ARIZONA WESTERN COLLEGE
SPORTS MEDICINE
VISITING ATHLETE TRY-OUT/WALK-ON PHYSICAL

I ______________________________, hereby acknowledge I (my child has) have no pre-existing injuries/illnesses, heart conditions, or asthma and am (is) in good physical health to participate in an open event put on by Arizona Western College. If these conditions exist I have a doctor's clearance to participate in sport or physical activity. If injury is to occur during sport or physical activity at Arizona Western College I am responsible for all injuries/illness or even death. I do not hold Arizona Western College responsible if any of the above is to occur during sport or physical activity. I understand every effort will be made to contact an emergency contact, but in the event someone cannot be immediately contacted, I authorize Arizona Western College staff to seek emergency medical attention for myself (my child). If you (your child has) have a medical condition such as asthma you are responsible for providing a proper inhaler and inform the coach/athletic trainer of your (his/her) medical condition.

SB1521 Youth Concussion Bill: Any participant under the age of 18 will be removed from the event by an athletic trainer, coach, official if they present with concussion symptoms. The participant may return to participation the following day if they have written clearance from a licensed physician, physician assistant, or athletic trainer.

I recognize this activity does have inherent risks that could result in serious injuries or death and I hereby hold Arizona Western College; it's District Governing Board, employees, and volunteers; and the Matador Athletic Association harmless for any injury or damage resulting from this activity. I will also be responsible for all costs related to my (child's) medical treatment.

I have read and understand the above statement and agree upon the terms.

___________________________________	___________________________________
Participant Name	Date
___________________________________	___________________________________
Participant Signature	Emergency Contact: Name/Phone #
___________________________________	___________________________________
Parent/Guardian Signature (if under 18 years of age)	Date

AWC Sports Medicine Physical Examination Form

Name: ________________________________ Sport:___________________ Birthdate:___________________
Class: Fresh / Soph SSN#:___________________ Cell #:__________________ Home #: _________________
PermanentAddress:___________________________________City:__________________St:_____Zip:______
Email (toro preferable):____ Student ID: __________________
Emergency Contact Information: Name: _____________________________ Phone: _____________________
Address: ____

(To be filled out by a physician)

Physical Examination:

Height: _______ Weight: ________ BP: _______/_______ Pulse: _______ Temp: _______Respiration: ______
Vision: R ______ L _______ Contacts Y/N Hearing: R_______ L________
Immunizations: DIP/TE ___________ (date) MMR ___________ (date)

General

_____Head/Scalp
_____Eyes/Pupils
_____Nose/Sinus
_____Throat/Pharynx
_____Thyroid
_____Lymph Nodes
_____Heart Conditions
_____Chest/Lungs
_____Spleen
_____Liver
_____Abdomen
_____Hernial Rings
_____Genitalia
_____Inguinal Nodes
_____Skin
_____Nailbeds – Fingers / Toes

Orthopedic

_____Neck
_____Jaw
_____Shoulders
_____Elbows
_____Wrists
_____Fingers
_____Spine
_____Ribs/Sternum
_____Pelvis
_____Hips
_____Knees
_____Ankles
_____Feet/Toes

Musculoskeletal:

Upper Extremity: R _________________________ L ___________________________
Lower Extremity: R _________________________ L ___________________________
Back: ___________________ Torso: ________________________
Gait Pattern: ________________________________

Neurological:

Reflexes: _____________________ Atrophy: _____________________ Paralysis: ____________________

Cardiovascular:

Murmurs (auscultation standing, supine, +/- Valsalva) Normal: ______________ Abnormal Findings: ________________
Location of point of maximal impulse (PMI) Normal: _______________ Abnormal Findings:_________________________

Are other Tests/Exams needed? Yes_____ No ______ What? _______________________________
Comments:____
____
____

Athletic Participation Clearance:

- ☐ Cleared
- ☐ Cleared after completing evaluation/ Rehabilitation for _______________________________________
- ☐ Not Cleared for:
  - o Collision
  - o Contact
  - o Non-contact

Due to: ____ _______________

Examining Physician: ___________________________ MD, DO, NP, PA-C Date of Exam: ____________________
Address: ____ Phone: _____________________

AWC Sports Medicine Medical History

Athlete History

Have you had or ever been treated for, please provide the DATE AND DETAILS:

Head Injury/Concussion	□ NO	□ YES	(Details:______________________________)
Bell Rung	□ NO	□ YES	(Details:______________________________)
Neurological Problem/Disorder	□ NO	□ YES	(Details:______________________________)
Dizzy Spells/Fainting	□ NO	□ YES	(Details:______________________________)
Vision Problems/Loss	□ NO	□ YES	(Details:______________________________)
Heat Illness/ Dehydration	□ NO	□ YES	(Details:______________________________)
Muscle Weakness	□ NO	□ YES	(Details:______________________________)
High/Low Blood Pressure	□ NO	□ YES	(Details:______________________________)
Anemia	□ NO	□ YES	(Details:______________________________)
Blood Disorder/ Hemophilia/Sickle Cell Trait	□ NO	□ YES	(Details:______________________________)
Heart Trouble/Chest Pain	□ NO	□ YES	(Details:______________________________)
Kidney/Bladder Problems	□ NO	□ YES	(Details:______________________________)
Ulcers/Stomach Trouble	□ NO	□ YES	(Details:______________________________)
Hepatitis	□ NO	□ YES	(Details:______________________________)
Tuberculosis	□ NO	□ YES	(Details:______________________________)
Measles	□ NO	□ YES	(Details:______________________________)
Epilepsy/Seizures	□ NO	□ YES	(Details:______________________________)
Diabetes	□ NO	□ YES	(Details:______________________________)
Allergies/Hay Fever	□ NO	□ YES	(Details:______________________________)
Pneumonia/Bronchitis	□ NO	□ YES	(Details:______________________________)
Asthma/Exercise Induced Asthma	□ NO	□ YES	(Details:______________________________)
Menstrual Problems	□ NO	□ YES	(Details:______________________________)
Hernia - Sports/Inguinal/abdominal	□ NO	□ YES	(Details:______________________________)
Addiction to Drugs/Alcohol	□ NO	□ YES	(Details:______________________________)
Mental Illness/Nervous Breakdown	□ NO	□ YES	(Details:______________________________)
Bone/Joint Disorder	□ NO	□ YES	(Details:______________________________)
Joint Dislocation	□ NO	□ YES	(Details:______________________________)
Fracture	□ NO	□ YES	(Details:______________________________)
Surgery	□ NO	□ YES	(Details:______________________________)

Have you ever been Hospitalized? □ NO □ YES If so, why? ______________________________
____

Are you currently taking any medications? ______________________________
____

Are you **allergic to any medications**? ______________________________
____

Family History:

Has anyone in your immediate family experienced, please write who (i.e. maternal grandmother) next to answer:

Heart Attack:	□ NO	□ YES	□ NOT SURE	______________________
High Blood Pressure:	□ NO	□ YES	□ NOT SURE	______________________
Circulatory Disorder:	□ NO	□ YES	□ NOT SURE	______________________
Heart Disease:	□ NO	□ YES	□ NOT SURE	______________________
Diabetes:	□ NO	□ YES	□ NOT SURE	______________________
Asthma:	□ NO	□ YES	□ NOT SURE	______________________

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

Signature of athlete: ______________________________ Date: ____________________

Signature of parent/guardian: ______________________________ Date: ____________________
(if athlete is under the age of 18)