UCF Athletics Association, Inc. (UCFAA)
Athletic Participation Release of Liability and Waiver of Liability
Please Read Carefully

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to catastrophic injury or death. Further, I voluntarily and knowingly accept the dangers and risks of playing, practicing, or training in any athletic activity including, but not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Furthermore, I understand and accept the risk of injury, catastrophic injury, and/or death. Additionally, I also understand that there are risks involved with traveling and other related activities connected with or related to my participation in intercollegiate athletics.

In consideration for UCF and UCFAA permitting me to participate in intercollegiate athletics and to engage in all related activities and travel related to my sport, **I hereby voluntarily and knowingly assume all risks associated with participation** and **agree to exonerate, save harmless, and release and waive my right to sue UCF, UCFAA, their agents, servants, volunteers, and employees from any and all liability, all claims, causes of action, lawsuits or demands of any kind and nature whatsoever, known or unknown, including, but not limited to, specifically any claims arising from the negligence or negligent acts or omissions of UCF, UCFAA, and their agents, servants, volunteers, and employees**, which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

Further, I agree to exonerate, save harmless, and release UCF, UCFAA, and their agents, servants, volunteers, and employees from any medical expenses not covered by my medical insurance or UCFAA's medical insurance coverage.

The terms hereof shall serve as a complete release and waiver of liability for myself, my heirs, my estate, executor, administrator, assignees, and all members of my family.

_____
Initial

I hereby attest that I have read, fully understand, and agree to the terms of the UCF Athletic Association, Inc. Sports Medicine Department's Athletic Participation Release or liability and Waiver of liability.

_____ _____
Student-Athlete Signature Date

_____ _____
Student-Athlete Print Name Sport

_____ _____
Parent/Guardian Signature ***(if under 18 years of age)*** Date

_____
Parent/Guardian Print Name

Internal Use:
The student-athlete has verbally confirmed with a UCFAA, Inc. Certified Athletic Trainer that they have read and understand all contents of this Athletic Participation Release of Liability and Waiver of Liability.

_____ _____
Athletic Trainer Signature Date

UCF Athletics Association Inc., Sports Medicine
Student-Athlete Physical Examination & Release Form

Student-Athlete Name:_____ SSN: _____ PID:_____

Date of Birth: _____ Sport(s):_____

Questions	Yes	No	Questions	Yes	No
1. Have you had a serious injury / been hospitalized?			22. Have you had an unfavorable/ allergic reaction to a drug, antibiotic, and/or medicine?		
2. Have you had a severe sprain / strain and/or fracture?			23. Do you have only one of two paired, functioning organs (eye, kidney, ovary, etc.)?		
3. Have you had a concussion and/or head injury?			24. Do you have any allergies?		
4. Have you been unconscious for any other reason than anesthesia?			25. Have you been diagnosed with asthma and/or exercise-induced asthma?		
5. Have you had a neck and/or back injury?			26. Do you require daily medications?		
6. Have you had a back injury or back pain?			27. Have you had trouble with coughing, wheezing, and/or breathing during exercise?		
7. Have you had a lower leg, ankle, and/or foot injury?			28. Have you been diagnosed with diabetes?		
8. Have you had a shoulder, elbow and/or wrist injury?			29. Have you been diagnosed with kidney disease?		
9. Have you had a hip and/or knee injury?			30. Have you been diagnosed with a hernia?		
10. Have you had a history of burners, stingers, numbness in neck, shoulder, and/or hand?			31. Have you experienced seizure or convulsions; and/or been diagnosed with epilepsy?		
11. Have you had an operation?			32. Have you been diagnosed with high blood pressure and/or high cholesterol?		
12. Are you currently undergoing physical therapy or rehabilitation for an injury?			33. Do you require any special equipment to participate in athletics?		
13. Do you have any medical problems about which we should be aware?			34. Have you been told by a physician to restrict your activity or not to participate in sport?		
14. Do you wear contact lenses, glasses, and/or safety glasses?			35. Are you currently taking any short course medication for any illnesses?		
15. Have you ever had frequent headaches?			36. Do you have any ongoing or chronic illnesses?		
16. Have you had a heat-related illness (heat cramps, heat exhaustion, and/or heat stroke)?			37. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?		
17. While exercising, have you suffered from a "racing heart", severe chest pain, lightheadedness, fainted, or has your heart ever "skipped" a beat?			38. Do you take vitamins, amino acids, creatine, and/or any other dietary supplement?		
18. Have you had a dental injury?			39. Have you had trouble with coughing, wheezing, and/or breathing during exercise?		
19. Do you wear a removable dental appliance?			40. Have you or any family member or relative suffered a stroke?		
20. Has any family member or relative died from heart problems OR sudden death before age 50?			41. Have you or any family member or relative been diagnosed with cancer of any kind?		
21. Have you been recently diagnosed with infectious mononucleosis, ("mono"), hepatitis B or C, HIV/AIDS, and/or any other serious infectious disease / viral infection?			42. Do you know of, or do you believe there is any health reason why you should not participate in intercollegiate athletics at The University of Central Florida?		

Females Only:

43. My periods are now: CIRCLE ONE
REGULAR (every 28-35 days) IRREGULAR (every 36 days or more OR less than 21 days) ABSENT (no periods for 3 months)
44. Have you had menstrual periods within the past 12 months? ☐ YES ☐ NO
What was the longest time between menstrual periods within the past year? _____
45. Do you have painful or heavy menstrual periods? ☐ YES ☐ NO
46. Do you take any medications during your menstrual periods? If yes, what? _____
47. Do you take birth control pills? If yes, what brand? _____
48. Have you ever had any problems with your breasts? If yes, explain:_____
49. Have you had a pelvic examination within the last year? ☐ YES ☐ NO

***If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail *(use additional sheet(s) if necessary).*

RELEASE:

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements are true and accurate; and that no answers or information have been withheld. Further, I acknowledge and agree to update these representations immediately once it is known that the disclosures are false, or incomplete. This duty shall continue as long as I remain a participant in intercollegiate athletics. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I knowingly and voluntarily agree that the UCF Athletics Association, Inc. (UCFAA, Inc.), its agents, servants, volunteers, and employees shall not be held liable for any injuries and/or illnesses omitted or for any inaccurate information supplied.

_____ _____

Student-Athlete Signature Date

UCF Athletics Association Inc., Sports Medicine

Student-Athlete Health Examination Form

(To be completed by the examining physician)

Vital Information:

☐Male ☐Female Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

Vision: R 20 / _____ L 20 / _____ Corrected? ☐ YES ☐ NO

Physical Exam:

	Normal	Abnormal Findings
Appearance: • *Marfan Stigmata (kyphoscoliosis, High-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)*	☐	
Skin: • *HSV, Lesions suggestive of MRSA, tinea corporis*	☐	
Eyes: • *Pupils equal*	☐	
Ears	☐	
Nose	☐	
Mouth / Throat	☐	
Lymph Nodes	☐	
Heart / Cardiovascular: • *Murmur* • *Auscultation standing, supine, +/- Valsalva* • *Simultaneous lower extremity and radial pulses*	☐	
Pulmonary / Lungs	☐	
Abdomen / Gastrointestinal • *Hernia*	☐	
Genitalia	☐	
Neurological	☐	

Tests Completed:

☐EKG ☐SCT ☐H&H *(Females Only)* ☐Ferritin *(Females Only)*

Additional Tests:

☐ECHO ☐MRI ☐CT SCAN ☐OTHER

Recommendations / Comments: _____

_____

_____

Status:

☐ Cleared without restriction

☐ Cleared without restriction with recommendation for further evaluation or treatment for _____

☐ Not cleared ☐*Pending Further Evaluation* ☐*For Any Sports* Reason _____

_____ _____

Examiner Signature Date

_____

Examiner Print Name

***This examination form was referenced from recommendations from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.*

UCF Athletics Association Inc., Sports Medicine

Parental Permission to Evaluate and Treat

Student-athletes under the age of 18 cannot be evaluated or treated by the UCF Athletics Association, Inc. (UCFAA, Inc.) Sports Medicine Staff, unless permission is granted by the student-athlete's parent/legal guardian. Please ***initial*** the statements below and sign at the bottom of the page, to give the UCFAA, Inc. Sports Medicine permission to evaluate and treat the underage student-athlete.

_____ I give permission for the UCFAA, Inc. Sports Medicine to conduct a pre-participation physical exam.

_____ I give permission for the UCFAA, Inc. Sports Medicine Staff to perform injury evaluations.

_____ I give permission for the UCFAA, Inc. Sports Medicine Staff to provide injury related treatment and rehabilitation.

_____ I give permission for the UCFAA, Inc. Sports Medicine Staff to provide over-the-counter medication, when requested by the student-athlete.

_____ I understand that the certified athletic trainers who perform these evaluations and treatments are under the supervision of the medical director, follow the code of ethics of the National Athletic Trainers' Association and follow the Laws of the State of FL, as licensed athletic trainers.

_____ If I have any questions or concerns, I can call the Director of Sports Medicine, at any time, at (407) 823-0963.

_____ _____

Student-Athlete Name Date

_____ _____

Parent/ Legal Guardian Print Name Date

_____

Parent/Legal Guardian Signature

_____

Parent/Legal Guardian Phone Number

UCF Athletics Association Inc., Sports Medicine

Student-Athlete Health History Questionnaire

The information contained in this medical history form will only be used by the Sports Medicine Department of UCFAA, Inc. for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(Please print clearly in ***BLUE or BLACK INK ONLY!)***

Name: _____ Date: _____

Social Security # _____ PID # _____ Date of Birth: _____

Race: ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other: _____

Sport(s): _____ Position(s): _____

Height: _____ Weight: _____ ☐ Right Handed ☐ Left Handed

PERMANENT ADDRESS:

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE CELL PHONE OTHER PHONE

FATHER / GUARDIAN Name: _____ Age: _____

If Deceased, Cause of Death: _____ Age @ Death: _____

Father's Employer: _____ Occupation: _____

Address ***(if different from permanent address):***

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE CELL PHONE WORK PHONE

MOTHER / GUARDIAN Name: _____ Age: _____

If Deceased, Cause of Death: _____ Age @ Death: _____

Mother's Employer: _____ Occupation: _____

Address ***(if different from permanent address):***

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE CELL PHONE WORK PHONE

1. Cardiovascular Risk Factors:

1-1). Have you ever had chest pain and/or shortness of breath during or after exercise / practice / game? ☐ YES ☐ NO

- Please Describe _____

1-2). Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice / game? ☐ YES ☐ NO

- Please Describe _____

1-3). Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice / game? ☐ YES ☐ NO

- Please Describe _____

1-4). Do you get tired more quickly than your teammates / friends do during exercise / practice / game? ☐ YES ☐ NO

- Please Describe _____

1-5). Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Date of Diagnosis: _____

1-6). Have you ever been diagnosed with hypertrophic cardiomyopathy (***Enlarged Heart***)? ☐ YES ☐ NO

- Date of Diagnosis: _____

1-7). Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please Describe _____

1-8). Have you ever had an electrocardiogram (EKG) of your heart? ☐ YES ☐ NO

- Date(s):_____ Reason: _____

1-9). Have you ever had an echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Date(s): _____ Reason: _____

1-10). Has any family member or relative died of heart problems and/or sudden death before age 50? ☐ YES ☐ NO

- Who? _____ Diagnosis:_____

1-11). Does anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Who? _____

1-12). Have you ever been told that you have / had high blood pressure? ☐ YES ☐ NO

- Date of Diagnosis: _____ Medication:_____

1-13). Does anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Who? _____

1-14). Have you ever been told that you have / had high blood cholesterol? ☐ YES ☐ NO

- Date of Diagnosis: _____ Medication:_____

2. Allergies:

2-1). Have you ever been diagnosed with seasonal allergies? ☐ YES ☐ NO

2-2). Are you presently taking or have you previously taken any allergy medications? ☐ YES ☐ NO

- Medications: _____

2-3). Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications, food items, insect stings/bites, grass, latex, or anything else? ☐ YES ☐ NO

- List allergy(ies):_____ Reactions(s):_____

_____ _____

_____ _____

3. Asthma:

3-1). Have you ever been diagnosed with asthma and/or exercised induced asthma? ☐ YES ☐ NO

- Date of Diagnosis: _____

3-2). Are you presently taking or have you previously taken any asthma medications and/or use an inhaler? ☐ YES ☐ NO

- If currently taking, how long? _____
- Medication(s): _____

3-3). How many times do you use your asthma medication and/or rescue inhaler (e.g. Albuterol, Proventil, etc.) during an average week? _____

3-4). How many acute asthma attacks have you had in the past 12 months? _____

- Date(s): _____
- Please Describe: _____

3-5). Have you ever been hospitalized as a result of asthma and/or exercised induced asthma? ☐ YES ☐ NO

- Date(s): _____
- Please Describe: _____

3-6). Have you ever been advised not to participate in athletic activities due to asthma or any related condition? ☐ YES ☐ NO

- Date (s): _____ Please Describe: _____

4. Head Injuries / Concussion:

4-1). Have you ever suffered a head injury or concussion (no matter how minor)? ☐ YES ☐ NO

- Date(s) of injury (LIST ALL): _____

4-2). Have you ever been evaluated by a doctor for a head injury or concussion? ☐ YES ☐ NO

- Date of Diagnosis(es): _____

4-3). Have you ever had any diagnostic tests performed for a head injury / concussion? ☐ YES ☐ NO

(Check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Neuropsychological Testing ☐ Other _____

- Results: _____

4-4). Have you ever been hospitalized, become unconscious, and/or had memory loss due to a head injury / concussion? ☐ YES ☐ NO

- Date(s): _____
- Please Describe: _____

4-5). Have you ever been advised not to participate in athletic activities due to a head injury / concussion? ☐ YES ☐ NO

- Please Describe: _____

4-6). Do you suffer from headaches? ☐ YES ☐ NO

- When? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
- Where are your headaches located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Your Head

4-7). Do you have a history of migraine headaches? ☐ YES ☐ NO

- How Often? _____ Symptoms: _____
- Medications taken for migraines? _____

4-8). Have You Had Headaches For More Than Three (3) Months? ☐ YES ☐ NO

- If yes, please explain: _____

5. Eye:

5-1). When was your last eye exam? _____

- Findings? _____

5-2). Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ YES ☐ NO

- Date(s) of Injury: _____
- Injury(ies) / Disease(s) _____

5-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-ray ☐ MRI ☐ CT-Scan ☐ Ultrasound ☐ Other _____

- Results: _____

5-4). Have you ever been hospitalized and/or seen an ophthalmologist for an eye injury? ☐ YES ☐ NO

- Reason(s): _____

5-5). Have you ever been advised not to participate in athletic activities due to an eye injury? ☐ YES ☐ NO

- Reason(s): _____

5-6). Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO

- Please Describe _____

5-7). Do you routinely wear glasses? ☐ YES ☐ NO

5-8). Do you routinely wear contact lenses? ☐ YES ☐ NO Type: _____ Prescription: _____

6. Ear / Nose / Throat:

6-1). Have you ever suffered an injury to your ear(s), nose, and/or throat? ☐ YES ☐ NO

- Date of injury(ies): _____ Injury(ies): _____

6-2). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-ray ☐ MRI ☐ CT-Scan ☐ Ultrasound ☐ Other _____

- Results: _____

6-3). Have you ever been hospitalized for an ear, nose, and/or throat injury? ☐ YES ☐ NO

- Reason(s): _____

6-4). Have you ever been advised not to participate in athletic activities due to an ear, nose, and/or throat injury? ☐ YES ☐ NO

- Reason(s): _____

7. Dental:

7-1). Are you currently having mouth, jaw, and/or tooth pain? ☐ YES ☐ NO

- Please Describe: _____

7-2). When was your last dental exam? _____ Findings? _____

7-3). Have you ever suffered an injury to your mouth, jaw, and/or teeth? ☐ YES ☐ NO

- Date of injury(ies): _____ Injury(ies): _____

7-4). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other _____

- Results: _____

7-5). Have you ever been hospitalized for a mouth, jaw, and/or tooth Injury? ☐ YES ☐ NO

- Reason(s): _____

7-6). Have you ever been advised not to participate in athletic activities due to a mouth, jaw, and/or tooth injury? ☐ YES ☐ NO

- Please Describe: _____

8. Cervical Spine / Neck:

8-1). Are you currently having pain in your cervical spine and/or neck? ☐ YES ☐ NO

- Please Describe: _____

8-2). Have you ever suffered an injury to your cervical spine and/or neck? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

8-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other

- Results: _____

8-4). Have you ever been hospitalized for a cervical spine / neck injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

8-5). Have you ever had surgery of any kind on your cervical spine / neck? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

8-6). Have you ever had "Burners", "Stingers", Brachial Plexus Injuries, or Thoracic Outlet Syndrome (TOS)? ☐ YES ☐ NO

- How Many? _____ Date(s): _____

8-7). Have you ever experienced numbness and/or tingling in your arm(s) / hand(s) / finger(s)? ☐ YES ☐ NO

- Date(s): _____
- Please Describe: _____

8-8). Have you ever been advised not to participate in athletic activities due to a cervical spine / neck injury? ☐ YES ☐ NO

- Please Describe: _____

8-9). Do you presently wear or have you worn a neck roll / collar, "cowboy collar" or helmet restrictor plate? ☐ YES ☐ NO

9. Shoulder / Upper Arm:

9-1). Are you currently having pain in your shoulder(s) and/or upper arm(s)? ☐ YES ☐ NO

- Please Describe: _____

9-2). Have you ever suffered an injury to your shoulder(s) / upper arm(s)? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

9-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

9-4). Have you ever been hospitalized for a shoulder / upper arm injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

9-5). Have you ever had surgery of any kind on your shoulder(s) / upper arm(s)? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

9-6). Have you ever been advised not to participate in athletic activities due to a shoulder / upper arm injury? ☐ YES ☐ NO

- Please Describe: _____

10. Elbow / Forearm:

10-1). Are you currently having pain in your elbow(s) and/or forearm(s)? ☐ YES ☐ NO

- Please Describe: _____

10-2). Have you ever suffered an injury to your elbow / forearm? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

10-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

10-4). Have you ever been hospitalized for an elbow / forearm injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

10-5). Have you ever had surgery of any kind on your elbow / forearm? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

10-6). Have you ever been advised not to participate in athletic activities due to an elbow / forearm Injury? ☐ YES ☐ NO

- Please Describe: _____

11. Wrist, Hand, & Fingers:

11-1). Are you currently having pain in your wrist(s), hand(s), and/or finger(s)? ☐ YES ☐ NO

- Please Describe: _____

11-2). Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

11-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

11-4). Have you ever been hospitalized for a wrist, hand, and/or finger injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

11-5). Have you ever had surgery of any kind on your wrist, hand, and/or finger(s)? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon? _____
- Surgery performed: _____

11-6). Are you missing part of or any of your fingers? ☐ YES ☐ NO

- Please Describe: _____

11-7). Have you ever been advised not to participate in athletic activities due to a wrist, hand, and/or finger injury? ☐ YES ☐ NO

- Please Describe: _____

12. Spine / Low Back / Sacroiliac Joint:

12-1). Are you currently having pain and/or numbness/tingling in your spine, low back, or sacroiliac joint? ☐ YES ☐ NO

- Please Describe: _____

12-2). Have you ever suffered an injury to your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

12-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

12-4). Have you ever been hospitalized for a spine / low back / sacroiliac joint injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

12-5). Have you ever had surgery of any kind on your spine / low back / sacroiliac joint? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon? _____
- Surgery performed: _____

12-6). Have you ever had numbness/tingling down one (1) or both legs, and/or buttock(s)? ☐ YES ☐ NO

- Date(s): _____
- Please Describe: _____

12-7). Have you ever been advised not to participate in athletic activities due to a spine, low back, or SI joint injury? ☐ YES ☐ NO

- Please Describe: _____

13. Hip / Groin:

13-1). Are you currently having pain in your hip(s) and/or groin(s)? ☐ YES ☐ NO

- Please Describe: _____

13-2). Have you ever suffered an injury to your hip / groin? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Symptoms: _____

13-3). Have you ever had a hernia and/or sport hernia? ☐ YES ☐ NO

- Please Describe: _____

13-4). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Ultrasound

- Results: _____

13-5). Have you ever been hospitalized for a hip, groin, and/or hernia/sport hernia injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

13-6). Have you ever had surgery for a hip, groin, and/or hernia/sport hernia Injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

13-7). Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury? ☐ YES ☐ NO

- Please Describe: _____

14. Thigh / Hamstring / Quadriceps:

14-1). Are you currently having pain in your thigh(s), hamstring(s), and/or quadricep(s)? ☐ YES ☐ NO

- Please Describe _____

14-2). Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? ☐ YES ☐ NO

- Date of injury(ies): _____
- Injury(ies) / Symptoms: _____

14-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

14-4). Have you ever been hospitalized for a thigh, hamstring, and/or quadriceps injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

14-5). Have you ever had surgery for a thigh, hamstring, and/or quadriceps injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon? _____
- Surgery performed: _____

14-6). Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, or quadriceps injury? ☐ YES ☐ NO

- Please Describe: _____

15. Knee / Patella:

15-1). Are you currently having pain in your knee(s) and/or patella (kneecap)? ☐ YES ☐ NO

- Please Describe: _____

15-2). Have you ever suffered an injury to your knee(s) and/or patella? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Symptoms: _____

15-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

15-4). Have you ever been hospitalized for a knee and/or patella injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

15-5). Have you ever had surgery for a knee and/or patella injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s) _____ Surgeon? _____
- Surgery performed: _____

15-6). Have you ever been advised not to participate in athletic activities due to a knee and/or patella Injury? ☐ YES ☐ NO

- Please Describe: _____

15-7). Have you ever or do you presently wear a knee brace? ☐ YES ☐ NO

- Which knee? _____ Brand / Model of brace: _____
- Reason for wearing: _____

16. Ankle / Lower Leg:

16-1). Are you currently having pain in your ankle(s) and/or lower leg(s)? ☐ YES ☐ NO

- Please Describe: _____

16-2). Have you ever suffered an injury to your ankle and/or lower leg? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Symptoms: _____

16-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

16-4). Have you ever been hospitalized for an ankle and/or lower leg injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

16-5). Have you ever had surgery for an ankle and/or lower leg injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

16-6). Have you ever been advised not to participate in athletic activities due to an ankle and/or lower leg injury? ☐ YES ☐ NO

- Please Describe: _____

16-7). Do You Presently ☐ Tape Your Ankle(s) ☐ Use Ankle Brace(s) ☐ Other

- Please Describe: _____

17. Foot / Toes:

17-1). Are you currently having pain in your foot and/or toe(s)? ☐ YES ☐ NO

- Please Describe: _____

17-2). Have you ever suffered an injury to your foot and or/ toe(s)? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Symptoms: _____

17-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

17-4). Have you ever been hospitalized for a foot and/or toe injury? ☐ YES ☐ NO

- Date(s): _____ Where?: _____
- Diagnosis(es): _____

17-5). Have you ever had surgery for a foot and/or toe injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

17-6). Are you missing part of or any of your toes? ☐ YES ☐ NO

- Please Describe: _____

17-7). Have you ever or do you currently wear orthotics or insoles? ☐ YES ☐ NO

17-8). Have you ever been advised not to participate in athletic activities due to a foot and/or toe injury? ☐ YES ☐ NO

- Please Describe: _____

18. Ribs / Thorax / Chest/ Lungs:

18-1). Are you currently having pain in your rib(s), thorax, chest, and/or lung(s)? ☐ YES ☐ NO

- Please Describe: _____

18-2). Have you ever suffered an injury to your rib(s), thorax, chest, and/or lung(s)? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Symptoms: _____

18-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

- Results: _____

18-4). Have you ever been hospitalized for a rib, thorax, chest, and/or lung(s) injury? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

18-5). Have you ever had surgery for a rib, thorax, chest, and/or lung(s) injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

18-6). Have you ever been advised not to participate in athletic activities due to a rib, thorax, chest, and/or lung(s) injury? ☐ YES ☐ NO

- Please Describe: _____

19. Abdomen:

19-1). Are you currently having pain your abdomen? ☐ YES ☐ NO

- Please Describe: _____

19-2). Have you ever been diagnosed with an injury and/or problem to your stomach, abdomen, intestines, or rectum? ☐ YES ☐ NO

- Date(s): _____
- Injury(ies) / Problem(s) / Symptoms: _____

19-3). If yes, were any diagnostic tests performed? **(Check all that apply)** ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Ultrasound

- Results: _____

19-4). Have you ever been hospitalized for an injury and/or problem to your stomach, abdomen, intestines, or rectum? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

19-5). Have you ever had surgery for a stomach, abdomen, intestine, and/or rectum injury? ☐ YES ☐ NO ☐ NO, BUT RECOMMENDED

- Date(s): _____ Surgeon: _____
- Surgery performed: _____

19-6). Do you routinely suffer from severe or recurrent abdominal pain and/or chronic or recurrent diarrhea? ☐ YES ☐ NO

- Please Describe: _____

19-7). Do you have only one of two paired, functioning organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO

- Please Describe: _____

19-8). Have you ever been advised not to participate in athletic activities due to an abdomen problem and/or Injury? ☐ YES ☐ NO

- Please Describe: _____

20. Medical Testing:

20-1). Have you ever been diagnosed with a communicable disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Tuberculosis, etc.)? ☐ YES ☐ NO

- Date(s): _____
- Diagnosis(es): _____
- Still receiving treatment? _____ Medications: _____

20-2). Have you ever been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) ☐ YES ☐ NO

- Date of Diagnosis: _____
- Medications currently taking: _____

20-3). Have you ever been hospitalized for a communicable disease? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

20-4). Have you ever been advised not to participate in athletic activities due to a communicable disease? ☐ YES ☐ NO

- Please Describe: _____

21. Dermatological:

21-1). Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please Describe: _____

21-2). Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

- Please Describe: _____

21-3). Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ YES ☐ NO

- Please Describe: _____

22. Nutrition:

22-1). What is your highest adult body weight? _____ Lowest? _____

22-2). Would you like to gain or lose body weight? ☐ YES ☐ NO **(Please specify)** Gain: _____lbs. Lose _____lbs.

22-3). Have you ever used any technique other than dieting to change your weight? ☐ YES ☐ NO

- Please Describe: _____

22-4). Have you ever had or are you concerned you may have an eating disorder? ☐ YES ☐ NO

- Please Describe: _____

22-5). Would you like to talk with the sports nutritionist about any questions or concerns? ☐ YES ☐ NO

22-6). How many meals per day do you eat? _____

22-7). How many snacks per day do you eat? _____

22-8). Please list any food groups you avoid eating for any reason (i.e. meat, dairy, etc.) _____

22-9). Have you changed the way you eat over the past year? (i.e. eating out more, no red meat, vegetarian, etc.) ☐ YES ☐ NO

- Please Describe: _____

22-10). How often do you consume the following items in a given week? **(List times per week)**

Milk_____ Cheese_____ Red Meat_____ Seafood_____ Poultry_____ Vegetables_____ Fruits_____ Fast Food_____ Nuts_____

Soda_____ Water_____ Gatorade/Powerade_____ Fruit Juice_____ Alcohol_____ Pasta/Rice_____ Candy_____ Bread_____

23. Prescription Medications:

23-1). Are you currently taking or have you taken in the past 12 months, any **PRESCRIPTION** medications? ☐ YES ☐ NO

DATE(S)	MEDICATION	PURPOSE	DOSAGE

23-2). Are you currently taking or have you taken in the past 12 months, any **OVER THE COUNTER** medications? ☐ YES ☐ NO

DATE(S)	MEDICATION	PURPOSE	DOSAGE

23-3). Are you currently taking or have you taken in the past 12 months, any **PRESCRIPTION** medication that was **NOT PRESCRIBED** to you? ☐ YES ☐ NO

DATE(S)	MEDICATION	PURPOSE	DOSAGE

24. Supplements / Ergogenic Aids:

24-1). Are you currently taking or have you taken in the past 12 months, any **NUTRITIONAL SUPPLEMENT** for the purpose of weight gain, weight loss, or performance enhancement? ☐ YES ☐ NO

DATE(S)	SUPPLEMENT	PURPOSE	DOSAGE

24-2). Are you currently taking any vitamin or mineral supplements? ☐ YES ☐ NO

- Please list: _____

25. Heat-Related Problems:

25-1). Have you ever suffered from a heat related injury? ☐ YES ☐ NO (check all that apply):

- ☐ Heat Cramps- Date(s): _____
- ☐ Heat Syncope (Fainting)- Date(s): _____
- ☐ Heat Exhaustion- Date(s): _____
- ☐ Heat Stroke- Date(s): _____

25-2). Have you ever received intravenous fluids (IV) for a heat-related problem? ☐ YES ☐ NO

- Date(s): _____

25-3). Have you ever been hospitalized for a heat-related problem? ☐ YES ☐ NO

- Date(s): _____ Where? _____
- Diagnosis(es): _____

25-4). Have you ever been advised not to participate in athletic activities due to a heat-related injury? ☐ YES ☐ NO

- Please Describe: _____

26. Diabetic History:

26-1). Have you ever been diagnosed with diabetes? ☐ YES ☐ NO

- Date: _____ Type: _____

26-2). Does anyone in your family have a history of diabetes? ☐ YES ☐ NO

- Who? _____

26-3). Are you presently taking or have you taken any diabetic medications? ☐ YES ☐ NO

MEDICATION	FORM	DOSAGE	FREQUENCY

26-4). Do you monitor your blood sugar level, daily? ☐ YES ☐ NO How many times per day? _____ Average level: _____

26-5). Have you had your A1C level checked within the last three (3) months? ☐ YES ☐ NO Level _____

26-6). Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months? ☐ YES ☐ NO

- Symptoms: _____
- What best resolves your symptoms? _____

26-7). Have you had any hyperglycemic episodes (high blood sugar) within the last twelve (12) months? ☐ YES ☐ NO

- Symptoms: _____ Ketone Levels: _____
- What best resolves your symptoms? _____

26-8). Have you ever been advised not to participate in athletic activities due to diabetes? ☐ YES ☐ NO

- Please Describe: _____

26-9). Are there any precautions that you take and/or additional information not mentioned above? ☐ YES ☐ NO

- Please Describe: _____

27. Sickle Cell Anemia:

27-1). Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Date: _____ Result: _____

27-2). Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Who? _____

27-3). Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO

- Please Describe: _____

28. Females Only:

28-1). My periods are now: CIRCLE ONE

REGULAR (every 28-35 days) IRREGULAR (every 36 days or more OR less than 21 days) ABSENT (no periods for 3 months)

28-2). Have you had menstrual periods within the past 12 months? ☐ YES ☐ NO

- What was the longest time between menstrual periods within the past year? _____

28-3). Do you have painful or heavy menstrual periods? ☐ YES ☐ NO

28-4). Do you take any medications during your menstrual periods? If yes, what? _____

28-5). Do you take birth control pills? If yes, what brand? _____

28-6). Have you ever had any problems with your breasts? If yes, explain: _____

28-7). Have you had a pelvic examination within the last year? ☐ YES ☐ NO

29. Please Answer: *{All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!}*

29-1). Have you ever had any injury or illness other than those already noted?	☐ YES ☐ NO
29-2). Do you have any ongoing or chronic illnesses?	☐ YES ☐ NO
29-3). Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?	☐ YES ☐ NO
29-4). Are you currently under a physician's care for any medical conditions?	☐ YES ☐ NO
29-5). Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?	☐ YES ☐ NO
29-6). Have you ever been told that you have kidney disease?	☐ YES ☐ NO
29-7). Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?	☐ YES ☐ NO
29-8). Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?	☐ YES ☐ NO
29-9). Have you ever had seizures, convulsions, and/or epilepsy?	☐ YES ☐ NO
29-10). Do you have ringing in your ears or trouble hearing?	☐ YES ☐ NO
29-11). Do you have frequent ear infections or nosebleeds?	☐ YES ☐ NO
29-12). Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)?	☐ YES ☐ NO
29-13). Have you ever had the chickenpox? If yes, when? _____	☐ YES ☐ NO
29-14). Are you aware of any reasons why you should not participate in intercollegiate athletics at UCF at this time?	☐ YES ☐ NO
29-15). Have you had a tetanus booster within the past five (5) years? If yes, when? _____	☐ YES ☐ NO
29-16). Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____	☐ YES ☐ NO
29-17). Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?	☐ YES ☐ NO
29-18). Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?	☐ YES ☐ NO
29-19). Do you have any questions regarding drugs, tobacco, or alcohol?	☐ YES ☐ NO
29-20). Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?	☐ YES ☐ NO
29-21). Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?	☐ YES ☐ NO
29-22). Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?	☐ YES ☐ NO
29-23). Have you ever been under the care of a psychiatrist and/or psychologist?	☐ YES ☐ NO
29-24). Do you feel stressed out?	☐ YES ☐ NO
29-25). Do you often have trouble sleeping?	☐ YES ☐ NO
29-26). Do you wish you had more energy most days of the week?	☐ YES ☐ NO
29-27). Do you often feel anxious and nervous?	☐ YES ☐ NO
29-28). Do you often feel sad or depressed?	☐ YES ☐ NO
29-29). Do you struggle with self-confidence?	☐ YES ☐ NO
29-30). Do you often feel hopeless about the future?	☐ YES ☐ NO
29-31). Do you have a hard time managing your emotions?	☐ YES ☐ NO
29-32). Have you ever thought about or attempted to hurt yourself or others?	☐ YES ☐ NO

If you have answered **YES** to any of the above, please explain:

_____

_____

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_____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

_____

_____

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_____

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_____

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fifteen (15) are true and accurate; and that no answers or information have been withheld. Further, I acknowledge and agree to update these representations immediately once it is known that the disclosures are false, or incomplete. This duty shall continue as long as I remain a participant in intercollegiate athletics. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm. I knowingly and voluntarily agree that the UCF Athletics Association, Inc. (UCFAA, Inc.), its agents, servants, volunteers, and employees shall not be held liable for any injuries and/or illnesses omitted or for any inaccurate information supplied.

_____ _____

Student-Athlete Signature Date

_____

Student-Athlete Print Name

_____ _____

Parent/Guardian Signature *(if under 18 years of age)* Date

_____

Parent/Guardian Print Name

_____ _____

Witness Date

Reviewed By:

_____ _____

Reviewer's Signature Date

_____

Reviewer Print Name