U.S. Luge Association Physical Exam Form

☐ **Annual Physical** ☐ **Resumption of Sport**

This page to be completed by athlete and parent/legal guardian
Please complete as accurately as possible for your "annual physical" & "Resumption of Sport".

Name _____ Sex ____ DOB _____ SS# _____ (last 4 digits only)
Address _____
Home Phone _____ Cell Phone _____ Work/Parent Day Phone _____ ext ____
Primary Healthcare Physician _____ Phone _____

EMERGENCY CONTACT INFORMATION *If under age 18, you must fill out this section. If age 18 or older, you're requested to fill out this section, and if you do so, you are waiving your rights to privacy under the HIPPA laws with respect to this Emergency Contact.*

Name _____ Relationship _____
Day Phone _____ Cell Phone _____ Evening Phone _____

INSURANCE INFORMATION
Insurance Carrier _____ Policy # _____
Policy Holder Name _____ Policy Holder DOB _____

PASSPORT INFORMATION *Exactly is it appears on your passport*
Name _____ Passport # _____
Place of Birth _____ Nationality _____ Expiration Date _____

YES answers for this section require explanation on this form or an attached sheet of paper

		YES	NO
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Do you have an ongoing or chronic Illness?	☐	☐
3.	Are you currently taking any medications (prescription or non-prescription)? *(Please List)* _____	☐	☐
	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve performance?	☐	☐
4.	Have you ever had a head injury?	☐	☐
	Have you ever been "knocked out", become unconscious, or lost your memory?	☐	☐
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Do you have any allergies *(Please List)*? _____	☐	☐
6.	Have you ever passed out during or after exercise?	☐	☐
	Have you ever been dizzy during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you tire quickly during exercise?	☐	☐
	Have you ever had a racing or skipped heartbeat?	☐	☐
	Have you ever had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or experienced a sudden death before age 50?	☐	☐
	Have you had a severe viral infection within the last month (i.e. mononucleosis, myocarditis)?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐

		YES	NO
7.	Do you have any current skin problems (i.e. rash, itching, warts, fungus)?	☐	☐
8.	Have you ever become ill from exercising in the heat?	☐	☐
9.	Do you cough, wheeze, or have trouble breathing during or after activity?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
10.	Have you had any problems with your eyes or vision?	☐	☐
	Do you wear glasses, contacts, or protective eyewear?	☐	☐
11.	Have you ever had a sprain, strain, or swelling after an injury?	☐	☐
	Have you broken or fractured any bone or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling muscles tendon, bones, or joints? ***check***	☐	☐
	☐ Head ☐ Chest ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Knee ☐ Shin/Calf ☐ Ankle ☐ Foot		
12.	Did anything mentioned previously result in surgery?	☐	☐

COMMENTS:

We hereby state that, to the best of our knowledge, our answers to the above questions are complete and correct.

Signature of Athlete: _____ Signature of Parent/Legal Guardian: _____ Date _____

PHYSICAL EXAMINATION **DATE OF EXAM** _____

Name _____ DOB _____

Height _____ Weight _____ Pulse _____ BP _____/_____

Vision: R 20/_____ L 20/_____ Corrected: YES / NO Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE FOR LUGE

☐ Cleared

☐ Cleared after completing evaluations/rehabilitation for:

_____

_____

_____

_____

☐ Not cleared for Luge, but cleared for athletic activity ☐ Not Cleared

Reason _____

Recommendation _____

_____

_____

The examiner, by signing this form, agrees that he/she understands the danger for catastrophic injury inherent in the sport of luge and further, certifies that there is no current health condition, nor any item in the athlete's medical history, which may interfere with the athlete's participation in the sport of luge, or make it inadvisable for the athlete to participate in the sport of luge.

Name of Physician/Nurse Practitioner/Physician's Assistant (print/type) _____ Date _____

Address _____ Phone _____

_____

Signature _____

Physician's Stamp

LIABILITY/MEDICAL RELEASE

If I am injured while residing at and/or participating in United States Luge Association (USLA) programs at either the United States Olympic Training Center (USOTC) or elsewhere, (1) I and my family agree to waive any legal claim against the USLA and those associated with the USLA; and (2) I give consent for the USLA to provide medical care and treatment, transportation, and emergency medical services as warranted. If the program in which I am participating includes Psychological, Physiological, and/or Biomechanical evaluations, I further consent to these evaluations that pose no unusual risks or hazards when customary safeguards are observed; and (3) I authorize the USLA to disclose medical information about me to facilitate medical treatment or services by providers. The USLA may disclose medical information about me to providers including doctors, nurses, technicians, medical students, or other medical personnel who are involved in taking care of me.

If injured while traveling to or from any USLA program by public, private, or any other means of conveyance, I agree to waive any legal claims against the USLA. By signing this release, I swear that I am in good physical condition and I am not aware of any health condition, disease, or injury that would result in my being injured during any program's participation.

If I am less than 18 years of age or a minor under the laws of the state where I live, my parent or guardian shall sign this release as requested below.

DATE: _____ _____

Signature of Athlete

DATE: _____ _____

Signature of Parent/Guardian (if under 18 yrs. of age)

This physical will be valid for one year from the date of the physician's exam date. **NO OTHER FORMS WILL BE ACCEPTED.**

AGREEMENT TO SUBMIT TO MEDICAL EXAMINATIONS AND TESTS

AND

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As an express condition of my residing at or participating in a United States Luge Association (USLA) program, I agree to submit to medical examination(s) and/or test(s) as directed by USLA if USLA suspects I have an injury or a medical condition that could affect or impair my athletic performance. I acknowledge that the results of such medical examination(s) and test(s) are pertinent to the USLA's administration and organization of the sport of luge, and that the failure to submit to such examination(s) or test(s) as directed by USLA is grounds for my removal from my current team status or a USLA program.

I hereby authorize any physician or any health care provider who participates in my examination or treatment of me to disclose to USLA, and to the United States Olympic Committee (USOC) in the case of any Olympic Team, any protected health information pertaining to me, including the results of any examination or treatment, for the purpose of permitting USLA, and the USOC in the case of any Olympic Team, to determine my fitness for participation in the sport of luge and my team status. This authorization shall expire in one year, on the last day of the calendar month in which I have signed this authorization.

I understand that I may revoke this authorization by sending a written revocation to the offices of the USLA, attention of the Executive Director. Such authorization shall be effective on receipt, except to the extent that action has been taken in reliance on this disclosure. I further understand that if I revoke this authorization, or refuse to authorize disclosure as provided in this paragraph, then I may be expelled from USLA programs, I may lose health benefits as a USLA athlete, and I may be removed from current team status. I further understand that any protected health information disclosed pursuant to this authorization is subject to redisclosure by the USLA and/or the USOC, and is no longer protected by the provisions of 45 CFR Parts 160 and 164.

If I am less than 18 years of age or a minor under the laws of the state where I live, my parent or guardian shall sign this authorization as requested below.

DATE: _____ _____

Signature of Athlete

DATE: _____ _____

Signature of Parent/Guardian (if under 18 yrs. of age)

(Please do not write below this line)

LAST REVISED: 12/6/2012