UNIVERSITY OF DELAWARE – RECERTIFICATION

NAME: _____ D.O.B.:_____

SPORT: _____ POSITION:_____

The University of Delaware requires a medical examination performed by a Student Health Sports Medicine Physician prior to a student-athlete's participation in an intercollegiate athletic program. The University of Delaware and the NCAA require an updated history (and medical evaluation done as warranted) annually.

SINCE YOUR LAST PHYSICAL EXAMINATION AT UD:

YES	NO	
		1. Have you had a serious injury?
		2. Have you missed any practices or games related to an injury or illness?
		3. Have you had a concussion?
		4. Have you been unconscious for any reason other than anesthesia?
		5. Have you had a neck injury?
		6. Have you had back pain or a back injury?
		7. Have you had burners, stingers, numbness in your neck, shoulder or hand?
		8. Have you had a shoulder injury?
		9. Have you had a knee injury?
		10. Have you had a fracture, broken bone, stress fracture?
		11. Have you had an x-ray, MRI, CT scan or other radiologic study?
		12. Have you had an operation (surgery)?
		13. Have you had frequent headaches?
		14. Have you had heat cramps, heat fatigue, heat exhaustion or heat stroke?
		15. Have you had a dental injury?
		16. Have you had "mono"?
		17. Have you had an unfavorable reaction to a drug, antibiotic, or other medication including non-prescription medication?
		18. Have you had a history of anorexia, bulimia (forced vomiting) or any eating disorder?
		19. Are you currently in physical therapy or rehabilitation?
		20. Has there been a significant change in family medical history?
		21. Do you wear contact lenses?
		22. Do you wear a removable dental appliance?
		23. Do you have only ONE of two paired organs? (eye, kidney, ovary, testicle, etc.)
		24. Do you have allergies (medications, food, insects, environmental)?
		25. Have you started taking any medications?
		26. Do you require daily medications?
		27. Have you been diagnosed with ☐ a heart murmur, ☐ asthma, ☐ wheezing, ☐ diabetes, ☐ kidney disease, ☐ hernia, ☐ epilepsy, ☐ high blood pressure, other _____
		28. Do you require any special equipment to participate in athletics?
		29. Do you have any concerns regarding drugs, tobacco or alcohol?
		30. Do you take any vitamins, amino acids or supplements?
		31. Do you know of or do you believe that there is any health reason why you should not participate in the UD intercollegiate athletic program?

For the following questions, circle your answer: (all questions are strictly confidential and will not be shared with parents or coaches)

	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2- 4 times/month	2-3 times/week	4 or more times/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

FEMALES ONLY

Menstrual History:
When did your last menstrual period begin?_____
How long does it usually last?_____
How many periods have you had in the past twelve months?_____
Do you take birth control pills?_____

THE UNDERSIGNED, HEREWITH:

A. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.

B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

C. Because of the dangers of participating in sports, I recognize the importance of following all instructions by the University of Delaware Athletics personnel. I understand and accept that I have the responsibility to report any and all injuries and illnesses, including signs and symptoms of concussions, to the medical staff at the University of Delaware. I have been presented with educational materials on concussions and understand that the University of Delaware Intercollegiate Athletic Program has a strict concussion management plan in place. I agree that I have been given the opportunity to ask questions about the concussion management plan and all other University of Delaware Athletics medical policies. I also understand that I may be medically disqualified from athletic participation if I fail to report concussion symptoms to medical/ athletic training staff at time of injury.

D. Certifies that the answers to the questions above or correct or true.

Date:_____ Student Signature:_____ Time:_____ SHS Initial:_____

RELEASE INFORMATION:

I hereby authorize the Student Health Service to release to the coach and/or trainer any information on my athletic physical examination or recertification relevant or pertinent to my participation in sports.

Date:_____ Student Signature:_____ Time:_____ SHS Initial:_____

I hereby authorize the Student Health Service/Sports Medicine to release to Athletic Department Administration any information acquired in the course of my treatment for injuries/illnesses during my participation in sports at the University of Delaware for the purpose of determining the extent of the institution's liability.

Date:_____ Student Signature:_____ Time:_____ SHS Initial:_____