University of Vermont
Walk-on Tryout Medical Packet

Please submit all forms no later than three (3) business days before the try-out to:
Athletic Medicine Department ◊ 97 Spear St, 140 Patrick Gym ◊ Burlington, VT 05405
(802) 656-7751 ◊ Fax (802) 656-9578

UVM Walk-On Tryout Medical History Questionnaire

**Please provide proof of a physical examination by a physician completed within the previous year from date of on-campus evaluation.
** Per the NCAA, all prospective student-athletes must provide documentation and results of a Sickle Cell test in order to participate in any activity.**

For prospective student-athletes: *Per UVM, you will need to have completed your immunization requirements.*

Please read all questions carefully and respond by selecting the appropriate response. All questions must be answered.

Demographic Information

Last Name _____
First Name _____
Middle Initial _____
Date of Birth _____
Current Age _____
Height _____
Weight _____

Emergency Contact Information

Parent/Guardian _____
Phone # _____
Parent/Guardian _____
Phone # _____
Emergency Contact _____
Relationship _____
Phone # _____

Health Insurance Information

Type of Insurance Plan:

____ Traditional Medical and Hospitalization
____ Health Maintenance Organization (HMO)
____ Preferred Provider Organization (PPO)
____ Point of Service (POS)

Insurance Policy Information:

Insurance Company _____
Insurance Co. Address_____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
Policy Number _____
Group # or Soc.Sec # _____
Policy Holder Name _____

Birthday of Policy Holder _____
Home Phone#/Policy Holder_____
Work Phone#/Policy Holder_____
Employer of Policy Holder _____
Employer Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____

Your Doctor:

Prospective Student-Athlete's
Primary Care Physician (Name) _____**Physician's Phone**_____

University of Vermont
Walk-on Tryout Medical Packet

Medical History

Section A: General **(Please answer all questions and explain YES responses/provide dates in the space provided**

Have you been treated for infectious Mononucleosis?
____ Yes (please specify date) _____
____ No

Have you been treated for Pneumonia?
____ Yes (please specify date) _____
____ No

Have you ever been hospitalized?
____ Yes (please specify date) _____
____ No

Are you presently taking any prescription or over the counter medications (albuterol inhalers, oral asthma medications, anti-inflammatories, anti-depressants, etc.)?
____ Yes (specify name of drug, reason for taking and usual dosage) _____
____ No

Are you allergic to any medications?
____ Yes (Please name) _____
____ No

Have you ever had a serious allergic reaction (i.e. anaphylaxis) to an insect bite or food source (e.g. peanuts)?
____ Yes (Please specify insect/food and reaction) _____
____ No

Do you have any other allergies?
____ Yes (Please specify) _____
____ No

Section B: Family Health History
Has anyone in your family (blood relatives) suffered from any of the following:

Sudden death from non-traumatic causes, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Cancer, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Diabetes, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Heart Trouble, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Sickle Cell Disease?
____ Yes (Please indicate relationship to you) _____
____ No

High Blood Pressure, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Marfan Sydrome?
____ Yes (Please indicate relationship to you) _____
____ No

Section C: Detailed Health History

Have you ever had a heat-related illness (heat exhaustion, heat stroke, etc.)?
____ Yes (Please give date and details) _____
____ No

Do you have problems with muscle cramps?
____ Yes
____ No

Do You have any disorders involving:
Eyes/Vision?
____ Yes (Please describe) _____
____ No

Ears/Hearing?
____ Yes (Please describe) _____
____ No

Kidneys?
____ Yes (Please describe) _____
____ No

Liver?
____ Yes (Please describe) _____
____ No

Spleen?
____ Yes (Please describe) _____
____ No

Heart?
____ Yes (Please describe) _____
____ No

Lungs?
____ Yes (Please describe) _____
____ No

Testicles?
____ Yes (Please describe) _____

____ No

Gastrointestinal Tract?
____ Yes (Please describe) _____
____ No

Other?
____ Yes (Please describe) _____
____ No

Have you ever had a concussion, had your "bell rung" or been knocked out?
____ Yes (Please give dates) _____
____ No

Do you wear eyeglasses or contacts?
____ Yes
____ No

Have you ever experienced a seizure or been informed that you have epilepsy?
____ Yes (Please give dates) _____
____ No

Have you had hepatitis at any time?
____ Yes (Please provide details including type of hepatitis) _____
____ No

Do you have any type of blood disorder (hemophilia, anemia, sickle cell trait, etc.)?
____ Yes (Please provide details) _____
____ No

Do you have any diabetes or have you ever been treated for diabetes?
____ Yes (Please give dates and details) _____
____ No

Have you ever been treated for kidney stones?
____ Yes (Please give dates and details) _____
____ No

Section D: Cardiopulmonary

Have you ever been told by a physician that you have asthma?
____ Yes (Please specify date) _____
____ No

Have you ever been told that you have a Heart Murmur or any other heart condition?
____ Yes (Please provide date) _____
____ No

Have you ever been held from competition for a heart murmur or condition?
____ Yes (Please specify date) _____
____ No

Have you ever had any tests done for a heart murmur?
____ Yes (Please list tests and dates) _____
____ No

Have you ever experienced and "irregular" heartbeat, dizziness, or chest pain with exercise?
____ Yes (Please provide date and details) _____
____ No

Have you ever been told that you have high blood pressure?
____ Yes (Please provide date and indicate if you have taken meds for this condition) _____
____ No

Have you ever fainted, passed out, or "blacked out" during exercise?
____ Yes (Please specify date) _____
____ No

Section E: Musculoskeletal

Please indicate if you have had any major injuries to the following areas within the last 3 years. A major injury for this purpose is one that required medical attention or held you out of practice/competition (i.e. a broken bone, surgery, concussions, major ligament sprain or muscle strain, etc.)

If yes, please indicate the body part, whether left (L) or right ®, and the type of injury in the space provided:

Head / Neck?
____ Yes (specify date) _____
____ No

Shoulder/ Elbow / Arm?
____ Yes (specify date) _____
____ No

Wrist / Hand?
____ Yes (specify date) _____
____ No

Back / Spine?
____ Yes (specify date) _____
____ No

Knee / Hip / Leg?
____ Yes (specify date) _____
____ No

Foot / Ankle?
____ Yes (specify date) _____
____ No

Have you had any surgical procedure to correct an injury or condition?
____ Yes (specify dates and details) _____

____ No

Do you have a pin, screw, plate, etc. somewhere in your body because of surgery?
____ Yes (please specify) _____
____ No

Section F: Other

Do you now or have you ever used illegal drugs?
____ Yes (please provide details) _____
____ No

Have you ever used anabolic steroids?
____ Yes (please provide details) _____
____ No

Do you now or have you ever had a drug or alcohol abuse, dependency or addiction problem?
____ Yes (please provide details) _____
____ No

Have you ever had any additional illnesses or injuries not covered by the previous questions?
____ Yes (please provide details) _____
____ No

Are you presently under a physician's care for a condition not covered by the previous questions?
____ Yes (please provide details) _____
____ No

Do you consider yourself in good physical shape and prepared to participate in this tryout?
____ Yes
____ No

The Fine Print (Read Carefully)

Please read the above over again carefully before signing below. By signing below you…

- ***Certify that the above answers are complete, correct and truthful to the best of your knowledge.***
- ***Fully realize that the University of Vermont cannot be held responsible for any previous medical condition(s) that you might have.***
- ***Fully realize that misrepresentation of information could have serious medical implications leading to injury and, in extreme circumstances, death.***

By submitting this, I agree to the terms set forth above:

_____ _____
Prospective student-athlete Date

_____ _____
Parent/Guardian if PSA under 18 Date

Please submit all forms no later than three (3) business days before the OCE to:
Athletic Medicine Department ◊ 97 Spear St, 140 Patrick Gym ◊ Burlington, VT 05405
(802) 656-7751 ◊ Fax (802) 656-9578

University of Vermont
Walk-on Tryout Medical Packet

Medical Requirements for On-Campus Evaluation

Prior to participation in an on-campus evaluation, a perspective student-athlete is required to provide the following documentation:

_____ Proof of insurance

_____ Proof of a physical examination by a physician completed within the previous year from date of on-campus evaluation.

_____ Completed Medical Questionnaire

_____ Documentation of Sickle Cell test and results

University of Vermont
Walk-on Tryout Medical Packet

Sickle Cell Trait Disclosure Form

I, _____ affirm that I have been informed by my family physician as to my Sickle Cell Trait Status, and/or have undergone the sickle cell trait screening, in the form of a blood test using Sickle Dex, at the University of Vermont Athletic Medicine Clinic.

1. **Sickle Cell Trait Positive** Initial _____

2. **Sickle Cell Trait Negative** Initial _____

About Sickle Cell Trait-

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.
- Likely sickling settings include timed runs, all out exertion of any type for 2 – 3 continuous minutes without a rest period, intense drills and other spurts of exercise after prolonged conditioning exercises, and other extreme conditioning sessions.
- Common signs and symptoms of a sickle cell emergency include, but are not limited to: increased pain and weakness in the working muscles (especially the legs, buttocks, and/or low back); cramping type pain of muscles; soft, flaccid muscle tone; and/or immediate symptoms with no early warning signs.

I, the undersigned, do hereby affirm that I have been informed of my sickle cell trait status by my family physician and/or one of the clinicians through University of Vermont Athletic Medicine. If my sickle cell trait status is positive, I understand that I am required to have a follow up test to determine if I have Sickle Cell Disease vs. Sickle Cell Trait. This follow up test will be performed at my own expense. I will also partake in educational sessions around the topic of sickle cell and understand that specific precautions that need to be undertaken due to the serious nature of the condition. The educational sessions will be administered by the University of Vermont Team Physician and/or a member of the Athletic Medicine Department. I also affirm that I have read through and University of Vermont Sickle Cell Position Statement.

_____ _____
Student-Athlete Signature (If under 18, include parent/guardian signature) Date

_____ _____
Examining Physician Signature Date

_____ _____
Examining Physician Print Name Date

_____ _____
Athletic Trainer Signature Date

_____ _____
Athletic Trainer Print Name Date