

## Varsity Student Athlete Physical Examination Form

**Only needs to be completed by students participating in their first year of intercollegiate varsity athletics**

**A physician, physician assistant, registered nurse, or nurse practitioner** who is not the student or a relative of the student must complete all questions in English and sign this page. Athletes must have a physical within 6 months of their sports start date (fall season date for spring sports) and must have a clinician complete the attached Sick Cell Trait Status form.

**Student surname (family name)** \_\_\_\_\_ **First name (given name)** \_\_\_\_\_

**DOB** \_\_\_\_\_ **Sport** \_\_\_\_\_ **MIT ID # if known** \_\_\_\_\_

### History and Review of Systems

Please answer all questions. Check "Y" for yes or "N" for no. If yes, please explain on page 2 under "Explain any abnormalities" or add an additional sheet for explanation if necessary.

**Has the patient had:**

	Y	N		Y	N		Y	N		Y	N
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Joint reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Knee/shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	<input type="checkbox"/>	<input type="checkbox"/>	Back/neck/spine problems	<input type="checkbox"/>	<input type="checkbox"/>	Exertional collapse	<input type="checkbox"/>	<input type="checkbox"/>
Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Stress fracture	<input type="checkbox"/>	<input type="checkbox"/>	Biological females:	<input type="checkbox"/>	<input type="checkbox"/>
Gum/tooth disease	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Eye/vision condition	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hernia/hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>
H/O appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Amenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
Any other surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Restriction/purging/binging	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of paired organ	<input type="checkbox"/>	<input type="checkbox"/>	Myocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Joint disease or injury	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>			

- **Keep a copy of the completed form for your records.**
- **To submit the form, visit [health.mit.edu/athletics](http://health.mit.edu/athletics) and follow the instructions. The deadline to submit the form is July 31.**

### Physical Examination

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Please check each system below and indicate if it is normal or abnormal. If abnormal, please give details below under "Explain any abnormalities."

System	Normal	Abnormal	System	Normal	Abnormal	System	Normal	Abnormal
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral vascular	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>
Chest/lungs	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any abnormalities:

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Is this person under treatment for any medical or mental health condition? If yes, please describe the problem and treatment:

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In your opinion, is there any contraindication for this person to participate in collision, contact, or non-contact sports? If yes, please describe the nature of your suggested limitation or your advice for further work-up:

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**Physical Examination, continued**

Do you have any recommendations for this person's health care while at MIT?

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**Certification by health care provider (required)**

Signature of physician/PA/NP/RN \_\_\_\_\_ Printed name \_\_\_\_\_

Date \_\_\_\_\_ Mailing address \_\_\_\_\_ Office phone \_\_\_\_\_

**MIT Use Only** — Intercollegiate sports participation Approved       Denied       Requires sports med physician review      INITIALS \_\_\_\_\_**Continues on next page...**

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## Sickle Cell Trait Status

Complete this form if you plan to participate in intercollegiate (varsity) sports. Submit this form with your physical examination.

Student surname (family name) \_\_\_\_\_ First name (given name) \_\_\_\_\_

DOB \_\_\_\_\_

To be medically cleared for intercollegiate (varsity) sports participation, all students, both undergraduate and graduate, are required to have a pre-entrance physical examination within 6 months of the first day of participation for their sport, and submit this form.

### 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.
- 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, decreased oxygen in the muscles may cause sickling of red blood cells (change from normal disc shape to a crescent, or “sickle,” shape). Sickled red blood cells can accumulate in the bloodstream and block blood vessels. This can lead to collapse from rapid breakdown of muscles without blood supply.

### Sickle Cell Screening

- Sickle cell trait testing in the form of a sickle cell screen blood test should be done by the student-athlete’s primary care clinician before coming to campus. If testing is not performed at home, you can request testing at MIT Health.

## Sickle Cell Screening Results and Clinician Signature

Sickle cell screen date: \_\_\_\_\_  
date (month/day/year)

Result: \_\_\_\_\_  
positive/negative

### Certification by health care provider (required)

Signature of physician/PA/NP/RN \_\_\_\_\_ Printed name \_\_\_\_\_

Date \_\_\_\_\_ Mailing address \_\_\_\_\_ Office phone \_\_\_\_\_