



**Exit Physical Questionnaire**

Name: \_\_\_\_\_ Sport: \_\_\_\_\_

In order to provide ongoing care for any of the injuries you received while participating in intercollegiate sports at the University of Delaware, an Exit Physical is required. At this physical, timeline for ongoing coverage will be reviewed as well as protocols to receive care once away from UD.

- I will waive my Exit Physical and relieve the University of Delaware of any liability or financial responsibility for any damages or injuries sustained.
- I have injuries to declare and will contact the Sports Medicine Clinic to coordinate any ongoing treatment. (Complete section below)

Please indicate which of the following you injured during **the past 2 years** while participating at the University of Delaware. Our insurance only will cover on-going claims for 2 years from DATE OF INCIDENT (Not date of graduation nor date of this physical).

<b><u>Spine</u></b>	<b><u>Date of incident</u></b>	<b><u>Skull</u></b>	<b><u>Date of incident</u></b>	<b><u>Lower Extremity</u></b>	<b><u>Date of incident</u></b>
___ Neck	___/___/___	___ Head	___/___/___	___ Gluteal muscle R / L	___/___/___
___ Mid back	___/___/___	___ Eye R / L	___/___/___	___ Hip R / L	___/___/___
___ Low back	___/___/___	___ Ear R / L	___/___/___	___ Groin muscle R / L	___/___/___
		___ Nose	___/___/___	___ Hamstring muscle R / L	___/___/___
<b><u>Chest</u></b>		___ Jaw	___/___/___	___ Thigh muscle R / L	___/___/___
___ Clavicle R / L	___/___/___	___ Concussion	___/___/___	___ Knee R / L	___/___/___
___ Sternum	___/___/___			___ Shin R / L	___/___/___
___ Ribs R / L	___/___/___	<b><u>Upper Extremity</u></b>		___ Achilles tendon R / L	___/___/___
		___ Shoulder R / L	___/___/___	___ Calf muscle R / L	___/___/___
<b><u>Abdominal Organs</u></b>		___ Upper arm R / L	___/___/___	___ Ankle R / L	___/___/___
___ Stomach	___/___/___	___ Elbow R / L	___/___/___	___ Foot R / L	___/___/___
___ Kidney	___/___/___	___ Forearm R / L	___/___/___	___ Toes R / L	___/___/___
___ Spleen	___/___/___	___ Wrist R / L	___/___/___	1 2 3 4 5	
___ Liver	___/___/___	___ Hand R / L	___/___/___		
___ Genitals	___/___/___	___ Fingers R / L	___/___/___	1 2 3 4 5	

Other: \_\_\_\_\_

Did you report each of these injuries to an athletic trainer or Sports Medicine?

- Yes  No If not, which ones went unreported? \_\_\_\_\_

I agree that the above is accurate and that falsification on my part would relieve the University of Delaware of being obligated for any condition that results from this falsification. I understand that I must contact UD Sports Medicine for authorization of any future care.

Signature of Student Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

*If this form is not returned to the Sports Medicine Clinic, it shall be assumed that you do **not** wish an exit physical and absolve the University of Delaware Intercollegiate Athletic Program of all responsibility for further treatment or rehabilitation of your injuries.*