowledgement Form

I, __________________________, acknowledge that I have to be an active participant in my own healthcare and have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing to the ASU Sports Medicine staff an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the NCAA Concussion fact sheet (http://fs.ncaa.org/Docs/health_safety/ConFactSheetsa.pdf) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the Sports Medicine staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have been cleared to do so by a team physician.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the NCAA the following sports have been identified as high risk for concussion: baseball, basketball, diving, equestrian, field hockey, football, gymnastics, ice hockey, lacrosse, pole vaulting, rugby, soccer, softball, water polo, and wrestling.

Baseline neuro-cognitive testing using the ImPACT computer program must be done at ASU prior to club sports clearance for: hockey, lacrosse, rugby, soccer, and, ultimate frisbee.

I represent and certify that I am at least 18 years old and that I have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be legally bound by this document.

Athlete Print Name: ___________________________ Signature: ___________________________ Date: ___________

If athlete under 18, parent or legal guardian must print and sign name below and indicate date signed:

Print Name: ___________________________ Signature: ___________________________ Date: ___________