Return form to: East Stroudsburg University of Pennsylvania-- Health Services - Telephone (570) 422-3553 Fax (570) 422-3731
200 Prospect Street, East Stroudsburg, PA 18301

East Stroudsburg University Athletic Training
Pre-Participation Athletic Physical Examination

(Physical must be completed within 6 months prior to any athletic participation)

Student-Athlete Name: _____ Sport(s):_____ Date of Birth: _____
Cell Number: _____ ESU Student ID:_____ SS#:_____

Step One: Health History (to be completed by athlete)

Have you ever had any of the following conditions?
Circle NO or write details on line.

Asthma	No
Allergies	No
Medications	No
Diabetes	No
ADHD	No
Heart Murmur	No
Irregular Heartbeat / Chest Pain	No
Anyone in your family died prior to age 50 to sudden death?	No
Hospitalized overnight	No
Surgery	No
Serious injury	No
Broken bone	No
Sprain/strain/dislocation	No
"Stinger/burner"	No
Concussion	No
Passed out with exercise / Loss of consciousness	No
Heat cramps/exhaustion/stroke	No
Chest pain	No
Seizure	No
High blood pressure	No
Skin conditions/MRSA	No
Any bleeding disorders?	No
Any ongoing medical problems?	No
Have you been previously withheld from athletics?	No
Sickle Cell Trait	No
Use glasses, contacts, braces, appliances?	No
Use special pads/braces for sports?	No
Do you use any nutritional supplements?	No
Date of last Tetanus: Td or Tdap (within last 10 years):	
Females: Date of last menstrual period:	
Additional Details / Any abnormalities:	
Have you seen an orthopedic specialist in the past year?	No
If yes for what:	
Orthopedic Specialist's name, phone number and fax:	

I authorize the release to the ESU Athletic Department of this participation in the ESU athletic program. I furthermore know of and accept the risks involved in the participation in athletics and understand that serious injury, even death is possible in such participation and voluntarily choose to accept such risks.

Student-Athlete Signature:

_____

Date Signed:

Step Two: Provider to complete assessment below:
(To be completed by MD/DO/NP/PA or ATC)
Check box if **normal**, Explain if abnormal

Musculoskeletal (ROM, Strength)		
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips/Thighs		
Knees		
Ankles / Feet		
Neuromuscular (DTR)		

Height: _____ Weight: _____ Pulse: _____ BP: _____
Vision: _____ Hearing: _____

Step Two Done By: _____
MD/DO/NP/PA/ATC

Step Three: Provider (MD/DO/NP/PA) to complete assessment:
Check box if **normal**, Explain if abnormal

Eyes		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Femoral Pulses		
Chest and Lungs		
Abdomen		
Skin		
Hernia		

Sickle Cell Trait Status	☐ Positive	☐ Negative
Date of Testing: _____ (must attach a copy of sickle cell blood test results)		
Comments:		

Cleared for full Participation: Yes: _____ No: _____
Limitations: _____
_____

X_____
Provider Signature **MD/DO/NP/PA**
Provider name, address and phone number (Stamp not accepted):

_____

_____

_____Date: _____

Physician License # _____

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200 prospect Street, East Stroudsburg, PA 18301-2999
Phone: 570-422-3553 Fax: 570-422-3731

REPORT OF MEDICAL HISTORY

Mandatory for International Students

Other Students: May be required for class scheduling of some academic majors i.e. Education, Health Sciences, other, etc.

Last Name_____ First Name_____ Middle Initial____ Student ID_____

Home Address_____ ❑ Male ❑ Female

City_____ State_____ Zip_____

Student Cell Phone#_____ Home Phone #_____ Birthday_____

Parent/Guardian/Emergency Contact Name_____ Contact Phone #_____

HEALTH INSURANCE (please provide a copy of the front and back of insurance card)

Insurance Company Name_____ Policy Number_____

Policy Holder Name_____ Group Number_____

ENROLLMENT STATUS (check all that apply)

❑ Undergrad ❑ Graduate ❑ Transfer ❑ International ❑Exchange ❑Other _____

MEDICAL HISTORY

N/A_____
Allergies to Medications/ Seasonal _____
Diseases/Surgeries/Injuries/Chickenpox:_____
Daily Medications_____
Have you ever been diagnosed with depression/anxiety/or other psychological illness? (Please explain on separate sheet)
Other:_____

MEDICAL RELEASE STATEMENT

By signing this, I affirm that all information in this document is correct and complete. I also agree to inform the Student Health Center of any changes in my health or in the information on this form. I grant permission to the staff of University Health Services to render any treatment necessary. I understand under certain circumstances or emergencies I may be referred to a hospital, diagnostic testing, or a medical specialist for diagnoses and /or treatment. Costs incurred for these services are the responsibility of the patient and I will be responsible for all bills incurred that are not covered by my health insurance carrier.

I authorize release of my medical records and information to my insurance company for the purpose of reimbursement.
I authorize the release of my medical records and information to a licensed physician, hospital, clinic, other medical personnel, including University Athletic Training Services and Counseling and Psychological Services, in the event of an emergency or continuation of care.
This authorization shall remain in effect while enrolled at East Stroudsburg University or written withdrawal of consent is received at University Health Services.

_____ _____

Student Signature (or Parent/Guardian if student is under 18 yrs) *Date*

IMMUNIZATIONS

Mandatory for International Students

Other Students: May be required for class scheduling of some academic majors i.e. Education, Health Sciences, other, etc.

Attach official documentation from a school, medical records, or have your physician complete this form

** May attach official copies of reactive Titer test results, in lieu of vaccination dates, for MMR, Tetanus, Hepatitis B, or Varicella

1. MMR (MEASLES/MUMPS/RUBELLA) Students born before JANUARY 1956 are exempt from MMR vaccinations

*Dates: #1*_____ *# 2* _____

2. TETANUS / TDAP (within past 10 years) Date: _____ *3. Polio Series competed Date:* _____

3. HEPATITIS B (Dates: #1 _____ *#2* _____ #3_____

4.. TUBERCULOSIS Screening:
TB testing is REQUIRED for □ ***International Students,*** □ ***Non****-USA born students,* □ students *who have been exposed to tuberculosis or are high risk*

TB PPD TEST done within past year: *DATE GIVEN:* _____ *DATE READ:* _____ *RESULTS:* _____ *mm Negative* _____ *mm Positive*

OR QUANTIFERON Test *DATE:* _____ *Results:* _____□ attach copy of lab results

□ *Attach a Copy of Report of Chest X-ray for positive PPD or positive Quaniferon test* DATE:_____

□*Treatment received for positive TB screening/CXR- DESCRIBE*_____

5. MENINGOCOCCAL QUADRIVAVALENT A, C, Y, W-135: (after age 16) ❑ YES Date: _____ ❑ NO
(Required if living in University owned housing)

□ *MENINGITIS WAIVER: Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of the vaccination, and has decided not to receive the vaccine, or has received the vaccine before age 16.*

_____ _____
Student Signature *(Parent/Legal guardian if student is under 18 yrs)* *DATE*

6. *VARICELLA: (optional) Dates: #1* _____ *#2* _____ OR Date of Disease: _____

7. HPV Vaccine (optional) Dates: #1 _____ *#2* _____ #3_____

_____
PHYSICIAN'S SIGNATURE (stamp not accepted) *DATE*
(If completed by PAC or NP include name of Physician Association)

**** Print Physician's Name* _____ **** License #*_____ *Telephone #*_____

_____ - _____
City or Town *State* *Zip Code*

International Students wishing to participate in Intercollegiate Athletics must also have their physician complete the Athletic Physical Examination Form

East Stroudsburg University

Immunization Exemption

(International Students may only be exempted from Immunizations for a medical contraindication)

_____ _____

Student Name (Print) Student ID#

To be completed and signed by a Medical Care Provider and the Student

CHECK ONE

1._____ **PERMANENT** medical contraindication (state vaccine):_____

Explanation_____

2. _____**TEMPORARY** medical contraindication (state vaccine):_____

Explanation_____

Anticipated Date of End of Exclusion _____

3._____ **DECLINED VACCINE** for personal or religious reasons:

The Student has been advised of the risks, the effectiveness, and availability of vaccines an**d has decided not to receive the vaccine(s) checked below:**

❑ Hepatitis B ❑ Tetanus/Diphtheria ❑ Pertussis ❑ Measles ❑ Mumps ❑ Rubella
❑ Meningococcal Quadrivalent *A, C, Y, W-135: (after age 16)* ❑ Varicella

❑ Tuberculosis testing:.
(Non-US born students, International students, and high risk students may not be exempt. TB testing is required for health and education related majors.) http://www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_Apr2011.pdf

I am unable to comply with the East Stroudsburg University Immunization Policy as set forth in ESU-SA-2101-017. I understand that if an outbreak of communicable disease occurs I may be required to leave campus immediately for a period of time determined by the University. This may negate my attending classes for this period of time.

_____

** **Student Signature** (REQUIRED) **Date**

_____

**** Signature of MD, NP, PAC, NP (Stamp not accepted)** **License #** **Date**
If completed by PAC or NP print name of Physician Affiliation

_____
Print Name of Medical Provider

_____
Street Address City State Zip