

NCFDP CAMP PARTICIPANT PHYSICAL SCREENING EXAM

Please Type as much as possible, hand-write the rest , then print and mail.

Name: Home Phone:

Age: Date of Birth: Emergency Phone:

A. Insurance Information and Consent to Participate

We understand that there are inherent risks involved with participation in sports camps. By participating we agree to assume those risks which include, but are not limited to, such injuries as death, paralysis, head/spinal injuries, sprains/strains, contusions, punctures and lacerations. We also understand that the USFA/NCFDP/UNCFC/UNC Department of Athletics/UNC Exercise Science Department cannot, and do not, provide medical insurance. We certify that is covered by accident/health insurance. This coverage is by virtue of :

Insurance Provider: **Policy #**

B. Personal History

Please answer the questions on this page only only. Answer as honestly as possible

	yes	no	don't know	Physician's Comments
1. Has anyone in your family (grandparents, parents, brother, sister) died before age 50?				
2. Have you ever stopped exercising because you were dizzy, or have you passed out during exercise?				
3. Have you ever been told you have a heart problem?				
4. Do you ever experience wheezing, difficult breathing, or coughing during exercise?				
5. Have you ever broken a bone, dislocated a joint, or had to wear a cast? If yes, where? _____				
6. Have you ever had a concussion, head/neck/back injury, or tingling/numbness in your arms/hands/legs/feet?				
7. Have you ever had a heart related illness(heart stroke/exhaustion) or had difficulty exercising in hot weather?				
8. Do you have anything you want to talk to the physician about?				
9. Do you have a chronic illness/injury, or see a physician/trainer regularly for any problem or treatment/rehab?				
10. Are you taking any medications? List: drug _____ dosage _____ times/day _____				
11. Are you allergic to any medications or insect stings? If yes, what emergency medication do you use? _____				
12. Do you have only one of any paired organs (eyes, kidneys, testicles, ovaries, etc.)?				
13. Do you wear contacts or eyeglasses?				
14. Do you feel you are over or under weight, and are you on any special diet?				
15. Has a physician ever told you to give up sports or limit your activity because of a health-related problem?				

I have read the above questions and, to the best of my knowledge, agree that they are true.

Athlete's Signature:

Parent's Signature:

C. Vital Statistics

Height: Weight: Vision(rt) Vision(lt) Blood Pressure

D. Musculoskeletal Exam

	Normal	Abnormal	Record laxity, weakness, instability, decreased ROM, abnormal tests
Neck			
Shoulder			
Spine			
Hip			
Knee			
Ankle			
Feet			
Other			

E. Physicians Exam

	Normal	Abnormal	Comments
ENT			
Heart			
Lungs			
Abdomen			
Skin			
Other			

F. Recommendations

- 1. Authorized to participate/compete without restriction
- 2. Authorized to participate/compete in non-contact activities only
- 3. Authorization deferred until:

G. Physician's Signature

I certify that I have examined the above athlete, and I am licensed to practice medicine in the state of:

Signature Date

Name(print) phone number