Date:_____

PLAYER CONTACT INFORMATION

Name _____ Date of Birth _____

USTA # :_____IPIN #:_____

High School/College:_____ Date of Graduation:_____

Amateur ☐ Professional ☐ Date Turned Pro:_____ Personal Coach:_____

Coach Phone #:_____

Race/Ethnicity (*Optional*): White Black Asian Hispanic Native American Other:_____

PERMANENT ADDRESS

_____
STREET CITY STATE ZIP CODE

_____
HOME PHONE ALTERNATE PHONE EMAIL

INSURANCE INFORMATION

Primary Medical Insurance Company_____ Phone #_____

Name of Insurance Policy Holder_____ Medical Insurance Policy Number _____

CREDIT CARD INFORMATION-REQUIRED

"I hereby authorize the use of my credit card to cover all medical expenses."

Card Type (select one): ☐VISA ☐ M/C Card Number: _____ Ex. Date: _____

Name on Card: _____ Signature: _____

Father's Name _____
Father's Occupation _____
Age ____If Deceased, Cause of Death _____
Deceased Age _____
Address *(if different from permanent address above):*

_____
STREET

_____
CITY, STATE, ZIP

_____
HOME PHONE

_____
ALTERNATE PHONE

Mother's Name _____
Mother's Occupation _____
Age ____If Deceased, Cause of Death _____
Deceased Age _____
Address *(if different from permanent address above):*

_____
STREET

_____
CITY, STATE, ZIP

_____
HOME PHONE

_____
ALTERNATE PHONE

***** PLEASE CONTINUE TO PROVIDE UPDATED INFORMATION TO USTAPD IN WRITING*****

USTA PLAYER DEVELOPMENT MEDICAL INFORMATION FORM

(Please complete both sides of this form – please print)

The information contained in this Medical Information Form will only be used by USTA Player Development for internal purposes and in the event of a medical emergency. This information will remain **CONFIDENTIAL**.

Player Name:_____ Gender: _____ Age: ____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: _____

Relationship to Player: _____

Cell Phone: _____

Emergency Contact #2: _____

Relationship to Player: _____

Cell Phone: _____

INSURANCE INFORMATION

Personal Physician:_____ Phone: _____

Insurance Company & Address:_____

Policy Number/Group Number: _____

Date of Last Tetanus Booster: _____

Please list ***Medications, Vitamins, and Supplements*** you are currently taking (include inhalers):

_____

_____

Please list ***ALL*** known allergies:

_____

_____

USTA PLAYER DEVELOPMENT MEDICAL INFORMATION FORM

(Please complete both sides of this form – please print)

MEDICAL HISTORY QUESTIONNAIRE

Please answer the following questions about your medical history. If the answer to any question is 'YES', please provide the requested additional information below.

1. Have you ever been hospitalized? ..... Yes or No
   Have you ever had surgery? ..... Yes or No
2. Have you ever passed out during exercise? ..... Yes or No
   Have you ever been dizzy during or after exercise? ..... Yes or No
   Have you ever had chest pain during exercise? ..... Yes or No
   Do you tire more quickly than your friends during exercise? ..... Yes or No
   Have you ever had high blood pressure? ..... Yes or No
   Have you ever been told that you have a heart murmur? ..... Yes or No
   Have you ever had a racing heart or skipped heartbeats? ..... Yes or No
   Has anyone in your family had heart problems or died of sudden death before 50? ..... Yes or No
3. Do you have any skin problems (itching, rashes, acne)? ..... Yes or No
4. Have you ever had a head injury? ..... Yes or No
   Date of injury and treatment: _____
   Have you ever been knocked out or unconscious? ..... Yes or No
   Have you ever had a seizure? ..... Yes or No
   Have you ever had a "stinger", "burner" or pinched nerve? ..... Yes or No
5. Have you ever had heat or muscle cramps? ..... Yes or No
   Have you ever been removed or limited from play because of dehydration? ..... Yes or No
   Have you ever passed out or been dizzy in the heat? ..... Yes or No
6. Do you have trouble breathing or do you cough during or after activity? ..... Yes or No
7. Do you use any special equipment (pads, braces etc)? ..... Yes or No
8. Do you have any problems with your eyes or vision? ..... Yes or No
   Do you wear glasses or contacts or protective eyewear? ..... Yes or No
9. Have you ever sprained/strained, dislocated, fractured or had repeated swelling or other injuries to any bones or joints? ..... Yes or No
10. Have you ever been diagnosed with an eating disorder? ..... Yes or No
11. If you are female, have you had your first period? ..... Yes or No
12. If you are female, are you presently using birth control pills? ..... Yes or No

Please list (including dates) any surgeries, hospitalizations, or injuries that resulted in having to stop tennis play:

_____

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

Signature of Athlete: _____ Date: _____

PARENT/LEGAL GUARDIAN SIGNATURE

This is to certify that I/We _____ the parent/legal guardian of the person listed above have reviewed and certify that the medical information provided above is accurate and truthful, and have no reason to believe that my son/daughter is unfit to participate in the USTAPD program.

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

2015 Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that you, or your legal representative, consent in writing to the disclosure of your protected health information, including your medical records. By signing this form, your protected health information can be given to the individuals and/or entities listed on this form, for the reasons listed in this form.

Please read all statements on this form carefully, as it describes your rights regarding the use or disclosure of your protected health information and medical records that are subject to this authorization.

I, the undersigned, authorize any Doctor and/or USTAPD Trainer and/or USTA Trainer and/or Evert Tennis Academy Trainer and/or Athletes Performance Trainer that provides medical treatment to me during my involvement in the USTA Player Development Program (the "Covered Entities") to disclose to designated USTAPD and USTA representatives, Evert Tennis Academy and Athletes Performance representatives, USTAPD and USTA Trainers, USTAPD and USTA Coaches, and/or medical personnel from the International Tennis Federation and the player's respective tour (ATP or WTA)(collectively, "Covered Entities), the following protected health information: medical records and/or treatment logs that contain information with respect to any treatment and/or medical services provided to me during my participation in the USTA Player Development Program.

The protected health information and medical records covered by this authorization may only be used by the Covered Entities for continuity of medical care and determination whether I am ruled unable physically to compete per the official rules. This authorization will remain effective for 12 months from the date signed below or until December 31, 2015, whichever is later.

I understand that I have the right to revoke this authorization, in writing, at any time (except to the extent that the Covered Entities have acted in reliance upon this authorization) by sending notification by secured carrier to: *General Counsel, USTAPD, 70 West Red Oak Lane, White Plains, NY 10604*. I understand that a revocation will prevent the Covered Entities from further use or disclosure of my protected health information, but it will not retract the uses or disclosures that have already been made pursuant to the authorization.

I understand that: (i) the protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law; (ii) I have the right to refuse to sign this authorization; (iii) the Covered Entities cannot condition my treatment based upon whether I sign this authorization; (iv) I have the right to inspect and copy the protected health information and medical records covered by this authorization upon request; and (v) I have the right to receive a copy of this authorization upon request.

Leave a voice mail recording including my protected health information on my home/business/cell phone: _____ Yes _____ No

Permit the following individual(s) to receive information on my protected health information: _____

By signing below I acknowledge that I have read and understand my rights relating to this authorization for the use or disclosure of my protected health information and medical records.

_____	_____	_____
Print Name	*Signature*	*Date*

_____ _____

Signature of Parent(s)/Guardian(s) (if under 18)

AUTHORIZATION TO RELEASE

This Authorization to Release is designed to protect all participants in the USTA Player Development Program ("Program"), including but not limited to the student-athletes, USTA Player Development Incorporated, the United States Tennis Association Incorporated, the USTA Certified Regional Training Centers, the organizers and host facility of such Program, and their respective officers, directors, employees, volunteers, agents, and representatives.

I am the parent and/or legal guardian of _____.

I hereby give permission to the staff of the Program to allow the following individual(s) to pick up and/or drop off my child from the Program:

_____

_____

_____

_____

_____

_____

It is understood and agreed that the above individual will be prepared to show identification if requested by any staff member of the Program.

_____ _____

Signature of Parent or Legal Guardian Date

WAIVER & RELEASE FORM

Participant herby agrees to this Waiver and Release as a condition of his/her participation in USTAPD or USTA programs, activities, or events relating thereto including any travel in connection therewith ("Program"). Participant certifies that he/she has no health conditions or defects that would prevent my safe participation in the Program.

PARTICIPANT HEREBY RELEASES, DISCHARGES AND HOLDS HARMLESS USTA PLAYER DEVELOPMENT INCORPORATED ("USTAPD"), UNITED STATES TENNIS ASSOCIATION INCORPORATED, USTA NATIONAL TENNIS CENTER INCORPORATED, EVERT TENNIS ACADEMY LLC, ANSCHUTZ SOUTHERN CALIFORNIA SPORTS COMPLEX LLC, CALIFORNIA STATE UNIVERSITY DOMINGUEZ HILLS, THE VENUES OF THE PROGRAM, AND EACH OF THEIR RESPECTIVE AFFILIATES, SECTIONAL ASSOCIATIONS, OFFICERS, DIRECTORS, AGENTS, EMPLOYEES, VOLUNTEERS, REPRESENTATIVES, MEMBER ORGANIZATIONS, SPONSORS, SUCCESSORS AND ASSIGNS (COLLECTIVELY, THE "RELEASEES") FROM AND AGAINST ANY AND ALL CLAIMS, DEMANDS, DAMAGES, CAUSES OF ACTION, PRESENT OR FUTURE, WHETHER KNOWN OR UNKNOWN, ANTICIPATED OR UNANTICIPATED, RESULTING FROM OR ARISING OUT OF PARTICIPANT'S PARTICIPATION IN THE PROGRAM, AND PARTICIPANT DOES HEREBY COVENANT AND AGREE THAT HE/SHE WILL NOT SUE OR OTHERWISE MAKE ANY CLAIM AGAINST RELEASEES FOR ANY REASON.

Participant hereby irrevocably consents, in perpetuity, throughout the world, to the use of his/her name, voice, image and/or likeness in any live or recorded transmission, recording, or photograph taken of Participant during the Program, published, produced, broadcasted or otherwise disseminated by Releasees in any and all media now existing or hereafter discovered or developed. Participant consents to all such uses without any further compensation or other consideration becoming due to Participant.

CONSENT TO MEDICAL TREATMENT & RELEASE: Participant consents that the Releasees may, but have no duty, to provide him/her, through personnel of their choice, assistance, transportation, and/or emergency medical services in the event Participant sustains any injury while participating in the Program. Participant further understands that he/she will be responsible for payment of any such medical care. Participant's participation in the Program is without assumption or responsibility of any kind by the Releasees for any Program in which he/she may be entered or may participate. In consideration of the acceptance of his/her participation, Participant hereby for and on behalf of his/herself, and his/her heirs and legal representatives release and forever discharge the Releasees from any and all claims and damages, losses or injuries which may be suffered or sustained by Participant in connection with the Program, and all claims are hereby waived and released, and Participant covenants not to sue therefore. Participant hereby agrees to abide by all applicable rules and regulations and codes of USTAPD and/or the same as may be adopted by USTAPD from time to time, and hereby consents to be tested for drugs pursuant to the provisions thereof.

This Waiver and Release is governed by and enforceable in accordance with the laws of the State of New York without giving effect to the principles of the conflicts of law for that State, and the parties submit to the exclusive jurisdiction of the New York Courts, County of Westchester. If any provision of this Waiver and Release should be adjudged illegal, invalid or unenforceable, the remaining provisions shall remain in full force and effect.

AGREED TO AND ACCEPTED:

I hereby represent that, if this form is not signed by my parent or guardian, I am eighteen (18) years of age or older. By participating in the Program, I acknowledge that my electronic signature is authentic and a valid form of acceptance.

Participant's Name (print): _____ Age (required only if Participant is under 18): _____

Participant's Signature: _____ Date: _____

THE FOLLOWING MUST BE COMPLETED IF PARTICIPANT IS UNDER 18 YEARS OLD

In consideration of Participant's participation, I, by my signature below, and in my capacity as Participant's parent or legal guardian, hereby (a) give permission for the Participant, who is my child or ward, to participate voluntarily in the Program, and (b) acknowledge and agree to all of the terms set forth in this Waiver and Release Form. I hereby acknowledge that my electronic signature is authentic and a valid form of acceptance.

Print Name of Parent or Guardian #1: _____ Print Name of Parent or Guardian #2: _____

Signature of Parent or Guardian #1: _____ Signature of Parent or Guardian #2: _____

Date: _____ Date: _____

RULES OF PLAYER CONDUCT

Behavior Rules

USTA Player Development Incorporated ("USTAPD") expects players be mentally and physically prepared to learn and develop their games to the highest level. We expect players to be responsible, self-motivated, and hard working individuals. All camps, trips or other USTAPD sponsored activities are designed to develop players to the highest level competition that he/she can achieve. All activities are taken seriously in furtherance of their development. Every player is expected to:

1. Strive to make the most of this opportunity for learning, both on and off the tennis court;
2. Be considerate and respectful of the coaches, staff and other players;
3. Respect the opportunities that students are offered here; and
4. Be positive and supportive of players

General Rules

1. Players are expected to stay with team members at all times and must inform the coaches as to their whereabouts at all times. Any deviation from the normal circumstances requires permission from the team coach in advance;
2. Smoking, use or possession of drugs or alcohol, gambling, use of profanity and cheating are strictly prohibited;
3. When under the supervision of USTAPD coaches or staff, players are prohibited from driving a motor vehicle or riding with someone who has not been approved by USTAPD Staff;
4. Players will wear appropriate tennis attire to all tennis related functions (practice, matches, etc.);
5. The USTAPD National Team Coaches will be responsible for all aspects of the tournament, including coaching, practice, training, nutrition and match evaluation; and
6. Any player who violates the above rules shall be subject to disciplinary measures.

Housing Rules

1. Male and female players are not allowed in each other's housing units at any time without staff permission;
2. Players are expected to abide by the curfew set by USTAPD National Team Coaches or staff;
3. Players will be expected to leave the housing units in the same condition that they were found and shall be kept presentable during the week. Room inspections will be held periodically throughout the event. *All players will be held financially responsible for damages sustained in the housing units;*
4. Players must travel and stay with the group during the entire event. Special transportation and housing arrangements with parents, other players or friends are not allowed unless approved in advance in writing by the USTAPD;
5. Use of any flammable devices is prohibited;
6. Players are expected to look presentable during meals and may not wear provocative clothing at any time; and
7. Players are expected to clean up after themselves at all times.

Failure to comply with any of the above rules of conduct may:

1. Result in notification of parents and USTAPD officials;
2. Result in the player being sent home immediately. The decision of the USTAPD Coaching Staff is final in this respect;
3. Result in suspension or dismissal from any Player Development programs and/or tournaments;
4. Result in loss of future opportunities to represent the United States in tennis or to attend any future camps; and/or
5. Result in the performance of an appropriate task(s), such as a written explanation and accounting of the incident.

We are happy to offer you this opportunity. Parents and personal coaches are encouraged to attend the event (at their own expense) with the understanding that they may not interfere with the players or the experience. Parents and personal coaches are responsible for their own arrangements for travel, lodging and meals which shall be independent of the group.

It is understood that all players are expected to play in team competitions if invited to represent the United States in ITF team competition, including, but not limited to, World Junior Tennis, Jr. Davis/Jr. Fed Cup, Davis/Fed Cup, and the Olympic Games.

I have read and understand the Rules of Player Conduct and will adhere to them while attending the event.

_____	_____	_____	_____
Player Signature	*Parent/Legal Guardian Signature*	*Personal Coach*	*Date*

Athlete Periodic Health Evaluation Form

MEDICAL HISTORY

Demographic

Personal Information

Last Name _____ First Name _____
Address: Street _____ City_____ Region_____
Post Code_____ Country_____
Preferred Language: _____
Birthdate: yyyy_____/mm_____/dd_____
Sex (M/F):_____
Phone: Home_____ Mobile_____
Emergency Contact 1: Name_____ Relationship _____ Phone _____
Emergency Contact 2: Name_____ Relationship _____ Phone _____
Health Care Insurance (company number): _____
Family Physician (name, phone number): _____

Background

The following questions ask for information regarding your personal background

What is your main sport? (sport, event/position): _____

Have you participated in other sports in the past (include those sports you have done competitively)? No❑ Yes ❑: _____
What is your ethnic origin?: _____

Do you have any religious convictions that could affect your medical treatment?	No ❑	Yes ❑
When was the last time you had a complete physical examination?: _____		
Have you ever failed a pre-participation examination for sports, or has your doctor ever stopped you from participating in sports for any reason?	No ❑	Yes ❑

In total, how many days have you missed practice or competition in the past year because of injury or illness?:
_____

Heart

Have you ever had any of the following heart or circulation related problems?:

Chest pain, discomfort, tighness or pressure with exercise?	No ❑	Yes ❑
Unexplained fainting or near fainting or passed out for no reason DURING or AFTER exercise?	No ❑	Yes ❑
Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise?	No ❑	Yes ❑
Do you get more tired or short of breath more quickly than your friends during exercise?	No ❑	Yes ❑
Does your heart race or skip beats (irregular beats) during exercise?	No ❑	Yes ❑
Heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem?	No ❑	Yes ❑
Have you ever had an unexplained seizure?	No ❑	Yes ❑
Any tests for your heart (for example, ECG or EKG, echocardiogram)?	No ❑	Yes ❑

Breathing

Have you ever had any of the following respiratory or breathing problems:

Do you have asthma?	No ❑	Yes ❑
Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu like illness?	No ❑	Yes ❑
Do you cough, wheeze or have more difficulty breathing than you should during or after exercise?	No ❑	Yes ❑
Have you ever used asthma medication (such as an inhaler)?	No ❑	Yes ❑
Have you ever had bronchitis, pneumonia, tuberculosis, cystic fibrosis or other respiratory or other breathing problem?	No ❑	Yes ❑

Heat

The following questions are about exercise in the heat:

Have you ever become ill while exercising in the heat?	No ❑	Yes ❑
Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia?	No ❑	Yes ❑
Do you get frequent muscle cramps while exercising?	No ❑	Yes ❑
Have you ever had electrolyte (salt) or fluid imbalance?	No ❑	Yes ❑

Medical

Do you have any ongoing medical conditions or illness?	No ❑	Yes ❑
Do you have, or have you ever had any symptoms of medical problems such as:		
Infections mononucleosis (**mono**), flu like symptoms or viral illness within the past month?	No ❑	Yes ❑
Disease of the **ears** (infections, hearing loss, pain), **nose** (sneezing, itchy nose, sinusitis, blocked nose) or **throat** (sore throat, hoarse voice, swollen glands in the neck)?	No ❑	Yes ❑
Blood disorders such as anemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder?	No ❑	Yes ❑
Immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication?	No ❑	Yes ❑
Skin problems such as rashes, infections (fungus, herpes, MRSA) or other skin problems?	No ❑	Yes ❑
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?	No ❑	Yes ❑
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhea, blood in the stools, or past history of liver, pancreatic or gallbladder disease?	No ❑	Yes ❑
Nervous system including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue?	No ❑	Yes ❑
Metabolic or hormonal disease including diabetes mellitus, thyroid gland disorders, or hypoglycemia (low blood sugar)?	No ❑	Yes ❑
Infections such as meningitis, hepatitis (jaundice), or chicken pox?	No ❑	Yes ❑
Arthritis or joint pain, swelling and redness not related to injury?	No ❑	Yes ❑
Were you born without, or are you **missing** a kidney, an eye or any other organ?	No ❑	Yes ❑

An **injury** to the any internal organs such as your liver, spleen, kidney(s) or lung? No ❑ Yes ❑
Have you ever had **surgery**? (explain) No ❑ Yes ❑
Do you get motion sickness (car, air or sea sickness)? No ❑ Yes ❑
Do you have any other medical problems? No ❑ Yes ❑

Family

Do any of your family members have a history of any of the following conditions (in male relatives < 55 years, female relatives < 65 years):

Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)? No ❑ Yes ❑
Unexplained fainting, seizures, or near drowning? No ❑ Yes ❑
Died before age 50 due to heart disease? No ❑ Yes ❑
Disability or symptoms from heart disease before age 50? No ❑ Yes ❑
Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, heart surgery, pacemaker or defibulator? No ❑ Yes ❑
High blood pressure or high blood cholesterol? No ❑ Yes ❑
Marfan's Syndrome? No ❑ Yes ❑
Bleeding disorder, Sickle cell trait or sickle cell disease? No ❑ Yes ❑
Tuberculosis or Hepatitis? No ❑ Yes ❑
Anaesthetic reaction or problem? No ❑ Yes ❑
Other condition such as stroke, diabetes, cancer, arthritis (describe)? No ❑ Yes ❑
Are you unsure of your family history? No ❑ Yes ❑

Medications

The following questions are about medications and supplements you are taking, or have taken in the past month:

Medications that have been prescribed by a doctor (include insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications etc.)? No ❑ Yes ❑
Non-prescription medications (include pain killers, anti-inflammatories, etc.)? No ❑ Yes ❑
Vitamin or mineral **supplements** or herbal medicines? No ❑ Yes ❑
Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)? No ❑ Yes ❑
Have you ever been offered or encouraged to use **banned performance enhancing drugs**? No ❑ Yes ❑

Allergies

Do you have any allergies to:

Medication? No ❑ Yes ❑
Anything else, such as foods, pollens, stinging insects, any plant material or any animal material? No ❑ Yes ❑

Immunization

Indicate which immunizations you have received:

Tetanus / Diptheria (Td or Tdap)? No❑ Yes ❑: Last shot? _____
Measles / Mumps / Rubella (2 shots)? No❑ Yes ❑
Chicken Pox (Varicella)? No❑ Yes ❑
Meningitis (Menimune or Menactra)? No❑ Yes ❑
Hepatitis A (2 shots)? No❑ Yes ❑
Hepatitis B (3 shots)? No❑ Yes ❑
Malaria? No❑ Yes ❑
Have you had a TB Test (PPD)? No❑ Yes ❑ Result? _____
Have you had any other immunizations? No❑ Yes ❑ Explain: _____

Female

These questions are for females only:

Have you ever had a menstrual period? No ❑ Yes ❑
What was your age at your first menstrual period?: _____
Do you have regular menstrual cycles? No ❑ Yes ❑
How many menstrual cycles did you have in the last year?: _____
When was your most recent menstrual period?: _____
Have you had a stress fracture in the past? No ❑ Yes ❑
Have you ever been identified as having a problem with your bones such as low bone density (osteopenia or osteoporosis)? No ❑ Yes ❑
Are you presently taking any female hormones (estrogen, progesterone, birth control pills)? No ❑ Yes ❑
Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, venereal warts, chlamydia or other infection? No ❑ Yes ❑

Male

These questions are for males only:

Do you have two normal testicles? No ❑ Yes ❑
Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)? No ❑ Yes ❑
Have you ever had an injury to a testicle? No ❑ Yes ❑
Have you ever had surgery for an undescended testicle, testicular injury or problem? No ❑ Yes ❑
Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, venereal warts, chlamydia or other infection? No ❑ Yes ❑

Head & Neck

Have you ever had any of the following problems related to your head or neck?:

Eye injury, or other problems with your vision? No ❑ Yes ❑
Headaches with exercise? No ❑ Yes ❑
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling? No ❑ Yes ❑
Do you have, or have you been x-rayed for, neck (atlantoaxial) instability? No ❑ Yes ❑
Have you had an injury to your teeth? No ❑ Yes ❑
Do you have any other decayed, missing or filled teeth? No ❑ Yes ❑
Do you have a dental prosthesis or appliance? No ❑ Yes ❑
Have you had your wisdom teeth removed? No ❑ Yes ❑

Injury

Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or

headache from a hit to your head, having your "bell rung" or getting "dinged")?	No ❑	Yes ❑
Have you had a problem or an injury like a sprain, strain, muscle or ligament tear, or tendonitis, broken bone, stress fracture or joint injury (that caused you to miss a practice or competition) to any of the following areas of your body?		
Neck or spine (including a "stinger," or "whiplash,")	No ❑	Yes ❑
Upper back (thoracic spine)	No ❑	Yes ❑
Lower back (lumbar spine)	No ❑	Yes ❑
Chest and ribs	No ❑	Yes ❑
Shoulder area (including collar bone)	No ❑	Yes ❑
Upper arm	No ❑	Yes ❑
Elbow	No ❑	Yes ❑
Lower arm (forearm)	No ❑	Yes ❑
Wrist	No ❑	Yes ❑
Hand or fingers	No ❑	Yes ❑
Pelvis, groin or hip (including sports hernia)	No ❑	Yes ❑
Thigh (including hamstrings and quadriceps)	No ❑	Yes ❑
Knee	No ❑	Yes ❑
Lower leg (calf or shin)	No ❑	Yes ❑
Ankle	No ❑	Yes ❑
Foot, heel or toes	No ❑	Yes ❑

Other

Tests - If not already mentioned above, have you had any other tests, for any injury or condition including blood tests, X-rays, MRI, CT scan, Bone scan, Ultrasound,Electroencephalogram (EEG), Electromyogram (EMG), Nerve conduction studies (NCS), Electrocardiogram (ECG/EKG), Echocardiogram (Echo), Exercise stress test or other tests?	No ❑	Yes ❑
Treatment - If not already mentioned above, have you ever received any of the following treatments for any condition?		
Surgery?	No ❑	Yes ❑
Been prescribed a **brace, sling, cast, walking boot, orthotic**, **crutches** or other appliance?	No ❑	Yes ❑
Cortisone injection?	No ❑	Yes ❑
Been prescribed other **rehabilitation or therapy**?	No ❑	Yes ❑
Have you ever spent the night **in a hospital** or been admitted to a hospital as an inpatient or outpatient?	No ❑	Yes ❑
Been referred to a **medical specialist** (cardiologist, neurologist or other medical person) for any condition not already mentioned?	No ❑	Yes ❑
Equipment		
Do you wear eye glasses or contact lenses?	No ❑	Yes ❑
Are you **currently** using any of the following protective equipment?	No ❑	Yes ❑
Do you use protective eyewear?	No ❑	Yes ❑
Special equipment (pads, braces, etc.)?	No ❑	Yes ❑
Mouth guard for sports?	No ❑	Yes ❑
If you wear a **helmet** for sports, how old is it?	No ❑	Yes ❑

Nutrition

The following questions are about nutrition:		
Do you worry about your weight or body composition?	No ❑	Yes ❑
Are you satisfied with your eating pattern?	No ❑	Yes ❑
Are you a vegetarian?	No ❑	Yes ❑
Do you lose weight to meet weight requirements for your sport?	No ❑	Yes ❑
Does your weight affect the way that you feel about yourself?	No ❑	Yes ❑
Do you worry that you have lost control over how much you eat?	No ❑	Yes ❑
Do you make yourself sick when you are uncomfortably full?	No ❑	Yes ❑
Do you ever eat in secret?	No ❑	Yes ❑
Do you currently suffer or have you ever suffered in the past with an eating disorder?	No ❑	Yes ❑
What is your current weight? ___	No ❑	Yes ❑
How tall are you without shoes? ___	No ❑	Yes ❑

Discuss

Do you have any other concerns that you would like to discuss with a doctor?	No ❑	Yes ❑

Explain "YES" answers here:

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

Signature of athlete: _____

Signature of parents or legal representative (when needed): _____ Date _____

PHYSICAL EXAMINATION

Date of Examination:_____

Medical	NORMAL	ABNORMAL (specify)
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lympth nodes		
Heart		
Rhythm		
Heart sounds / murmurs in supine and standing		
Peripheral oedema		
Physical stigmata of Marfan's syndrome		
Blood vessels		
Peripheral pulses		
Delay in femoral pulses		
Vascular bruits (femoral)		
Varicose veins		
Blood Pressure in Sitting Position (after 5 minutes rest)		
Right arm		
Left arm		
Heart rate (after 5 Minutes rest)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Eyes		
visual acuity (corrected/uncorrected)		
equal pupils		

Musculoskeletal		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		

Leg/ankle		
Foot/toes		

Investigations

12 Lead ECG (every 2 years) Details: Date:

- ❑ Normal / no changes
- ❑ Common and training-related ECG changes
- ❑ UnCommon training-unrelated ECG changes

Blood Tests Other:

Haemoglobin	
Haematocrit	
Erythrocytes	
Thrombocytes	
Leukocytes	
Ferritin	
Sodium	
Potassium	
Creatinine	
Cholesterol (total) (every 4 years)	
LDL Cholesterol	
HDL Cholesterol	
Triglycerides	
Glucose	
Serum Urea	

Clinical Evaluation Outcome

The athlete does not present apparent clinical contraindications to practice the following sport(s)

1 (specify): No • Yes •

If the answer to question 1 is “No”, it is recommended that the athlete:

avoids participating:

- in training (explain) No • Yes •

- in competition (explain) No • Yes •

respects the following restrictions:

- during training (specify) No • Yes •

- during competition (specify) No • Yes •

undergoes further examinations (specify):

Examining physician

Name: _____ Phone Number: _____

Address: _____ Email _____