UNIVERSITY OF SAN DIEGO
TOREROS
CAMPUS RECREATION

USD Sport Club
NEW MEMBER MEDICAL PACKET

This packet is for individuals who have never participated in Sport Clubs at USD.
Medical clearance is only required once per academic year.

Complete all steps as indicated below. Upload packet as PDF to DSE registration under "Medical Info" or "Documents". Please note the upload is not a confidential form of communication. If preferred, there's an option to drop off a physical copy of the packet at the Sports Center. The dropbox is located in the Campus Recreation Main Office.
***Allow up to 3 business days to process**

Club Athlete Name: _____

Club Athlete 9 digit USD ID#: _____

List ALL Anticipated Sport Club(s): _____

Medical Approval Process

1. A department-approved sports physical (PPE) is required for participation in the Sport Club program. Follow this guide to learn more about the process.
2. Once this form is completed, download it as a PDF and upload it, along with your **health insurance card**, to your DSE registration under the "Medical Info" or "Documents" tab.
   a. If you are participating in more than one Sport Club, only one upload is needed.
3. Once your medical packet & health insurance card are uploaded, the Sport Club Athletic Trainer will review. If the medical documents are approved, your DSE status will change to "Pending Approval".
4. If your status is "Pending Approval," then your medical clearance is complete, but your financial clearance is pending. To complete your financial clearance, follow Step 2 on the member registration document.

Other Resources

- **Member Registration Process**
- **Sports Physical**
- **Sport Club Forms**
- **Sport Club Handbook**

The USD Campus Recreation office reserves the right to decline an athlete packet for any reason. Incomplete packets will not be accepted, and individuals cannot participate until they are marked as "Approved-Active" in DSE on the Club-specific registration.

UNIVERSITY OF SAN DIEGO TOREROS CAMPUS RECREATION

SPORT CLUB HEALTH HISTORY FORM

***Complete as fillable PDF or use blue or black ink. *ALL ATHLETES MUST COMPLETE THIS FORM EVERY ACTIVE YEAR.**
NEW PARTICIPANTS: PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR SPORTS PHYSICAL (REQUIRED)

Physical Exam Date (new members only):_____ **Sport(s):**_____ **Email:**_____

Name:_____ **Date of Birth:**_____ **USD ID #:**_____

Mark an "X" in one of the boxes below. Explain any "Yes" answers in the "Explain" section in the bottom right text section.

	YES	NO
GENERAL HISTORY:		
1. Has a medical provider ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or over-the-counter medication or supplements? List names and what you take it for in "Explain" section.	☐	☐
4. Are you using alcohol, tobacco, marijuana or illegal substances? (Disclosure on this form is not required. Discuss with your provider.)		
5. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, What? _____	☐	☐
6. Do you require medication for anaphalaxis?	☐	☐
7. If so, are teammates/friends aware of what your allergy is, medication location and how to assist you?	☐	☐
HEART HEALTH:		
8. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
9. Have you ever passed our or nearly passed out AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
11. Does your heart race / skip beats during exercise?	☐	☐
12. Has a medical provider ever told you that you have (check all that apply): ☐ High BP/Cholesterol ☐ Heart Murmur ☐ Positive Sickle Cell ☐ Heart Infection	☐	☐
13. Has a medical provider ever ordered a test for your heart (e.g., ECG, echocardiogram)?	☐	☐
FAMILY HEART HISTORY:		
14. Has anyone in your family died for no apparent reason?	☐	☐
15. Does anyone in your family have a heart problem?	☐	☐
16. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
17. Does anyone in your family have Marfan syndrome?	☐	☐
OTHER HEALTH HISTORY:		
18. Have you ever spent the night in a hospital?	☐	☐
19. Have you ever had surgery?	☐	☐
20. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? ***If yes, check affected area in chart below.**	☐	☐
21. Have you had any broken or fractured bones or dislocated joints? ***If yes, check affected area in chart below.**	☐	☐
22. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? ***If yes, check affected area in chart below.**	☐	☐

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND/ FINGERS	CHEST
☐	☐	☐	☐	☐	☐	☐	☐
UPPER BACK	**LOWER BACK**	**HIP**	**THIGH**	**KNEE**	**CALF/ SHIN**	**ANKLE**	**FOOT/ TOES**
☐	☐	☐	☐	☐	☐	☐	☐

23. Have you ever had a stress fracture?	☐	☐
24. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
25. Do you regularly use a brace or an assistive device?	☐	☐

	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
27. Is there anyone in your family who has asthma?	☐	☐
28. Have you ever used an inhaler or taken asthma medicine?	☐	☐
29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
30. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
31. Do you have an rashes, pressure sores or other skin problems?	☐	☐
32. Have you had a MRSA infection?	☐	☐
33. Have you had a herpes skin infection?	☐	☐
34. Have you had a concussion? If so, how many?_____ When was the most recent? _____	☐	☐
35. Have you been hit in the head and been confused or lost your memory?	☐	☐
36. Have you ever had a seizure or stroke?	☐	☐
37. Do you have headaches with exercise?	☐	☐
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
39. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
40. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
41. Has a medical provider told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
42. Have you had any problems with your eyes or vision?	☐	☐
43. Do you wear glasses or contact lenses?	☐	☐
44. Do you wear protective eye wear, such as goggles or a face shield?	☐	☐
45. Are you dissatisfied with your weight?	☐	☐
46. Are you trying to gain or lose weight?	☐	☐
47. Has anyone recommend you change your weight or eating habits?	☐	☐
48. Do you limit or carefully control what you eat?	☐	☐
49. Do you have any concerns that you would like to discuss with a medical provider?	☐	☐
FEMALES ONLY:		
50. Have you had a menstrual period?	☐	☐
51. How old were you when you had your first menstrual period?_____		
52. How many periods have you had in the last 12 months? _____		

Explain ALL "Yes" (except #50) answers here:

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.
I understand that intentional misrepresentation of the above information may pose a risk to my health and safety and may result in my exclusion from participating in sports clubs.

Signature of Club Athlete:_____ **Parent/Guardian Signature: (If under 18 years of age) :**_____ **Date:**_____

University of San Diego
Athletic Medical Physical Examination - Sport Club Member

MDs, DOs, NPs and PAs are the <u>ONLY</u> ones approved to perform USD physicals.

Name: _____ **USD ID#:** _____

Sport: _____ **Eligibility:** Fresh Soph Jr Sr 5th Year

I. I have not had any illness or injury; or developed any new symptoms since I completed the Health History Form on:

If Ht.> 6'0" male or 5'10" female measure: Symph to floor =_____ arm span_____
UB/LB ratio_____is or is not <0.89
Arm span/height_____ is or is not >1.05

Athlete Signature: _____

II. Health History Form reviewed (Physician Initials _____)

EXAM: **Height:** _____ **Weight:** _____ (%) **Pulse:** _____ **BP:** _____/_____

Vision: R 20/____ L 20/____ **Corrected:** Y N **Pupils:** Equal Unequal

Previous Concussion Hx: List any concussion date, time out of sport, testing results and date released to resume sport

Medical	**Normal**	**Abnormal Findings**	**Dr. Initials**
Appearance			
Eye/Ears/Nose/Throat			
Neuro			
Heart		**Exam performed supine, standing, and with valsalva**	
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Musculoskeletal		**Medical exam performed by:**	
Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/Ankle			
Foot			
Other		**No physical stigmata of Marfan's**	

Orthopedic exam performed by:

CLEARANCE:

_____ **Cleared** - Based on my examination of this patient, I determine he/she can fully participate in sports clubs at USD.

_____ **Cleared after completing rehabilitation for:** _____

_____ **Not cleared for:** _____ **Reason:** _____

_____ **Clearance decision deferred pending further work-up or obtaining records**

COMMENTS and RECOMMENDATIONS:

OBTAIN OFFICE STAMP OR ATTACH PHYSICIAN'S BUSINESS CARD BELOW
(physical is invalid without stamp or business card)

Physician's Signature **Date**