



FREDERICK COMMUNITY COLLEGE

DEPARTMENT OF ATHLETICS

TRYOUT MEDICAL CLEARANCE PACKET

PROSPECTIVE STUDENT-ATHLETE INFORMATION

Last Name:		First Name, MI:	Preferred Name:	
Student ID:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Sport:		Date of Tryout:		

EMERGENCY CONTACT INFORMATION

Name:		Relationship:	
Home Phone:		Work/Cell Phone:	

The National Junior College Athletic Association's policy requires that a student-athlete participating in an audition/tryout must provide verification that they have received a physical examination administered by a physician within 13 months prior to the audition/tryout. Frederick Community College supports and adheres to this NJCAA requirement. Please read carefully and complete the following questions regarding your medical history and have the physician that performed your physical examination complete the Pre-Participation Physical Exam form on pages.

SURGICAL / HOSPITALIZATION HISTORY

List all surgical procedures or instances for which you have been admitted to a hospital in the past year:

Date:	Procedure / Reason for admittance:	Physician / Hospital Information:

MEDICATION

Are you currently taking any PRESCRIBED or **OVER-THE-COUNTER MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS**? (Please include birth control pills, insulin, allergy shots/medications, asthma inhalers, anti-depressants, anti-inflammatory medications, aspirin, ADD/ADHD medications, vitamins and dietary supplements.

Medication: (Example - Ibuprofen)	Dose/Strength: (Example - 400mg)	Frequency: (Example - 4 times/day)

ALLERGIES

Are you allergic to any of the following:	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction:
	Sulfa Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction:
	Other Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction:
	Over-the-counter Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction:
	Latex / Iodine / Tape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:
	Foods	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:
	Insects / Pollens / Environmental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:
	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:

MEDICAL HISTORY

Cardiovascular History:

Have you ever been told by a physician you have any of the following?

Heart Disease / Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Hypertrophic Cardiomyopathy/HCM	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Kawasaki Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Wolff-Parkinson-White Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
High / Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
High blood cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Pericarditis / Myocarditis / Endocarditis / Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Marfan Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Blood Clots / Embolisms	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Other:	Please Specify:	

During or after exercise have you ever experienced the following?

Dizziness or light headedness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Unusual fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Fainting or near fainting (syncope)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Unexplained seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':

Has a physician ever ordered any of the following tests to evaluate your heart health?

EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Result of Test:
Stress EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Result of Test:
Echocardiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Result of Test:
Stress Echo	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Result of Test:
Pulmonary Function Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/Result of Test:

Does anyone in your family have a history of the following?

Sudden unexplained death before age 50 including: Heart attack / Stroke / Drowning / Unexplained car accident / Sudden Infant Death (SIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Marfan Syndrome / Hypertrophic Cardiomyopathy (HCM) / Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) / Long QT Syndrome / Short QT Syndrome / Arrhythmia (Brugada Syndrome)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have a heart problem, pace maker or implanted defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Unexplained fainting / unexplained seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':

Orthopedic History

Have you ever sustained an injury to a bone, muscle, ligament or tendon in any of the following areas that caused you to miss practice or a game?

Head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Shoulder / Clavicle / Upper Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Elbow / Forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Hand / Wrist / Fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Chest / Ribs / Sternum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Back / Low Back / Sacrum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Hip / Pelvis / Femur / Thigh	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Foot / Heel / Toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever broken a bone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever had a stress fracture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever dislocated a joint?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever had an injury that required an MRI?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever had an injury that required an X-ray or CT-Scan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Have you ever had or been told to have X-rays for neck instability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you have a history of juvenile arthritis or connective tissue disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you regularly use braces, orthotics or other assistive devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do any of your joints become painful, swell, feel warm or look red?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you have any ongoing injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':

General Medical Questions:

Have you ever received treatment from a physician or been told by a physician you have any of the following medical problems?

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Mononucleosis in the past month	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
MRSA or Herpes skin infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Rashes, pressure sores or other skin problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Head injury or Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Head injury that caused confusion, prolonged headache or memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Heat Stroke / Heat Exhaustion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Become ill from exercising in the heat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':

Frequent muscles cramps during exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Numbness, tingling or weakness in your arms or legs after being hit or falling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Being unable to move your arms or legs after being hit or falling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Injury to spleen other organ(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Injury to a paired organ: kidney / eye / testicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Missing a paired organ: kidney / eye / testicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Vision or eye problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you wear glasses or contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Sickle cell trait (or a family history of)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Sickle cell disease (or a family history of)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Frequent colds / flu	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Frequent nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Rhabdomyolysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Recommended you gain or lose weight	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you worry about your weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Are you on a special diet/do you avoid certain types of food?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':

Females Only:		
At what age did your menstrual cycle start?	Age / Year	
How many have you had in the past 12 months?		
Have you ever gone more than 3 months between periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain a 'Yes':
Do you have any concerns you would like to discuss with a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify
In the past 12 months have you been told by a physician not to participate in sport	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:

ATTENTION PROSPECTIVE STUDENT-ATHLETE:

FREDERICK COMMUNITY COLLEGE REQUIRES THE RETURN OF THE HARD COPIES OF THESE FORMS WITH ORIGINAL SIGNATURES FOR REVIEW, **SCANNED/EMAILED COPIES OF THESE FORMS WILL NOT BE ACCEPTED** FOR COMPLETION OF THE AUDITION/TRYOUT MEDICAL CLEARANCE PROCESS.

It is the responsibility of the student-athlete to make sure that the physician performing the Pre-Participation Physical Examination endorse your level of fitness to participate and signs and dates the form on page 6.

FAILURE TO COMPLETE BOTH ITEMS WILL RESULT IN A DELAY IN THE MEDICAL CLEARANCE PROCESS.

2023-2024 TRYOUT PRE-PARTICIPATION PHYSICAL EXAMINATION

The National Junior College Athletic Association's policy requires that a student-athlete participating in an audition/tryout must provide verification that they have received a physical examination administered by a physician ****within 12 months prior to participating in the audition/tryout****; Frederick Community College supports and adheres to this requirement.

Last Name:	First Name, MI:
Preferred Name:	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Sport:	* Date of Examination: Date of last Tetanus:

PLEASE COMPLETE ALL SECTIONS BELOW; FAILURE TO DOCUMENT ALL FINDINGS WILL RESULT IN A DELAY IN MEDICAL CLEARANCE.

Height:	Weight: lbs	Pulse: bpm	Brachial Bp: /
General Appearance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Marfan Stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity		<input type="checkbox"/> Normal/Absent <input type="checkbox"/> Present	
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Eyes	Visual Acuity	RIGHT: 20 /	LEFT: 20 /
	EOM		
	Pupil RXN		
Nose	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Throat	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Mouth/Teeth	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Ears / Hearing	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Thyroid	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Lymph Nodes	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Chest / Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Heart	Murmurs Standing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Findings:
	Murmurs Squatting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Findings:
Abdomen/Femoral Pulse	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	
Genitourinary (males only)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:	

Neurological	DTRs	Findings:
	Alertness	Findings:
	Psychological	Findings:

Allergies	Medications	Findings:
	Foods	Findings:
	Environmental	Findings:

ORTHOPEDIC:		
Spine	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Shoulder	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Arms	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Elbow	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Wrist/Hand	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Hip	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Knee	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Legs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Foot / Ankle	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Findings:
Other:		

Sickle Cell	<input type="checkbox"/> Trait Positive	Date / Type of Test:	<i>NJCAA Recommends documentation of the student-athlete's sickle cell status; please endorse as appropriate if available.</i>
	<input type="checkbox"/> Negative		
	<input type="checkbox"/> Sickle Cell Disease		

TO BE COMPLETED BY THE EVALUATING PHYSICIAN

The Frederick Community College Department of Athletics requires the physician, who is performing the **Pre-participation Physical Examination (PPE)**, to review the information contained in the **Athletic Medical History** with the perspective student-athlete and appropriately refer as needed. The below signature verifies the physician has completed this requirement.

General Health Status:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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Recommendations for further studies and/or suggested referrals:	

<input type="checkbox"/> Athlete is CLEARED for full athletic participation at Frederick Community College.	_____ Physician Signature
<input type="checkbox"/> Athlete is NOT CLEARED for full athletic participation at Frederick Community College.	
<input type="checkbox"/> Athlete is given LIMITED CLEARANCE for athletic participation at Frederick Community College.	

Physician Association with Student-Athlete:	<input type="checkbox"/> Family Physician	_____ Physician's Office Stamp
	<input type="checkbox"/> Pediatrician	
	<input type="checkbox"/> Clinic Affiliation	
	<input type="checkbox"/> General Referral	
	<input type="checkbox"/> Other:	

Frederick Community College Office use only:	
Reviewed by: (ATC Signature)	Date Reviewed:



FREDERICK COMMUNITY COLLEGE
DEPARTMENT OF ATHLETICS – AUDITION/TRYOUT WAIVER

ATHLETE INFORMATION

Last Name:		First Name, MI:	
Sport:	Date of Birth:	Cell Phone:	

By signing this statement, I express my desire to participate in the tryout for the sport identified above ("Sport") at Frederick Community College ("FCC" or the "College"), and, in consideration of being allowed to participate in the Sport, I hereby acknowledge and agree as follows:

1. I acknowledge that I am a fulltime student at the college and that I am participating in these activities voluntarily.
2. I understand that participation in intercollegiate athletics involves a risk of injury which may range in severity from minor to catastrophic, including, but not limited to serious permanent paralysis, bone/joint or other bodily injury, concussions, other chronic disabling conditions and even death. I further understand that such injuries may occur in the absence of negligence. To minimize the risk of injury, I agree to obey all safety rules and to report fully any problems related to my physical condition to the sport coach(s).
3. I have consulted with a medical doctor regarding my personal medical needs. I represent that I am fit to participate in sport related activities, I have a current physical from a physician in the within the past 12 months and that there are no health-related reasons or problems, which preclude or restrict my participation in sport related activities.
4. I am aware that the College assumes no financial responsibility for payment of medical expenses for any injuries incurred while I participate in the sport tryout period.
5. The tryout period is one (1) day during which I am allowed to participate **ONLY** in team practice activity to include skill work and conditioning sessions. *During the tryout period I am specifically prohibited from participating in any activity that involves outside teams to include scrimmages and games both home and away.* At the end of the tryout period, if I am added to the team roster, I will refrain from any athletic activity with the College team until I have completed the Athletic Department's medical clearance process.

My signature below indicates that I am aware of the risks of injury inherent in athletic activities and that such risks may include death, paralysis and other serious permanent bodily injury. I voluntarily assume all risks of loss, damage, illness, or injury that I may sustain while participating in this sport, including travel and usage of any equipment or facilities. I (including my parents, legal guardians, and legal representatives) hereby agree to make no claim against, release, indemnify, defend and hold harmless the College and its employees, officers, agents from any claims, demands, suits and causes of action for any injury or loss, of for damages, cost, expenses, or compensation which may arise from my participation in the College's tryout period; or from any treatment, medical, or otherwise provided to me by the College's Athletic Training Staff.

Further, I absolve, indemnify, defend and hold harmless FCC from any breach of these presentations.

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> PRINT STUDENT'S NAME	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> STUDENT'S SIGNATURE
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> PARENT/GUARDIAN (IF ATHLETE IS UNDER 18)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> DATE