### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason?
   - Yes
   - No

2. Do you have any ongoing medical conditions? If yes, please identify:
   - [ ] Asthma
   - [ ] Diabetes
   - [ ] Seizures
   - [ ] Other_________________________

3. Have you ever spent the night in a hospital?
   - Yes
   - No

4. Have you ever had surgery? If yes, circle below:
   - [ ] MRI
   - [ ] CT
   - [ ] Surgery
   - [ ] Injections
   - [ ] Rehabilitation
   - [ ] Physical therapy
   - [ ] Brace
   - [ ] Cast

5. Have you ever passed out or nearly passed out during exercise?
   - Yes
   - No

6. Have you ever passed out or nearly passed out after exercise?
   - Yes
   - No

7. Have you ever had discomfort, pain, or pressure in your chest during exercise?
   - Yes
   - No

8. Does your heart race or skip beats at rest or during exercise?
   - Yes
   - No

9. Has a doctor ever told you that you have:
   - [ ] High Blood Pressure
   - [ ] High Cholesterol
   - [ ] Other_________________________

10. Has a doctor ever ordered a test for your heart? (for example, ECG, Echocardiogram).
    Have you ever seen a cardiologist for any reason? If yes, specify_________________________

11. Do you get more tired or short of breath more quickly than your friends during exercise?
    - Yes
    - No

12. Have you ever had an unexplained seizure?
    - Yes
    - No

### HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever had a heart murmur or heart infection?
   - Yes
   - No

23. Has a doctor ever told you that you have asthma or allergies?
    - Yes
    - No

24. Do you cough, wheeze, or have difficulty breathing during or after exercise?
    - Yes
    - No

25. Have you ever used an inhaler or taken asthma medicine?
    - Yes
    - No

26. Is there anyone in your family who has asthma?
    - Yes
    - No

27. Were you born without or are you missing a kidney, eye, testicle, or any other organ?
    - Yes
    - No

28. Have you had infectious mononucleosis (mono) within the last month?
    - Yes
    - No

29. Do you have any rashes, pressure sores, or other skin problems?
    - Yes
    - No

30. Have you had a herpes skin infection?
    - Yes
    - No

31. Have you ever had a head injury or concussion?
    - Yes
    - No

32. Have you ever had a hot or blow to the head that caused confusion, prolonged headache, or memory problem? If yes, specify (include dates):
    ___________________________

33. Have you ever had a seizure?
    - Yes
    - No

34. Do you have headaches with exercise?
    - Yes
    - No

35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
    - Yes
    - No

36. Have you ever been unable to move your arms or legs after being hit or falling?
    - Yes
    - No

37. When exercising in the heat, do you have severe muscle cramps or become ill?
    - Yes
    - No

38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
    - Yes
    - No

39. Have you had any problems with your eyes or vision?
    - Yes
    - No

40. Do you wear glasses or contact lenses?
    - Yes
    - No

41. Do you wear protective eyewear, such as goggles or a face shield?
    - Yes
    - No

42. Are you happy with your weight?
    - Yes
    - No

43. Are you trying to gain or lose weight?
    - Yes
    - No

44. Has anyone recommended you change your weight or eating habits?
    - Yes
    - No

45. Do you limit or carefully control what you eat?
    - Yes
    - No

46. Have you ever had an eating disorder?
    - Yes
    - No

### MEDICARE QUESTIONS

5. Have you ever had a heart murmur or heart infection?
    - Yes
    - No

23. Has a doctor ever told you that you have asthma or allergies?
    - Yes
    - No

24. Do you cough, wheeze, or have difficulty breathing during or after exercise?
    - Yes
    - No

25. Have you ever used an inhaler or taken asthma medicine?
    - Yes
    - No

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    - No

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    - Yes
    - No

29. Do you have any rashes, pressure sores, or other skin problems?
    - Yes
    - No

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    - Yes
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    - Yes
    - No

45. Do you limit or carefully control what you eat?
    - Yes
    - No

46. Have you ever had an eating disorder?
    - Yes
    - No

### BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? If yes, circle affected area below.
    - Yes
    - No

18. Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below.
    - Yes
    - No

19. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, brace, cast, or splint? If yes, circle below.
    - Yes
    - No

<table>
<thead>
<tr>
<th>Bone and Joint Injury Location</th>
<th>Neck</th>
<th>Shoulder</th>
<th>Upper Arm</th>
<th>Elbow</th>
<th>Forearm</th>
<th>Hand/Fingers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper back</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower back</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thigh</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Foot</td>
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<td></td>
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<tr>
<td>Shin</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Testicle</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other organ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Have you ever had a stress fracture?
    - Yes
    - No

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?
    - Yes
    - No

22. Do you regularly use a brace or assistive device?
    - Yes
    - No

### MEDICATIONS AND ALLERGIES

Please list all the prescription and over the counter medicines and supplements (herbal and nutritional) that you are currently taking:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you have any allergies?  [ ] Yes  [ ] No
If yes, please identify specific allergy below:
[ ] Pollens  [ ] Food  [ ] Stinging Insects  [ ] Medications
### Follow-Up Questions on More Sensitive Issues

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel stressed out or under a lot of pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel safe?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you currently smoke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days did you use chewing tobacco, snuff or dip?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 30 days have you had at least 1 drink of alcohol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever taken steroids without a doctor’s prescription?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever taken any supplements to help you gain or lose weight or improve performance?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**This part to be Completed by a Licensed Health Care Professional**

Date: ___________  Height: _______  Weight: _______  BMI: _______  B/P Arm: _______

Pulse: _______  Pupils: Equal _____  Unequal ____  Vision: R 20/ _____ L20/ _____  Corrected: Y N

### NORMAL  ABNORMAL FINDINGS

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Eyes/ears/nose/throat/hearing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lymphatics</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rhythm ✔️ Normal</td>
<td></td>
</tr>
<tr>
<td>Heart murmur ☐ No ☑ Yes</td>
<td></td>
</tr>
<tr>
<td>Systolic murmur grade 3 or more ☐ Yes ☐ No Location: _____</td>
<td></td>
</tr>
<tr>
<td>Does murmur increase with Valsalva? ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Diastolic murmur ☐ Yes ☐ No Location: _____</td>
<td></td>
</tr>
<tr>
<td>Delay in femoral pulses? ☐ Yes ☑ No</td>
<td></td>
</tr>
<tr>
<td>Marfan Criteria (Chest deformities, long arms and legs, wrist/joint hyperflexibility, flat foot, scoliosis, lens dislocation, high arched palate, etc): ☐ Yes ☑ No If yes, specify: __________________________</td>
<td></td>
</tr>
<tr>
<td>Comments: __________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
<th>Abdomen</th>
<th>Genitourinary/Testicles</th>
<th>Hernia</th>
<th>Skin</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sickle Cell Trait Status Physician Verification (NCAA requires confirmation of sickle cell trait status for all Division III athletes or signed waiver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I verify that the above named individual has been tested for sickle cell trait.</td>
</tr>
<tr>
<td>Date of Sickle Cell Trait Testing _______________  Results (circle):  Positive  Negative</td>
</tr>
<tr>
<td>☐ Student declined sickle cell trait testing. Student has signed sickle cell testing waiver (on page 3 of this form).</td>
</tr>
</tbody>
</table>

**12-lead Resting ECG Required. Please attach interpretable copy of ECG.**

☐ Cleared without restriction  ☐ Cleared with restriction. Specify: __________________________

☐ Not cleared. Reason: _________________________________________________________________

Name of physician (print/type) ________________________________  Date ________________

Signature of physician ________________________________________  MD or DO

Address ___________________________________________  Phone __________________________
Muhlenberg College Athletic Training Office

Sickle Cell Trait Testing Student Form

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 has been associated with a condition known as exertional rhabdomyolysis, renal failure and death. Complicating factors include extreme exertion, increased heat, altitude and dehydration.
- 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). Sickled cells can accumulate in the bloodstream and “logjam” blood vessels, leading to a collapse from the rapid breakdown of muscle starved of blood.
- Please review “Sickle Cell Trait – A Fact Sheet for Student-Athletes” from the NCAA.

Sickle Cell trait Testing:
- The NCAA requires confirmation of sickle cell trait status for all Division III student-athletes.
- Muhlenberg College requires confirmation of sickle cell trait status for all Men’s Ice Hockey & Women’s Rugby players

ALL STUDENT-ATHLETES MUST CHECK ONE OF THE BOXES BELOW:

Sickle Cell Trait Testing Verification or Sickle Cell Trait Testing Waiver
- After reviewing the above information and the NCAA “Sickle Cell Trait – A Fact Sheet for Student-Athletes” I have elected to do one of the following (please check and fill in):
  □ I have provided documented proof of my Sickle Cell Trait status by having my physician complete the Sickle Cell Trait Status Physician Verification Section of the physical examination form.
  □ I, _____________________________, understand and acknowledge that the NCAA and Muhlenberg College recommends 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 testing.
    I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify, and hold harmless the Muhlenberg College, 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 recommendation of the NCAA and Muhlenberg College.

ALL STUDENT-ATHLETES MUST COMPLETE THE SECTION BELOW:
I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student-Athlete Name: __________________________________________   Date of Birth: _____________
(please print)

Student-Athlete Signature ________________________________________ Date _____________________

Parent/Guardian Signature (if under 18 years of age) ___________________________ Date: __________

Parent/Guardian Name _________________________________________
(please print)
The undersigned herewith:

1. Understands that the above information will be reviewed by the Health Services and Athletic Training staff, who will determine the athlete’s ability to fully participate in athletics. The athlete may not participate until such time medical clearance is granted.

2. Understands that he/she must refrain from practice or play while ill or injured, whether or not receiving medical treatment and during medical treatment, until he/she is discharged from treatment or is given permission by the physician/athletic trainer to restart participation despite continuing treatment.

3. Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.

4. Allows Muhlenberg College Health Services to share all health information relevant to my athletic participation with the Muhlenberg College Athletic Training Staff for the duration of my enrollment at Muhlenberg College, and understand that subsequent disclosure of that information, i.e. to coaches, cannot be controlled by Health Services.

Signature of Student Athlete ________________________________ Date __________________

Printed Name of Student Athlete ____________________________________________ DOB: __________

BELOW TO BE COMPLETED BY MUHLENBERG COLLEGE SPORTS MEDICINE

CARDIOVASCULAR SYSTEM

<table>
<thead>
<tr>
<th>Heart Rate at Rest</th>
<th>BPM</th>
<th>Cardiology work-up if resting HR &lt;40 or ≥100 beats/min or irregular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure at rest</td>
<td>mmHg</td>
<td>Cardiology work-up if BP ≥ 140/90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History (see answers to heart questions in player history)</th>
<th>Normal</th>
<th>abnormal or positive (requires Cardiology work up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Examination</td>
<td>Normal</td>
<td>abnormal or positive (requires Cardiology work up)</td>
</tr>
<tr>
<td>12-lead resting ECG</td>
<td>Normal</td>
<td>abnormal or positive (requires Cardiology work up)</td>
</tr>
</tbody>
</table>

Current Risk Rating (circle one):

0: Minimal Risk: No history of heart disease or symptoms, negative family history, normal examination, normal ECG.

1: Low Risk: CLEARED
   a. History of grade 2 or less systolic murmur which does not increase with Valsalva
   b. Corrected heart disease for which Bethesda Guidelines allow play
   c. Treated blood pressure ≤140/90 mmHg
   d. Mildly abnormal ECG but normal history and physical examination
   e. Positive family history, but unlikely to have inherited heart disease

2: Significant Risk (circle any or all that apply): NOT CLEARED
   a. B/P ≥ 140/90
   b. More than 10mm Hg difference in B/P in arms
   c. Cardiac symptoms suspicious for underlying heart disease
   d. Delay in femoral pulses
   e. Grade 3 or more systolic murmur, or murmur that increases with Valsalva
   f. Diastolic murmur
   g. Positive answers to family history, likely to have inherited heart disease
   h. Positive answers to pre-existing heart disease for which Bethesda Guidelines do not allow play
   i. Stigmata of Marfans
   j. Distinctly abnormal ECG.

GENERAL & ORTHOPEDIC PARTICIPATION CLEARANCE

Current Risk Rating: 0 1 2 3 4 5/1 5/2 5/3 5/4 5/5 (Circle one)

0: Minimal Risk: No injuries - normal examination.
1: Low Risk: History of injury or problem - otherwise normal examination.
2: Medium Risk: Problem by history, examination or radiograph that may cause significant problems in the future but does not effect current playing status (i.e.: meniscus tear, post op subtotal meniscectomy or mild articular damage).
3: Significant Risk: Significant injury that has undergone successful treatment but player has not yet proven the ability to return to pre-injury activities (i.e.: post op ACL reconstruction with excellent functional strength that has not played).
4: High Risk: Significant current problem (i.e.: degenerative joint disease, ACL or PCL deficiency) that will almost guarantee lost time and/or is potentially career ending.
5: No Play: This category is to be used for someone who is currently unable to play due to orthopedic condition or suspected cardiac or medical illness. The number next to the FIVE (5) indicates physician's best estimate of the risk rating the player will receive after the player achieves maximum medical improvement/permanent and stationary status.

Comments: ______________________________________________________________________________________

Date: _____ Not approved; Requires: _________________________________ Signature: __________________________

Date: _____ Approved for participation. Evaluating Physician Signature: ________________________________