Athlete Name: __________________________________________________________

Sport: Cheerleading  Squad: ____________________________________________

Please fill out all information in PEN

Stephen F. Austin
State University

New / Incoming Athlete

Due: June 1, 2012

PHYSICAL APPOINTMENT:

Date: _______________________________

Time: ________________  AM  PM
Last Name: _________________________________________  First Name: ____________________________

Middle Name: _________________________________________  Nickname: ____________________________

SS#: ________ - ______- _________   Campus ID # ________________________________   Sport: Cheerleading

Birth Date: ______ / ______ / __________   Age: ______   Sex: _____   Marital Status: S / M / D

Preferred Email Address: ____________________________________________ @

Current SFA Classification:   ______ Incoming Freshman   ______ Sophomore

   ______ Junior   ______ Senior   ______ Graduate Student

Local / Campus/

Dorm / Apt. Address: ____________________________________________

Phone: (_____ ) ______ - _________

City: Nacogdoches   State: Texas   Zip: 7596   Mobile Phone: (_____ ) ______ - _________

Father / Guardian: ________________________________________________

Home Address: ____________________________________________________

Home Phone: (_____ ) ______ - _________

City: _________________________ State: __________ Zip: ____________

Mobile Phone: (_____ ) ______ - _________

Email Address: ____________________________________________________

Work Phone: (_____ ) ______ - _________

Mother / Guardian: ________________________________________________

Home Address: ____________________________________________________

Home Phone: (_____ ) ______ - _________

City: _________________________ State: __________ Zip: ____________

Mobile Phone: (_____ ) ______ - _________

Email Address: ____________________________________________________

Work Phone: (_____ ) ______ - _________

Contact Person in Case of an Emergency (Non-Relative):

Name: _________________________ Relationship: _________________________

Mobile Phone: (_____ ) ______ - _________

Family Physician: ________________________________________________

Phone: (_____ ) ______ - _________
Stephen F. Austin State University – Insurance Information Questionnaire

Athlete’s Name ________________________________ Sport CHEERLEADING

Social Security Number (Athlete) __________-________-________

Parent/Guardian Information

Father/Guardian Name ____________________________ Address __________________________

Telephone __________________ Email Address:________________________________________

Is Father employed? Yes / No Employer _________________________________

Emp. Address ________________________________ Emp. Telephone ________________________________

Is Father insured? Yes / No Insurance Company Plan __________________________

Policy Number __________________________________ Group Number ________________________________

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits, either to myself, or to the party who accepts assignments below. I authorize payment of medical benefits to physicians or suppliers of medical services.

Signature of Insured (Parent) __________________________ Date __________________________

Social Security Number of Insured (Parent) __________________________

Birth Date of Insured (Parent) __________________________

My insurance company requires special forms to be filled out: Yes _____ No _____

If yes, please attach signed forms.

Mother/Guardian Name ____________________________ Address __________________________

Telephone __________________ Email Address:________________________________________

Is Mother employed? Yes / No Employer _________________________________

Emp. Address ________________________________ Emp. Telephone ________________________________

Is Mother insured? Yes / No Insurance Company Plan __________________________

Policy Number __________________________________ Group Number ________________________________

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits, either to myself, or to the party who accepts assignments below. I authorize payment of medical benefits to physicians or suppliers of medical services.

Signature of Insured (Parent) __________________________ Date __________________________

Social Security Number of Insured (Parent) __________________________

Birth Date of Insured (Parent) __________________________

My insurance company requires special forms to be filled out: Yes _____ No _____

If yes, please attach signed forms.

* Please attach a copy of the front and back of your insurance card (s) *
Concussion Notification and Agreement Policy

I, ______________________________________________, acknowledge and affirm that I have been educated on concussions and the importance of notifying an athletic trainer as soon as I am aware that I may have developed signs and/or symptoms of a concussion. I understand and affirmatively accept full responsibility for my safety and health while participating in intercollegiate athletics at Stephen F. Austin State University, including reporting any injury or illness to athletic training staff, and am duly aware of the dangers in continued participation with any such injury or illness and that I will not allow my desire to play impede my judgment or cause me to give false information to the evaluating athletic trainer.

I also HEREBY give my permission for the athletic trainer and/or physician to make all return to play decisions on my concussion status. I also understand that I will fully cooperate with the athletic training staff and physicians in the management of my concussion(s).

This agreement will remain in effect for the duration of my intercollegiate career at Stephen F. Austin State University.

_________________________________________  ______________  __________________________
Student-Athlete Signature               Date                Parent/Guardian (if under 18)
Student-Athlete Authorization/Consent for Disclosure of Protected Health Information for NCAA-Related Research Purposes

I, ________________________________ hereby authorize _________________________

   Name of Student-Athlete   Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation regarding any injury, illness, treatment or participation related to or affecting my training for participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA), and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used by the NCAA, and authorized third parties to receive such information for the purpose of using injury, relevant illness and participation information collected from multiple student-athletes and institutions in a manner that does not identify myself or my school. The information is provided to NCAA committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate the effectiveness of health and safety rules and policy, and the study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns and help develop education on student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPPA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the director of athletics of my institution. I understand that a revocation takes effect on its date and does not affect any action taken prior to that date.

______________________________ ________________________________
Printed Name of Student-Athlete   Signature   Date
MEDICAL CONSENT - Part I

I hereby grant permission to the Stephen F. Austin State University team physicians and /or their consulting physician to render to my son or daughter or myself, any treatment or medical or surgical care that they deem reasonably necessary to the health and well being of the athlete.

I also hereby authorize the athletic trainers at Stephen F. Austin State University who are under the direction and guidance of the Stephen F. Austin State University team physicians, to render to my son or daughter or myself, any preventative, first aid, rehabilitative, or emergency treatment that they deem reasonably necessary to the health and well being of the athlete.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

DATE: ____________________

____________________________________
SIGNATURE

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian.

____________________________________
SOCIAL SECURITY NUMBER

____________________________________
PARENT OR GUARDIAN

AUTHORIZATION FOR RELEASE OF INFORMATION - Part II

This is to authorize the Stephen F. Austin State University athletic trainers, team physicians, and athletic coaches to release medical information on my son or daughter, or myself, to the Stephen F. Austin State University Sports Information Department, and the various media outlets, any information concerning illness or injury relative to my past, present, or future participation in athletics at Stephen F. Austin State University.

DATE: ____________________

____________________________________
SIGNATURE

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian.

____________________________________
SOCIAL SECURITY NUMBER

____________________________________
PARENT OR GUARDIAN
AUTHORIZATION FOR RELEASE OF INFORMATION - Part III

I, __________________________________________, hereby authorize and request Stephen F. Austin State University, the Board of Regents, the Stephen F. Austin Athletic Department and their duly authorized agents, servants, or employees (including coaches, trainers, and physicians) to furnish to all professional athletic teams, their scouts, representative agents, trainers, physicians, servants, or employees, any and all information concerning or having bearing upon my participation in athletics at Stephen F. Austin State University. Said authorization shall include, but is not limited to any and all information within their knowledge, or contained in any records under their supervision or control concerning my physical condition, illnesses, injuries, and any treatment, hospitalization, examinations, X-rays, and otherwise, and to make such reports to such persons or organizations concerning myself as they may request; and I hereby fully discharge all parties to whom this authorization extends from any and all privilege in connection with the disclosure of information included in this authorization.

DATE: ____________________  
SIGNATURE

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian.

SOCIAL SECURITY NUMBER

PARENT OR GUARDIAN

SHARED RESPONSIBILITY FOR SPORTS SAFETY - Part IV

Participation in sport requires an acceptance of risk or injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

Periodic analysis of injury patterns, refinements in rules, and other safety decisions are being made. However, to legislate safety via a rulebook and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rulebook is as insufficient as to rely on warning labels to produce compliance with safety guidelines. “Compliance” means respect on everyone’s part for the intent and purpose of a rule or guideline.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at Stephen F. Austin State University.

DATE: ____________________  
SIGNATURE

Signature may be that of athlete over 18 years of age; if under 18, please have it signed by parent or guardian.

PARENT OR GUARDIAN
Please be reminded of the medical policy of No Visible Jewelry for all practices and events. Visible jewelry is defined as any items that are readily visible in your normal practice or game uniform. If your typical practice attire does not include a shirt and you have a belly button ring, it must be removed. Items that are always visible and therefore must be removed are earrings, necklaces, watches, fingers rings, brow rings, belly button rings, nose rings, and tongue piercing.

This policy is for the safety you, the athlete, and for the safety of your teammates.

Five typical injuries can happen while wearing these items.

5. Direct blow to the pierced area resulting in a laceration to you or to your opponent/teammate.

4. Opponent/teammate catches the article and rips it from your body. Usually this results in the jewelry being damaged. If a teammate catches a 'ring of some sort with a finger, etc., the ring will be forcibly ripped from your body resulting in probable damage of the item and guaranteed damage to your body; not to mention the damage to your teammate's finger (It's called a tendon avulsion and requires surgery to repair.).

3. Swallowing of the items. Internal organs do not like objects with points on the end. An Esophageal piercing is not very pretty. No one will notice your statement.

2. Tooth damage by biting down on such items and breaking a tooth. Most dental plans will not pay for this type of dental repair and neither will the SFA Athletic Department.

1. And the most life threatening way to injury yourself while wearing a tongue ring is asphyxiation. Should the tongue ring remove itself from your tongue and you breathe it into your lungs, it becomes a life threatening emergency that will require your immediate removal from the game/practice and its immediate removal from your lungs.

At all pre-season meetings I addressed this situation and it seemed like you (the athlete) understood the athletic training room's opinion. By the repeated actions of some athletes, it is obvious that you did not understand that opinion. Let me be blunt:

NO VISIBLE JEWELRY OF ANY TYPE WILL BE ALLOWED DURING ANY PRACTICE OR PERFORMANCE. THE JEWELRY WILL BE REMOVED OR YOU WILL BE REMOVED FROM THE PRACTICE OR PERFORMANCE.

The Athletic Training Staff has been instructed to inform you that you need to remove it and then inform your coach if you do not remove the problematic item. If you refuse, you will be removed from practice and will not return until it is removed.

Covering is not removing. It just doesn't work.

Thank you for your cooperation in keeping yourself and your teammates as injury free as possible.

I have read the above policy ___________________________________________
Female Athletes Only

The enclosed is for your protection and for the protection of your unborn child, should the situation occur. I cannot force you to inform the medical staff that you have become pregnant; but I hope you will do what is in the best interest of you and your unborn child - inform us so we can protect the health of both of you.

Table 29-2

American College of Obstetricians and Gynecologists (ACOG)
Guidelines for Exercise During Pregnancy (Feb. 1994)

An exercise prescription in pregnancy should be individualized and should include a health assessment. It must be emphasized that none of these recommendations has a firm basis in prospective, randomized, clinical trials.

These guidelines follow from a critical analysis of the available physiologic data regarding exercise and pregnancy and represent reasonable extrapolations from such knowledge.

Recommendations for Exercise in Pregnancy and Postpartum

There are no data in humans to indicate that pregnant women should limit exercise intensity and lower target heart rates because of potential adverse events. For women who do not have any additional risk factors for adverse maternal or prenatal outcome, the following recommendations may be made.

1. During pregnancy, women can continue to exercise and derive health benefits even from mild-to-moderate exercise routines. Regular exercise (at least three times per week) is preferable to intermittent activity.

2. Women should avoid exercise in the supine position after the first trimester. Such a position is associated with decreased cardiac output in most pregnant women; because the remaining cardiac output will be preferentially distributed away from splanchnic beds (including the uterus) during vigorous exercise, such regimens are best avoided during pregnancy. Prolonged periods of motionless standing should also be avoided.

3. Women should be aware of the decreased oxygen available for aerobic exercise during pregnancy. They should be encouraged to modify the intensity of their exercise according to maternal symptoms. Pregnant women should stop exercising when fatigued and not exercise to exhaustion. Weight-bearing exercises may under some circumstances be continued at intensities similar to those prior to pregnancy throughout pregnancy. Non-weight-bearing exercises such as cycling or swimming will minimize the risk of and facilitate the continuation of exercise during pregnancy.

4. Morphologic changes in pregnancy should serve as a relative contraindication to types of exercise in which loss of balance could be detrimental to maternal or fetal well being, especially in the third trimester. Further, any type of exercise involving the potential for even mild abdominal trauma should be avoided.

**copied from ACSM’s Handbook for the Team Physician**

I have read the recommendation of the American College of Obstetricians and Gynecologists.

Please sign here
I. SPECIFIC MEDICAL QUESTIONS:

Y / N 1. Have you been under the care of a physician, any time in the PAST 3 YEARS? If yes, please explain: ____________________________________________________

Y / N 2. Have you ever had any SURGERY (including pin, plate, fracture, etc.)? If yes, please explain (date, site of injury, type of surgery)
   Date: ____ / ____ / ________ Injury/Surgery: ____________________________________________________

Y / N 3. Have you ever had any MAJOR injuries resulting from sports participation? If yes, please explain: ____________________________________________________

Y / N 4. Have you ever had any MAJOR injuries not resulting from sports participation? If yes, please explain: ____________________________________________________

Y / N 5. Have you ever had an illness or injury to any of the following organs?
   a. Eyes: ____________________________________________________
   b. Ears: ____________________________________________________
   c. Heart: ____________________________________________________
   d. Lungs: ____________________________________________________
   e. Kidneys: ____________________________________________________
   f. Reproductive Organs: __________________________________________
   g. Liver: ____________________________________________________
   h. Other: ____________________________________________________

6. Immunizations (Date of last booster)
   Tetanus: ____ / ____ / ________
   MMR(measles, mumps, rubella): ____ / ____ / ________

7. Gynecological Exam (Females)
   Date of last PAP Smear: ____ / ____ / ________
II. DISEASE & ILLNESS:

Have you suffered from, or been told (by a physician or parent) that you have had:

Y / N 1. Diabetes
Y / N 2. Epilepsy
Y / N 3. Hepatitis
Y / N 4. Marfans Syndrome
Y / N 5. Measles
Y / N 6. Mononucleosis
Y / N 7. Mumps
Y / N 8. Rheumatic Heart Disease
Y / N 9. Scarlet Fever
Y / N 10. Tuberculosis

III. ALLERGIES / MEDICATIONS:

1. Do you suffer from:

   Y / N a. Asthma: Type of Inhaler: ____________________________

   Y / N b. Hay fever

   Y / N c. Skin Allergies: _______________________________

   Y / N d. Other Allergies: _______________________________

2. Have you ever been tested for: SICKLE CELL ANEMIA TRAIT (if applicable)?
   If yes, give date: _____ / ____ / ______ Please explain results: ______________
   ________________________________________________________

3. Are you presently taking any medications?
   If yes, please explain: ______________________________________
   ________________________________________________________
   ________________________________________________________

4. Are you allergic to any medications?
   (Please list any prescription, over the counter, and/or topical.) __________________
   ________________________________________________________
IV. HEAD & NECK:

Y / N 1. Have you ever had a head/neck injury that has interrupted your athletic participation? If yes, how long were you inactive? __________________________

Y / N 2. Do you have frequent headaches?
If YES, how severe are they? __________________________
Do you become dizzy? __________________________

Y / N 3. Have you ever been knocked unconscious or suffered from a concussion in the past three years? If yes, give date: ____ / ____ / ________

Y / N 4. Have you been knocked unconscious more than once?
If yes, how often? __________________________

Y / N 5. Have you ever been hospitalized for a head injury?
If yes, when: ____ / ____ / ________ How long: __________________________

Y / N 6. Have you ever suffered from a pinched nerve of the arm or of whiplash?
If yes, when: ____ / ____ / ________

Y / N 7. Have you ever been hospitalized for a neck injury?
If yes, when: ____ / ____ / ________ How long: __________________________

Y / N 8. Do you suffer from pain, stiffness, or limited movement of the neck?
If yes, please explain: __________________________

Y / N 9. Have you ever been X-RAYED for a head or neck injury?

V. EYES:

Y / N 1. Do you wear glasses?

Y / N 2. Do you wear contacts?
If Y, Hard or Soft lenses (Please circle one)?

Y / N 3. Do you wear either of the above during sport activity?
If the answers above are yes, name the prescribing consultant:
_________________________________________   (______) ______ - ________
Name of Physician   Phone

VI. DENTAL:

Y / N 1. Do you wear any dental appliance (braces, caps, etc.)?
If yes, please explain: __________________________

Y / N 2. When were you last examined by a Dentist (for regular dental care)?
Date: ____ / ____ / ________

2012 – 2013 ACADEMIC YEAR  Page 14 of 18
VII. NOSE:

Y / N 1. Have you ever fractured your nose?

2. Do you suffer from:
Y / N a. Sinus problems?
Y / N b. Frequent nose bleeds?
Y / N c. Nasal blockage?

VIII. HEART:

Y / N 1. Have you ever been told you have a heart murmur or palpitation?
If yes, please explain: __________________________________________________________

Y / N 2. Have you ever had any testing done on your heart?
(Ex: stress test, EKG, Echocardiogram, etc.) ________________________________
__________________________________________________________________________

Y / N 3. Do you have chest pain during or after athletic activity?

IX. SKELETAL STRUCTURE:

Y / N 1. SHOULDER
- Have you suffered from a shoulder injury that has incapacitated you
(for more than two weeks) during the past THREE years? R / L
If yes, please explain: _______________________________________________________

2. ELBOW- Have you suffered from:
Y / N a. Sprains R / L
Y / N b. Hyperextension R / L
Y / N c. Dislocation R / L
Y / N d. Other: ____________________________________________________________ R / L

3. WRIST & HAND - Have you suffered from:
Y / N a. Fractures R / L
Y / N b. Sprains R / L
Y / N c. Dislocations R / L
Y / N d. Other: ____________________________________________________________ R / L
4. BACK

Y / N  a. Have you ever suffered from a back injury?  
If YES, did you see a physician?  Date: _____ / _____ / ________
Y / N  Was you back X-RAYED?
Y / N  b. Do you experience frequent back pain?
Y / N  c. Have you ever suffered from an injury to the vertebral column?
Y / N  d. Have you been told that you have SCOLIOSIS?

5. HIP

Y / N  a. Have you ever suffered from a hip injury?  R / L
Y / N  b. Were you ever told you had a ligament injury?  R / L
If YES, when? _____________________________________________

6. KNEE

Y / N  a. Have you ever suffered from a knee injury?  R / L
Y / N  b. Were you ever told you had a ligament injury?  R / L
Y / N  c. Were you ever told you had a meniscus (cartilage) injury?  R / L
Y / N  d. Have you ever suffered from Osgood-Schlatter's Disease?  R / L
If YES, when? _____________________________________________

7. ANKLE

Y / N  a. Have you sprained an ankle in the past THREE years, which incapacitated you for more than two weeks?  R / L
Y / N  b. Have you ever had an injury involving the Achilles Tendon?  R / L

8. FOOT - Have you suffered from:

Y / N  a. Fractures  R / L
Y / N  b. Sprains  R / L
Y / N  c. Arch Problems  R / L
Y / N  d. Other: ___________________________________________  R / L

X. GENERAL MEDICAL DATA:

Y / N  1. Were you ever advised to a wear a brace or harness during physical activity?  
If YES, what type: ___________________________________________
Y / N  2. Have you ever experienced illness or injury due to HEAT EXPOSURE?  
If YES, explain: _____________________________________________
Y / N  3. Have you ever been treated for Ulcers?
Y / N  4. Have you ever suffered from or been told you have a Hernia?  
If YES, where: _____________________________________________
Was it surgically repaired? Y / N When: _______________________
Y / N 5. Have you ever suffered from kidney infections?

Y / N 6. Do you suffer from frequent blisters or shin splints?

Y / N 7. Have you ever had any significant injury or illness (related or unrelated to athletics) not covered by any of the above questions?
If YES, please explain: ________________________________________________________________

Y / N 8. Has a physician ever advised you NOT to participate in contact sports or physical activity? If YES, please explain: ________________________________________________________________

Y / N 9. If any SURGERIES have been performed, give the physician's name(s) and address, and obtain a copy of the surgery report and send to the Head Athletic Trainer for your medical records.

_________________________________________________________ (_____) ______ - ______
Name of Physician Phone

_________________________________________________________
Street Address

City State Zip

XI. FAMILY HISTORY:
Check the following disease, if present, in any blood relation family member.
If checked, state whom was affected. Relation

Y / N 1. Cancer _____________________________

Y / N 2. Diabetes _____________________________

Y / N 3. Heart Disease _____________________________

Y / N 4. High Blood Pressure _____________________________

Y / N 5. Blood Disease _____________________________

Y / N 6. Sickle Cell _____________________________

Y / N 7. Sudden Death, unexplained _____________________________

I / We hereby certify the above questions are answered completely and truthfully to the best of my / our knowledge.

ATHLETE'S SIGNATURE: ______________________________ DATE: ____ / ____ / ________

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ____ / ____ / ________
Name: ____________________________  Sport: CHEERLEADING  Date of Exam: _______ / _______ / _______

Campus ID: _________________________  Date of Birth: _______ / _______ / _______  Age: _______  SSN _______ / _______ / _______

Height: _______' ________"  Weight: __________ lbs.  Pulse: _______ bpm  Blood Pressure: _______ / _______  Sex: M / F

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<td>Objective Refraction</td>
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<tr>
<td>Internal Health</td>
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<tr>
<td>External Health</td>
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</table>

**ORTHOPEDIC**

<table>
<thead>
<tr>
<th>Orthopedic Examination</th>
<th>(R)</th>
<th>(L)</th>
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</thead>
<tbody>
<tr>
<td>Upper Extremities</td>
<td></td>
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<tr>
<td>ROM / Atrophy</td>
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<tr>
<td>Hx. Of Dislocation or significant trauma?</td>
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<tr>
<td>Shoulders</td>
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<td>Elbows</td>
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<tr>
<td>Wrist / Hands</td>
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<tr>
<td>LKS Palp?</td>
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<td>Hernia?</td>
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<td>Scars?</td>
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<tr>
<td>Lower Extremities</td>
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<tr>
<td>Asymmetry / Atrophy</td>
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<tr>
<td>Hamstrings / Quadriceps</td>
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<td>Spine</td>
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<td>Valgus / Varus Legs</td>
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<tr>
<td>Hips</td>
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<tr>
<td>Knees (1-3 degrees)</td>
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<tr>
<td>Instability (MCL / LCL)</td>
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<tr>
<td>(ACL / PCL)</td>
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<tr>
<td>Effusion / ROM</td>
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<tr>
<td>Past Surgeries</td>
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<tr>
<td>Significant History?</td>
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<tr>
<td>Remarks:</td>
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</tbody>
</table>

**M.D. Name:**

(Please print or place printed label here)

**Address:**

City, State Zip:

Office Phone: ( ) -

**HOLD - Further Testing**

(Please Explain)

**Required Medication**

- OR -

**Allergies**

"OK" - M.D. Signature

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[2012 – 2013 ACADEMIC YEAR]