

UNIVERSITY OF WISCONSIN-OSHKOSH SPORTS MEDICINE

Physical Examination Record



Directions to the Student-Athlete: 1) Please complete and print a copy of medical questionnaire from ATS medical website located at https://atsusers.com 2) Present questionnaire to physician or physician's staff 3) Return <u>both</u> questionnaire and physical exam record to athletic training staff prior to participation.	Directions to the Examining Physician: 1) Please review and sign medical history questionnaire 2) Please complete and sign this physical examination form 3) Please complete Sickle Cell Trait Verification Form 4) Please clarify any abnormal findings and recommendations 5) Please return the completed form to the athlete
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(PLEASE PRINT CLEARLY IN BLUE OR BLACK INK ONLY)

Student-Athlete's Name _____ Height _____ Weight _____

Sex Male Female Date of Birth (mm/dd/yy) _____ Sport(s) _____

Pulse _____ BP ____/____ Vision: R 20/____ L 20/____ Corrected Yes No _____

Medical	Normal	Abnormal Findings/ Explanation of Findings
Appearance		
EENT		
Lymph Nodes		
Heart (Circle appropriate response/ Explain)		
Rhythm:	<i>Regular</i> <i>Irregular</i>	Femoral Pulses: <i>Normal</i> <i>Diminished</i>
Murmurs:	Yes No	Marfan's Stigmata: Yes No
Lungs		
Abdomen		
Genitalia		
Skin		
Neurological		
Sickle Cell Trait (Must be confirmed *) Positive Negative		
Musculoskeletal		
Neck		
Back		
Shoulder/Arm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

***In order to comply with new NCAA rules, each athlete must have a confirmed Sickle Cell Trait test prior to participation in UW Oshkosh intercollegiate athletics. Please circle appropriate test result above and fill out Sickle Cell Verification Form attached to this physical form.**

Labs:	Medications:	Allergies:

Assessment:

Recommendations:

- I find nothing in the medical history questionnaire and physical examination to preclude participation. I recommend full participation.
- One or more issues have been identified that need to be addressed prior to participation.
- I do not recommend participation for this individual. See Assessment.

Name of Physician (PRINT) _____ Signature _____

Date _____ Address _____ Phone _____

UNIVERSITY OF WISCONSIN-OSHKOSH SPORTS MEDICINE
Sickle Cell Trait Test Verification Form



Directions to the Student-Athlete:

- 1) Please fill out top portion of form
- 2) Please bring form to physician to complete
- 3) Return verification form to athletic training staff prior to athletic participation

Directions to the Examining Physician:

- 1) Please fully complete form and return to athlete

Student-Athlete's Name: _____ Date: _____

Sport(s): _____ Student ID#: _____

To be completed by Physician:

I verify that the above named individual has been tested for Sickle Cell Trait.

The result of the test was:

Positive _____

Negative _____

Date of Test: _____

Physicians Signature: _____

Date: _____

Physicians Name (Print): _____

Physicians Address: _____

Physician's Phone Number: _____

Return this form to:

Wade Peitersen
Head Athletic Trainer
UW Oshkosh Sports Medicine
800 Algoma Boulevard
Kolf 169
Oshkosh, WI 54901

Or fax form to:

(920)-424-1068