



Athletic Training Department
2020 S. Ave. 8E | PO Box 929
Yuma, AZ 85366
Fax: 928-344-7537

Please Print Your Name: _____ Sport: _____

In anticipation for the upcoming athletics season, this letter is to inform you of the requirements at Arizona Western College to participate in intercollegiate athletics.

Under the NJCAA Eligibility Rules (Article 5 Section 7), all student-athletes are required to have a valid physical on file with the athletic department of the college prior to their involvement in any college-sponsored in-season or off-season practice, workouts, and/or contests. (5.7.A4.b.) This requirement applies to any athlete that is beginning their initial season of eligibility or trying out for an athletic team. This exam, administered by a licensed health care professional, must take place within 13 months prior to the intended date of NJCAA sanctioned practice/competition. (5.7.A3.) It is also recommended (not required) that a cardiovascular screening be done as part of the physical examination. (5.7.A2.) Without a valid physical student-athletes are ineligible to dress, practice, or participate in any contest. (5.7.A4.a)

Each student-athlete is required to sign and submit the following prior to participation:

- AWC Medical Information Policy
 - Note: Athletic trainers will only speak to parents/guardians if student-athlete is under 18 years of age or by appointment (phone acceptable) with the student-athlete present.
- Athletic Insurance Policy
- Student-Athlete Current Insurance Information
 - (If Applicable) Copy of the Front and Back of Insurance Card
- Concussion Policy and Treatment Protocol
- Assumption of Risk Waiver
- Sickle Cell Trait Testing Results or Release Form
- Student-Athlete and Emergency Contact Information
- Student-Athlete Medical History
- Student-Athlete Physical Examination (Completed by a DO, MD, or PA-C)

Completion and submission of **ALL** parts of this physical examination and waiver packet are due back to the athletic training staff prior to participation in any athletic event. If you have any questions, feel free to contact the athletic training staff.

Sincerely,
Allison Griffin, LAT, ATC
Allison.Griffin@azwestern.edu
Office: 928-344-7541
Fax: 928-344-7537

AWC Athletic Training Medical Information Policy

This form authorizes Arizona Western College and its personnel to release certain personal information about student-athletes for educational purposes, including information that may be subject to the Family Education Rights and Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Please read it carefully.

“Personal information” means specific information about **you** - this includes educational records and personal health information. Arizona Western College may disclose this information as a condition to permit you to participate in intercollegiate athletics; to benefit you in pursuing athletics beyond Arizona Western College; to address your health as you participate in intercollegiate athletics; and/or to highlight Arizona Western College’s athletics programs or your participation in them. This information can include: your name, address, telephone number, email address, date/place of birth, your home town, medical or health conditions, weight, height, participation in officially organized activities and intercollegiate athletics (i.e. positions played or statistics), dates of college attendance, major field of study, degrees and awards, grade point average, the name of your high school(s), and the name of any other post-secondary institution you have attended. This may also include any photo, portrait, video clip, or other image of you created on behalf of Arizona Western College.

By signing this form, I certify that:

1. I have read and understand the definition of “personal information” specified in this form.
2. I authorize the release of my personal information for the purposes specified in this form EXCEPT for those listed below:

3. I authorize **full disclosure** of personal information concerning any athletic injury I may sustain while participating in intercollegiate athletics. Furthermore, I understand that some or all of the following persons may be told about my health conditions/athletic injuries: coaches, media, parents, athletic director, team physicians, doctors’ staff, referral sources, and the Arizona Western College insurance brokers or companies.
4. I authorize the use and disclosure of personal information for the following purposes:
 - a) In promotional literature or video presentations about college athletic programs or about Arizona Western College in general
 - b) In any website maintained by or for the benefit of Arizona Western College
 - c) To disseminate to the National Junior College Athletic Association concerning my participation in intercollegiate athletics
 - d) To include in any program or publication about an athletic event sponsored by Arizona Western College or by any other organization and in which Arizona Western College is participating
 - e) To disseminate to other postsecondary institutions in connection with their recruitment activities
 - f) To release to any newspaper, broadcasting entity, or any other media outlet
 - g) To disseminate to any high school or other educational institution I have attended
5. I understand that I have the right not to consent to the release of my personal information and to receive a copy of them on request. This consent shall remain in effect until revoked by me in writing and delivered to Arizona Western College. Any revocation will not affect disclosures that Arizona Western College made before receiving my revocation.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If Student-Athlete is Under 18)

Signature of Parent/Guardian: _____ Date: _____

AWC Athletic Insurance Policy

Student athletes who sustain injuries while participating in an organized team practice and/or competition have the right to see a physician of their choice and/or our team physician. All billing is subjective to insurance provider and policy coverage/deductibles. Before returning to team activity, the following must be provided prior to clearance of participation:

- dictations from office visit of attending physician
- dictations from pre and post-operative procedures/visits of attending physician
- restrictions/limitations or clearance to participate
- rehabilitation protocol
- copies of any diagnostic testing

Student-athletes will only be covered by Arizona Western College's insurance for *injuries that occur while participating in organized team activities* (camps and off-season classes are not considered team activities). Medical expenses for any pre-existing injuries/conditions/illnesses are the sole responsibility of the student athlete for their duration at AWC. Any medical/diagnostic testing ordered by a physician for participation clearance during physicals is the sole responsibility of the student-athlete. If it is determined that the student athlete did not disclose a pre-existing injury or condition during their physical, any injury associated with that pre-existing injury/condition will not be covered by Arizona Western College. Arizona Western College serves as the secondary provider to any existing coverage for in-season athletic accidental injuries. In the event that you are referred to a physician for an athletic injury, your primary insurance will be billed first. After your primary insurance pays their normal benefits, Arizona Western College's supplemental accident insurance will pay its benefits.

All student-athletes must complete a current insurance information form and **provide a copy of the front AND back of their insurance card.** (This includes the subscriber's name, date of birth, relationship to athlete, and social security number.) Each student-athlete is responsible for updating his or her personal insurance information should it change over the course of the year. **Failure to do so may result in the student-athlete incurring ALL medical expenses.**

AWC athletic trainers will assist you with filing a claim with the supplemental accident insurance carrier. It is important to note that all medical bills are the responsibility of the student-athlete. It is also the responsibility of the student-athlete that all medical claims are properly filed with their own personal insurance carrier and with the school provided supplemental accident insurance carrier. If a medical claim is not filed properly or the guidelines are not followed, the student athlete will be responsible for any and all medical bills. To best assist you with this process, please bring in all bills and explanation of benefits from providers and insurance companies to the athletic trainers. Failure to follow through with these requests can lead to delayed or missed payments for medical bills and the possibility of the student-athlete going into collections.

My signature verifies that I understand the insurance policy provided by Arizona Western College is a supplemental insurance policy. I also understand that if I do not follow the claim filing procedures set forth by my primary insurance carrier and the school provided supplemental insurance carrier, I will be responsible for all medical bills.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If Student-Athlete is Under 18)
Signature of Parent/Guardian: _____ Date: _____

AWC Student-Athlete Current Insurance Information

All student-athletes must complete a current insurance information form and provide a copy of the front AND back of their insurance card. (This includes the subscriber's name, date of birth, relationship to athlete, and social security number.) Each student-athlete is responsible for updating his or her personal insurance information should it change over the course of the year. Failure to do so may result in the student-athlete incurring ALL medical expenses.

You **must** check one of the following:

I am NOT covered under a group insurance and/or have no insurance coverage

I am covered under the following plan:

Insurance Company: _____ Insurance Phone: _____

Insurance Policy Number: _____ Group Number: _____

Insurance Type: HMO PPO Other: _____

The following needs to be filled out with information regarding *the subscriber of the insurance policy*. Please understand that if you are covered under your parent/guardian's insurance plan that this is asking for their personal information and not yours.

Subscriber's Name: _____ DOB: _____

Relationship to Student-Athlete: _____ SSN: _____

Subscriber's Employer: _____ Cell #: _____

You must attach a copy of the front AND back of your insurance card to complete this form.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If Student-Athlete is Under 18)

Signature of Parent/Guardian: _____ Date: _____

AWC Athletic Training Concussion Policy

It is the goal of Arizona Western College to provide the best care possible to all students participating in intercollegiate athletics. The following comprehensive concussion policy has been developed in an effort to maintain the highest standard of care in the treatment of cerebral concussion injuries.

What is a Concussion?

A concussion is a disturbance in brain function that occurs following either a blow to the head or as a result of the violent shaking of the head which results in a wide range of physical, cognitive, emotional, and/or sleep related symptoms. As described in the NCAA Sports Medicine Handbook, a concussion is a “complex physiological process affecting the brain induced by traumatic biomechanical forces”. While most concussion injuries are a result of a direct blow to the head, a concussion may also result from a force elsewhere to the body that is transferred to the head. It may take days and weeks for concussion symptoms to resolve.

Second Impact Syndrome (SIS):

Second Impact Syndrome occurs when an athlete, who has already sustained a head injury, sustains a second head injury prior to complete resolution of symptoms from the first injury (including post-concussion syndrome symptoms). The second injury to the head, even if it is mild, results in the loss of autoregulation of the blood supply in the brain leading to excessive swelling of the brain and increased intracranial pressure causing the brain to herniate through the skull. Second Impact Syndrome can lead to permanent brain damage or, in extreme cases, death due to the increased pressure in the skull.

Neurocognitive Testing (ImPACT Test)

While a neuroimaging examination (MRI, CT, EEG) of a concussive injury is important to rule out physical intracranial injury, this examination will not determine the effects of a concussion. The reason being that concussions are a metabolic injury rather than structural injury. Thus, structural neuroimaging techniques like an MRI or CT scan are insensitive to the detecting the effects of a concussion.

The ImPACT neurocognitive test is given as a pretest to all athletes participating in intercollegiate sports at Arizona Western College to provide a baseline measure in even of an injury. If injured, athletes will need to rest until asymptomatic and then take the ImPACT neurocognitive test again for comparative purposes. Post-testing with ImPACT may continue as indicated by physician or athletic trainer until results are similar to their baseline test.

Common Signs (Observed by ATC, Coach, Professor, etc.)	Common Symptoms (Felt by Student-Athlete)
<ul style="list-style-type: none">• Appears to be dazed or stunned• Confused about assignment/task• Unable to remember plays• Unsure of game, score, opponent• Slow to answer questions• Moves clumsily or off-balance• Loss of consciousness• Vomiting• Shows behavior or personality changes• Can't recall events before the hit• Can't recall events after the hit• Inability to focus on conversation• Lack of coordination	<ul style="list-style-type: none">• Headache• Nausea or vomiting• Pressure in head• Dizziness or balance problems• Double/blurred/fuzzy vision or any other visual alteration• Sensitivity to light and/or noise• Feeling sluggish, slow, “foggy”, or groggy• Difficulty concentrating or remembering• Confusion• Extreme body fatigue or low energy levels• Irrational or heightened emotional state• Drowsiness• “Don't feel right”

Treatment Protocol

All athletes suspected of sustaining a concussion will follow this treatment protocol **without exception**.

1. Removal from activity (contest/practice) following signs and symptoms of concussion
2. No return to play in current activity (contest/practice)
3. Medical evaluation following injury
 - a. Rule out serious intracranial injury
 - b. Neurocognitive Testing
4. Stepwise Return-to-Play Guideline
 - a. No activity and rest until asymptomatic (including post-concussion symptoms)
 - b. Neurocognitive re-test (must “pass” or return to baseline scores)
 - c. Day 1: Light aerobic exercise (cannot start until neurocognitive test is normal)
 - d. Day 2: Exertional testing
 - e. Day 3: Non-contact drills or no “live” practice
 - f. Day 4: Full-contact drills or “live” practice
 - g. Resume game play
 - h. If at any point during the RTP protocol concussive symptoms return, the protocol is to be restarted from the first step
5. Stepwise Return-to-Class Guideline
 - a. Case by case dependent
 - b. No class attendance for 48 hours
 - c. Return to class progressively based on post-concussion symptoms

I recognize this injury does have inherent risks that could result in permanent brain damage or death. I have read and understand the Arizona Western College Athletic Training Concussion Policy.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If Student-Athlete is Under 18)

Signature of Parent/Guardian: _____ Date: _____

Return to Play Protocol

To ensure the health and safety of student athletes, the certified athletic trainer is a medical consultant for the student athlete’s health. In the event an athlete is injured s/he will be referred to the certified athletic trainer(s). The certified athlete trainer(s) will do an assessment and communicate a recommendation to the athlete, coach and, if necessary, the student’s healthcare provider. Due to the variance in our medical community and the greater medical community, any medical clearance made by a licensed physician will undergo a guided return to play process with the certified athletic trainer(s). The coach(es) will be informed and involved as needed in the return to play process, but a coach may not be the determining factor to return to activity. The certified athletic trainer(s) is the medical professional representative for Arizona Western College and will make the final decision on return to play status. Return to play status will be communicated to the student athlete orally and the coach through oral and/or written communication.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If Student-Athlete is Under 18)

Signature of Parent/Guardian: _____ Date: _____

Assumption of Risk and Release of Liability

I, _____ (Print Your Name), freely choose to participate in the athletic program at Arizona Western College. I am aware that participating in any sport can be a dangerous activity involving many risks of injury, including but not limited to the potential for catastrophic injury. I understand that the dangers and risks of participating in any athletic activity include, but are not limited to: death; serious neck and spinal injuries (which may result in a complete or partial paralysis or brain damage); serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system; serious injury or impairment to other aspects of my body, general health, and wellbeing. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics. Due to the aforementioned dangers of participating in athletic activity, I recognize the importance of following all instructions of the coaching staff and Athletic Training Department.

In consideration of Arizona Western College permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless Arizona Western College; its District Governing Board, employees, and volunteers; and the Matador Athletic Association from any and all liability, any medical expenses not covered by Arizona Western College Athletic Department's accident coverage insurance, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connections with my participation in any activities related to intercollegiate athletics. The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Arizona Western College.

I hereby attest that I have read and fully understand the Arizona Western College Athletic Training Department's Physical Examination and Waiver Packet. Further, I abide by all requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

Printed name: _____ Date of Birth: _____

Signature: _____ Date: _____

Signature of Parent/Guardian if under 18: _____ Date: _____

AWC Student-Athlete and Emergency Contact Information

Full Legal Name: _____ Nickname(s): _____

Student ID: _____ Class (Please Circle One): Freshman / Sophomore

Sex (Please Circle One): Female / Male Birthdate (Month/Day/Year): _____

Social Security Number: _____ Cellphone #: _____

Sport (Please Check All That Apply):

- | | |
|-----------------------------------------|-------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Football |
| <input type="checkbox"/> Basketball (M) | <input type="checkbox"/> Soccer (M) |
| <input type="checkbox"/> Basketball (W) | <input type="checkbox"/> Soccer (W) |
| <input type="checkbox"/> Cheer Team | <input type="checkbox"/> Softball |
| <input type="checkbox"/> Dance Team | <input type="checkbox"/> Volleyball |

Address (Include Apt. or Suite Numbers): _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Email (Toro Preferred): _____

Emergency Contact #1 Name: _____

Relationship to Student Athlete (Please Check One):

- | | | | |
|------------------------------------|--------------------------------------|-----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aunt | <input type="checkbox"/> Father | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Step-Mother |
| <input type="checkbox"/> Boyfriend | <input type="checkbox"/> Friend | <input type="checkbox"/> Husband | <input type="checkbox"/> Step-Father |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Girlfriend | <input type="checkbox"/> Mother | <input type="checkbox"/> Uncle |
| <input type="checkbox"/> Coach | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Sister | <input type="checkbox"/> Wife |
| <input type="checkbox"/> Cousin | <input type="checkbox"/> Grandmother | | |

Address (Include Apt. or Suite Numbers): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

(Optional) Emergency Contact #2 Name: _____

Relationship to Student Athlete (Please Check One):

- | | | | |
|------------------------------------|--------------------------------------|-----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aunt | <input type="checkbox"/> Father | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Step-Mother |
| <input type="checkbox"/> Boyfriend | <input type="checkbox"/> Friend | <input type="checkbox"/> Husband | <input type="checkbox"/> Step-Father |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Girlfriend | <input type="checkbox"/> Mother | <input type="checkbox"/> Uncle |
| <input type="checkbox"/> Coach | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Sister | <input type="checkbox"/> Wife |
| <input type="checkbox"/> Cousin | <input type="checkbox"/> Grandmother | | |

Address (Include Apt. or Suite Numbers): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

AWC Student-Athlete Medical History

(This form is to be filled out by the student-athlete and reviewed with a physician or physician assistant.)

Medicines and Allergies: Please list all of the prescription/over-the-counter medications and supplements (herbal and nutritional) that you are currently taking: _____

Do you have any allergies? Yes No If yes, please identify specific allergy below:

Medicine _____ Food _____ Insects _____ Pollen/Seasonal

General Questions	No	Yes	Explanation (Specific dates and details.)
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? Please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____			
3. Have you ever spent the night in the hospital?			
4. Have you ever had surgery? If yes, please give details and dates.			
Heart/Lung Health Questions About You	No	Yes	Explanation (Specific dates and details.)
5. Has a doctor ever ordered a test for your heart? (Like an ECG, EKG, or echocardiogram?)			
6. Have you ever fainted/passed out or nearly fainted/passed out during or after exercise?			
7. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
8. Do you get light-headed or get shortness of breath (more than normal) during exercise?			
9. Do you ever get excessively fatigued or light-headed when you exercise?			
10. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A Heart Infection <input type="checkbox"/> Other _____			
11. Do you have asthma or exercise induced asthma? If yes, do you have an inhaler? <input type="checkbox"/> Y <input type="checkbox"/> N			
Bone, Joint, and Injury Questions	No	Yes	Explanation (Specific dates and details.)
12. Have you ever fractured a bone?			
13. Have you ever had a stress fracture?			
14. Have you ever dislocated a joint?			
15. Do you have a history of arthritis or connective tissue disorder?			
16. Do you regularly use a brace, orthotics, or other assistive device when playing?			
17. Do you have a bone, muscle, or joint that bothers you when you play?			
18. Have you ever had a hernia? (Sports, inguinal, or abdominal)			If yes, did you get surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

Neurological/Medical Questions	No	Yes	Explanation (Specific dates and details.)
19. Have you ever had a concussion?			
20. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
21. Have you had infectious mononucleosis (mono) within the last month?			
22. Have you ever had a herpes or MRSA skin infection?			
23. Have you ever had numbness, tingling, or weakness in arms/legs after being hit or falling?			
24. Do you have a history of dehydration or heat illness?			
25. Do you get frequent cramps when exercising?			
26. Do you have problems with your eyes/vision?			
27. Do you wear glasses or contacts?			<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
28. Do you get frequent migraines/headaches?			
29. Do you have a history of epilepsy or seizures?			
30. Have you ever had an eating disorder?			
31. Do you have a blood disorder? If yes, please indicate below: <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Trait <input type="checkbox"/> Hemophilia <input type="checkbox"/> Other _____			
32. Do you have kidney or bladder problems?			
33. Do you have ulcers or digestive trouble?			
34. Do you have any mental/psychological illnesses or suffer from nervous breakdowns?			
35. <u>Females Only</u> : Do you have menstrual problems?			
36. Do you have any concerns that you would like to discuss with a doctor?			
Family History Questions	No	Yes	Explanation – indicate either ‘maternal’ or ‘paternal’ with each family member.
37. Has anyone in your immediate family experienced heart attack?			
38. Does anyone in your immediate family have high blood pressure?			
39. Does anyone in your immediate family have a circulatory disorder?			
40. Does anyone in your immediate family have diabetes?			
41. Does anyone in your immediate family have asthma?			

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

Signature: _____ Date: _____

(If Student-Athlete is Under 18)

Signature of Parent/Guardian: _____ Date: _____

AWC Student-Athlete Physical Examination

(This form is to be filled out by a physician or physician assistant.)

Important to Notes: Physicals completed by a chiropractor (DC), nurse practitioner (NP) or naturopathic physician (ND or N.M.D) will not be accepted by AWC. Physicals from a previous institution will be accepted if they have been completed within one calendar year.

AWC strongly recommends athletes be tested for Sickel Cell Trait.

Name: _____ Birthdate (Month/Day/Year): _____
 Sport: _____ Height: _____ Weight: _____ Sex: F M Temperature: _____ °F
 Blood Pressure: _____ / _____ Resting Pulse (bpm): _____ Respiration (rpm): _____
 Vision: R 20/ _____ L 20/ _____ Corrected? N Y If yes, how? Glasses Contacts

Testing for Sickel Cell Trait:

Has this athlete been tested for sickel cell trait? Yes No

If yes, please indicate results of sickel cell trait test and submit documentation of test results with this packet:

Negative Positive Further Testing Needed

Medical Item:	Findings:	Comments:
General Appearance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Head/Scalp	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Eyes/Ears/Nose/Throat	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Thyroid/ Lymph Nodes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Heart (Murmurs, etc.)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Chest/Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Spleen/Liver	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Hernia	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Genitalia (Males Only*)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Inguinal Nodes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Skin (Lesions, etc.)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Nailbeds – Fingers/Toes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Orthopedic Item:	Findings:	Comments:
Jaw/Neck	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Spine/Back	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Ribs/Sternum	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Shoulders	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Elbow/Forearm	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Wrist/Hand/Fingers	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Pelvis/Hip/Thigh	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Knees	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Ankles	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Feet/Toes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Continued Details: _____

AWC Student-Athlete Physical Examination
 (This form is to be filled out by a physician or physician assistant.)

Musculoskeletal Evaluation	Normal	Abnormal Findings
Upper Extremity		
Lower Extremity		
Back		
Torso		
Gait Pattern		

Neurological Evaluation	Normal	Abnormal Findings
Reflexes		
Atrophy		
Paralysis		

Cardiovascular Assessment	Normal	Abnormal Findings
Murmurs or Arrhythmia		
Location of Point of Maximal Impulse (PMI)		

Are any other tests/exams needed? Yes No

If yes, please explain: _____

Any other comments or recommendations? Yes No

If yes, please explain: _____

Athletic Participation Clearance:

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendation for further evaluation/treatment for: _____
- Cleared with the following restrictions:
 - No-Collision
 - Non-Contact
 - Other: _____
- Not Cleared
 - Pending Further Evaluation for _____
 - For Any Sports
 - For Certain Sports _____

Name of Athlete: _____ Date of Exam: _____

Examining Physician (Print/Type): _____ MD, DO, or PA-C

Examining Physician Signature: _____ MD, DO, or PA-C

Address: _____ Phone: _____