PRE-PARTICIPATION EXAMINATION GUIDELINES

1. **All new UC Davis student-athletes** are required to have a complete pre-participation physical examination and Medical History review (using UC Davis Sports Medicine Forms) within **60 days** of the sport’s first practice date. Hand written notes will not be accepted. **Exams must be performed by a licensed MD, DO (Doctor of Osteopathic Medicine), or PA/NP only.**

2. ALL transfer student-athletes must have a UCD pre-participation exam and Medical History review regardless of the paper work from their prior school. If a student "tries out" for a sport and does not make it, then “tries out” for another sport greater than 60 days later, they must have a new pre-participation exam and Medical History review.

3. **All returning** student-athletes must complete the Medical Clearance forms (medical history, insurance information, and supplements) on-line by the date assigned to the team in order to be cleared prior to the first practice. Forms and deadlines can be found on the web at the Student-Athlete Main Page.

4. Certain medical conditions may require additional evaluation by a UC Davis sports medicine physician. If indicated, there will be no charge for the evaluation, but, further diagnostic tests may result in additional charges at the student–athlete’s expense.

5. The completed UC Davis Pre-Participation Examination **AND** History Forms must be returned by your sport's due date to:
   Athletic Training Room
   264 Hickey Gym UC Davis Davis, CA 95616

6. No student-athlete may participate/practice unless s/he has presented a completed medical clearance packet **and** been cleared by the Certified Athletic Trainer and/or UC Davis Sports Medicine Physician.

7. Any student-athlete who cannot see a private physician for the physical examination may obtain this service at the UC Davis Student Health Services. This physical examination will be by appointment only and current student fees will apply. The student is responsible for making their own appointment for this service.

Dear Health Care provider (M.D., D.O., PA/NP):

Thank you for seeing this prospective UC Davis student-athlete.

Your exam is to be recorded on the PHYSICAL EXAMINATION and HISTORY forms provided and both forms returned to your patient. If you note any problems that might interfere with this student-athlete's ability to participate, please refer him/her for the appropriate evaluation or notify us about the problem by submitting a summary letter and/or sending appropriate medical records.
Dear incoming student-athlete,

The NCAA mandates that all incoming Division I student-athletes must have knowledge and documentation of their sickle cell trait status before participating in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc. The sickle cell trait status document must be attached to the UC Davis Pre-Participation Examination Form that will be made available to you this summer.

Starting in 1990, all infants born in the state of California were tested for Sickle Cell Disease/Trait as a component of the California Newborn Screening Program. Most other states instituted similar programs. The results of these tests were then sent to the obstetrician responsible for overseeing the infant’s birth (you!), or to the pediatrician responsible for discharging the infant home from the hospital (you again!) You may be able to obtain the results of your Sickle Cell tests from the obstetrician or pediatrician who cared for you at the time of your birth.

Alternatively, you can obtain this information free of charge by contacting the California Newborn Screening Program at http://www.cdph.ca.gov/programs/NBS/Pages/NBSFAQTraitAthletes.aspx and clicking the <Student Athlete Request for Newborn Screening Results link>. Please use Director of Athletic Training Services in the Attention To box. It will take 2-4 weeks to produce these documents, therefore, it could hold up your eligibility if you do not act promptly to obtain this medical information.

If you are unable to obtain the results of your newborn screening tests, you can ask your physician to order a sickle cell screening test or you can contact the UC Davis Athletic Training Program and inquire about a team physician ordering the test. Both options may require a fee that you could be responsible for paying.

Please contact the Athletic Training Program at 530-752-0647 or -7515 if you have questions.

About Sickle Cell Trait
- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle cell trait is a common condition (> three million Americans)
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape), which can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.
### General Assessment

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### Musculoskeletal Evaluation

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### Recommendations:

Cleared ☐ YES ☐ NO ☐ Pending Consultation

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Physical Exam must be dated in order to be accepted.

Clinician's Name (please PRINT):  
Clinician's Signature:  
Date:  
Phone:  
Office Address:  
I have reviewed the history form ☐
Preparticipation Physical Examination

DATE OF EXAM __________________________

Name ________________________________ Sex _______ Age _______ Date of birth _______________

Sport(s) ____________________________________________________________________________

Address _____________________________________________________________________________ Phone __________________

Personal physician ____________________________________________________________________

Explain “Yes” answers below.
Circle questions you don’t know the answers to.

1. Has a doctor ever ordered a test for your heart? 
   Yes No

2. Have you ever been unable to move your arms or legs after being hit or falling? 
   Yes No

3. Has anyone recommended you change your weight or eating habits? 
   Yes No

4. Are you happy with your weight? 
   Yes No

5. Are you trying to gain or lose weight? 
   Yes No

6. Do you wear protective eyewear, such as goggles or a face shield? 
   Yes No

7. Do you wear glasses or contact lenses? 
   Yes No

8. Have you ever had a head injury or concussion? 
   Yes No

9. Do you have an ongoing medical condition (check all that apply): 
   □ High blood pressure □ A heart murmur
   □ High cholesterol □ A heart infection

10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) 
    Yes No

11. Has anyone in your family have a heart problem? 
    Yes No

12. Does anyone in your family have a heart problem? 
    Yes No

13. Has anyone in your family have Marfan syndrome? 
    Yes No

14. Have you ever had surgery? 
    Yes No

15. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below: 
    Yes No

16. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle affected area: 
    Yes No

17. Have you ever had a stress fracture? 
    Yes No

18. Have you ever been told that you have or you had an x-ray for atlantoaxial (neck) instability? 
    Yes No

19. Do you regularly use a brace or assistive device? 
    Yes No

20. Has a doctor ever told you that you have asthma or allergies? 
    Yes No

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete __________________________ Signature of parent/guardian __________________ Date ______________

I have reviewed the questions above. Signature of Clinician __________________ Date ______________