If you are trying out for a team at Kent State University, the following must be submitted to the Athletic Training department prior to the tryout:

- Provide proof of a physical within the last 6 months (form attached if needed)
- Show proof of sickle cell test results or sign a waiver refusing sickle cell testing
- Sign an Assumption of Risk document
KENT STATE UNIVERSITY
INTERCOLLEGIATE ATHLETICS

General Medical Entrance Examination

NAME: _________________________________  SS# _____________________  DATE: ________________

SPORT: __________________  HOME PHONE: (_______) __________________

HOME ADDRESS: ________________________________________________________________
Street __________________________________  City ___________________  State _______  Zip ______

Student-Athlete: Please read and sign the last section on the second page!

DATE OF LAST IMMUNIZATION: (Please attach copy of Immunization Record. Also required by UHC)
TDap: _______________   MMR: _______________

Physician/Clinician to Complete:

HEIGHT: _______________  WEIGHT: _______________

Vitals:

B/P: _______________  PULSE: _______________  RESPIRATION: _______________

EYES: ____________________________________  VISUAL ACUITY: Right _____/_____  Left _____/_____

EARS: ____________________________________  HEARING: Right _____________  Left ______________

NOSE: ____________________________________  DENTAL: _______________________________________

THROAT: __________________________________

HEART: __________________________________  LUNGS: ________________________________

ABDOMEN: __________________________________  SKIN: ________________________________

LYMPH: ____________________________________  GENITALIA/HERNIA: _______________________

MUSCULOSKELETAL:

NECK: ________________________________

SHOULDER: _________________________

UPPER EXTREMITIES: ....

TRUNK/BACK: ______________________

THIGH: _____________________________

KNEE: _____________________________

ANKLE: ____________________________

FOOT: _____________________________

NEUROLOGICAL: ________________________________
LABORATORY: (Only if Indicated by previous injury/illness or family history)
Urinalysis: Protein _______________ Glucose _______________
Hematology: Hct _______________
Sickle Cell Anemia: Results: _______________ Date: ____________
Test or Waiver Required by NCAA

COMMENTS AND RECOMMENDATIONS:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

PARTICIPATION RECOMMENDATIONS: (Please Circle One Below AND List Any Comments/Restriction):
FULL PARTICIPATION
LIMITED/RESTRICTED PARTICIPATION
NO PARTICIPATION

COMMENTS AND RECOMMENDATIONS:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

PHYSICIAN’S SIGNATURE: __________________________ Date: ____________ / ____________________
Physician’s Printed Name: ........
Physician’s Address: ........
Street __________________________ City __________________________ State __________________________ Zip __________________________

Student-Athlete: Please complete the following

I, __________________________, the undersigned, herewith:

A. Understand that I must refrain from practice or play while ill or injured, whether or not receiving medical treatment and during medical treatment until I am discharged from treatment or I am given permission by the clinical practitioner to restart participation despite continuing treatment.

B. Understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at the time of said physical examination.

Date: __________________________ Athlete’s Signature: __________________________

Oct 1 General Medical Exam (2015)
Kent State University Sports Medicine

Sickle Cell Trait Screening Waiver

- The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.
- In accordance with the NCAA recommendation, Kent State University Sports Medicine is encouraging sickle cell trait testing for all student-athletes.

I, ____________________________, (Print Name) understand and acknowledge that the NCAA and Kent State University Intercollegiate Athletics mandate that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Kent State University Sports Medicine personnel.

I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Ohio, the University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the mandate of the NCAA and Kent State University Department of Intercollegiate Athletics. I have read and signed this document with full knowledge of its significance. I have received a Sickle Cell Education Materials packet provided by the Kent State University Sports Medicine Staff. I understand the results of this test will not affect my eligibility nor influence depth chart decisions. I further state that I am at least 18 years of age and competent to sign this waiver.

_________________________________________  ____________________________
Student-Athlete Signature  Date

_________________________________________
Sport  SS#

_________________________________________
Parent/Guardian Signature (if minor)  Date

_________________________________________
Parent/Guardian Printed Name
By signing this document, you will waive certain legal rights. Please read carefully!

1. I, __________________________, understand and agree that my participation at Kent State University ("University") Department of Intercollegiate Athletics facilities is voluntary. I further understand and acknowledge that my participation in this PAS Program will require my voluntary participation in physical demonstrations and activities including, but not limited to: stretching, running, jumping, walking, throwing, catching, shooting and will involve certain inherent known and unknown risks associated with my participation in said activities held at the University on ____________. I further understand that such risks may include but are not limited to: bodily injury, death, and/or other possible dangers associated with my participation in such activities. Herein Defined as “RISKS”. I further understand that there are Risks in such activities and in the training and preparation for such activities. I understand, acknowledge and agree that it is my sole responsibility to participate only in those activities for which I have the prerequisite skills, qualifications, preparations, and training, and for which I am willing to assume all Risks.

2. To the best of my knowledge, I am not aware of any physical condition or disability or health-related reasons or problems which would preclude or restrict my (or my minor child’s) participation in the University’s PAS Program athletic activities. All prospects must submit a copy of a medical examination/physical performed by a physician within the last six (6) months (or within six months of the start of the prospect’s basketball season), which includes sickle cell testing or a waiver of the sickle cell test to the Sports Medicine staff prior to engaging in athletic activity in Kent State University facilities.

3. I am fully aware of the Risks inherent in the University PAS Program’s athletic activities, and I hereby elect (or allow my minor child) to voluntarily participate in such activities, knowing that the activities may be hazardous to my (or my minor child’s) person. I understand that if I (or my minor child) have (has) questions about possible Risks, it is my (and my minor child’s) responsibility to seek additional information from the person named below*** prior to signing this document or from the relevant coach or leader prior to participating in any activities.

4. In consideration for my (or my minor child’s) participation in the University PAS Program’s athletic activities, I voluntarily ASSUME FULL RESPONSIBILITY FOR ANY RISKS AS A RESULT OF BEING ENGAGED IN SUCH ACTIVITY. Additionally, you (or the parent if a minor child) authorize Kent State University to call for emergency assistance if it should become necessary, and upon any such occurrence, the minor child’s parent/s will be contacted.

5. In addition, in consideration for Kent State University (the “University”) allowing my (or my minor child’s) participation in University athletic activities, I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE the University, its trustees, officers, agents, and/or employees (including, but not limited to, student drivers) from any and all liability, claims, actions, demands, expenses, attorney fees, breach of contract actions, breach of statutory duty or other duty of care, warranty, strict liability actions, and causes of action whatsoever, that I (or my minor child) might have or in the future acquire, arising out of or related to any injury, including death, that may be sustained by me (or my minor child), while participating in any University PAS Program athletic activity, or any related activity, including, but not limited to, games, competitions, scrimmages, practices, training, or equipment of the University including, but not limited to, any claim that the act of omission complained of was caused in whole or in part by the negligence in any form of the University or any of its trustees, officers, agents, or employees. In other words, I agree that I (and my minor child) cannot sue or recover anything from the University or any of its trustees, officers, agents or employees if I (or my minor child) am (is) injured in any way, or if anything happens to me (or my child’s) person, including as a result of any claimed future negligence or carelessness of the University, or while preparing for or participation in any University athletic activity.

6. It is my express intent that this General Assumption of Risk, Waiver of Liability, Release, and Covenant not to sue, for Prospects, Alumni, and Other Community Members Participating in University athletics, shall bind me, if I am alive, and my heirs, and personal representatives, if I am deceased, and shall be deemed as an assumption of Risks.

7. I hereby further agree that this Release shall be construed in accordance with the laws of State of Ohio, and that if any portion is deemed to be invalid, the remainder of the Agreement will be still binding and enforceable.

8. I hereby further agree that this Release shall be binding from this date forward for all University athletic activities.

9. In signing this Release, which consists of two (2) pages, I acknowledge and represent that I have read the document in full, that I understand it and sign it voluntarily, and that no oral representations, statements, or inducements, apart from the foregoing written document have been made to me on the subject matter of this document, that I am fully competent, and that I execute this Release for full, adequate, and complete consideration fully intending for me (and my minor child) to be bound by the same.

I further understand that I am waiving and releasing any and all legal rights that I may have against the University and/or any of its trustees, officers, agents and/or employees for any and all known and unknown risks associated with, and/or involving negligence with respect to my care, participation, preparation and travel to and from athletic activities in this program. I understand and agree that I have the right to consult legal counsel prior to engaging in this PAS Program to further understand the possible ramifications of signing this Waiver and Release of Liability form.
10. I further certify that:

☐ I am at least eighteen (18) years of age and fully competent; or that I am

☐ Under eighteen (18) years of age, and my parent or guardian is also signing individually and on my behalf and we both agree to be bound by the terms of the agreement.

Name: __________________________ Signature: __________________________ Date: ________________

Parent/Guardian Signature (if participant is under 18): __________________________ Date: ________________

Emergency Contact Information (Person, cell phone): __________________________