**UNIVERSITY OF WASHINGTON ATHLETIC TRAINING ROOM**
**REQUIREMENTS FOR ALL INTERCOLLEGIATE ATHLETIC TRYOUTS**

In order for the tryout procedure to run smoothly we have provided the following three forms:

1. **CRITERIA FORM**
2. **WAIVER FORM - TO BE FILLED OUT DURING INITIAL TRY-OUT MEETING**
3. **BLANK PHYSICAL FORM**

Please read the criteria form and bring the waiver form ***BLANK*** to your initial try-out. Some physicians may ask for a blank physical form. We have provided one if you need it. If you are using their form make sure all the required information is on it.

**CRITERIA FORM**

1. Proof of physical within the last six months by a Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (LNP), or Doctor of Osteopathy (DO) indicating you are cleared to participate without restriction(s). It needs to have the name, address, phone number of clinic and the doctor's name on the form. It needs to be signed and dated by your doctor. If your doctor requests a blank physical form from us prior to your physical see attached.

2. Proof of medical insurance. Proof of medical insurance includes:
   a. A legible copy of your insurance card front and back **(the actual card is preferable)**
   **OR**
   b. The following information: Insurance Plan Name**,** Subscriber Name (Subscriber means the person who the plan is under - ie. mom, dad, you, etc)**,** Subscriber's Phone Number**,** Subscriber ID Number**,** Group Number, and Insurance Plan Phone Number.

3. Fill out the waiver form completely. If you have a legible copy (front and back) of your insurance card or the actual card for us to copy then you will not need to fill out the insurance information section. In the section "Check the following:" under "I have disclosed all medical conditions that may impact my ability to participate in rigorous athletic activities. They are the following:" Here are some examples that may apply to you:
   a. If you are asthmatic and use an inhaler
   b. Allergic to bees and require an epi pen (indications for use)
   c. Require glucose for diabetes
   d. Or any other medical conditions we need to be aware of.

**If you do not have any medical conditions we should be aware check the first line.**

**If you are under the age of eighteen a parent or legal guardian must also sign the waiver.**

**Remember to bring the required forms with you.**

**The try out period for Intercollegiate Athletics is exactly as stated on the waiver form below without exception.**

If you make the squad and are added to the official roster you will then be required to have an official pre-participation examination by a University of Washington Team Physician. **These exams must be scheduled through the athletic training room.** After passing the pre-participation physical exam you will be eligible to compete in Intercollegiate Athletics at the University of Washington.

**All forms must be filled out and signed in blue/black ink**.

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UNIVERSITY OF WASHINGTON

# ASSUMPTION OF RISK RESPONSIBILITY WAIVER

INTERCOLLEGIATE ATHLETICS

Legal Last Name _____ Legal First Name _____ MI _____ Activity _____

I have been informed and fully understand that the University of Washington is **NOT** responsible in the event of an injury or illness incurred as a result of/or during an athletic tryout. I hereby waive all future claims against the University of Washington and specifically the Department of Intercollegiate Athletics, arising out of such an athletic tryout. I am aware that if medical care arising out of such an athletic tryout becomes necessary, it is my own responsibility to seek such care and I agree to assume full responsibility for any financial charges incurred.

I have been examined by a licensed Medical Doctor (MD), Physician Assistant (PA-C), Nurse Practitioner (LNP), or Doctor of Osteopathy (DO) and ***will submit, prior to tryout***, a signed physical examination document. This document will verify that I am in good health and may participate without any restrictions.

My tryout period for **Men's Freshman Crew** starts _____ and ends _____. I do understand that if I am selected to become a member of a University of Washington team, I must undergo an Intercollegiate Athletic physical examination which will be administered by the ICA Medical Staff.

**CHECK ONE OF THE FOLLOWING:**

- ◯ I have **no known** medical conditions that would prevent me from participating in rigorous athletic activities.
- ◯ I have disclosed ***ALL*** medical conditions that may impact my ability to participate in rigorous athletic activities. They are the following:

They are the following _____

**CHECK ONE OF THE FOLLOWING:**

- ◯ I have **provided documentation** of my Sickle Cell Trait Status to the University of Washington Sports Medicine staff.
- ◯ I have been made aware of the necessity of Sickle Cell Trait Testing and **decline** a blood test.

Insurance Information (if no card is available)

Insurance Plan Name _____

Subscriber Name _____

Subscriber Phone # _____

Subscriber ID # _____

Group # _____

Insurance Plan Phone # _____

**PLEASE BRING YOUR MEDICAL INSURANCE CARD OR BRING A COPY OF IT (FRONT & BACK ENLARGED TO 129%).

Signature _____ Date _____

Cell/Phone # _____

**If under the age of 18, this form must be signed by a parent or legal guardian.**

Signature _____ Date _____

Relationship to Athlete _____

Staff Initials/Authorization _____

# Preparticipation Physical Evaluation

Name _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ BP ____/____ (____/____, ____/____)

Vision R 20/_____ L 20/_____ Corrected: Y____ N____ (contacts/ glasses)

List any known allergies: _____

| | 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 | | | |

**[] Cleared**

**[] Cleared after completing evaluation/ rehabilitation for**:

_____

_____

**[] Not cleared for (Reason/ Recommendations)**:

_____

_____

**Name of physician (print/type)**_____ **Date** _____

**Signature of physician** _____, **MD or DO**

Practice located at: UW Sports Medicine Clinic _____ **Hall Health** _____ **Other** _____

Phone # _____

Print Form