

Name of Student-Athlete: _____ **Sport:** _____

Dear Student-Athletes & Parents:

We would like to welcome you back to the St. Thomas University Athletics family. The following is a checklist to better assist you in making the process of completing physicals easier. Please make sure to have all of the necessary paperwork completed prior to arriving on campus. The waivers can be accessed online at <https://blueocean.orchr.com> under Forms and must be completed prior to the date of physicals. Please make sure to update your profile with your current information in the case of an emergency.

If you forgot your credentials, please log in to: <https://blueocean.orchr.com>.

- Click on New User
- Click on the Forgot Credentials tab
- Select either Forgot Password or Forgot User ID

Please note that any paperwork completed the day of or after the date of physicals may potentially delay initial clearance to participate in athletics. Should you have any questions or concerns, please contact the St. Thomas University Athletic Training Staff.

- _____ Update BlueOcean Profile
- _____ Complete and sign BlueOcean waivers
 - _____ HIPAA
 - _____ Consent for Participation
 - _____ Insurance
 - _____ Secondary Insurance Explanation
 - _____ Drug and Alcohol Policy
 - _____ Concussion Acknowledgement Form
- _____ Upload Insurance Card on NExTT Pic App
- _____ Completely fill out pages 1-2 prior to entering physicals

<u>STAFF USE ONLY</u>
<input type="checkbox"/> Pgs. 1-2 Complete <input type="checkbox"/> BlueOcean Profile Updated <input type="checkbox"/> BlueOcean Waivers Complete <input type="checkbox"/> Insurance Card Uploaded
Reviewed By: _____

*** THIS IS NOT A WAIVER FOR THE ST. THOMAS UNIVERSITY STUDENT INSURANCE PLAN!**

Thank you,

George Fernandez, MS, ATC/LAT
Head Athletic Trainer

E: gfernandez5@stu.edu

O: 305-628-6533

Player Information and Contact Sheet

Student-Athlete Name: _____ **Date of Birth:** _____
(Last, First, MI)

Sport(s): _____ **STU I.D.#:** _____

STU Email Address: _____ **Year:** So Jr Sr 5th

Live On Campus Live Off Campus; if so Local Address: _____

Permanent Home Address: _____

City, State, Zip Code: _____

Cell Phone #: _____ **Home Phone #:** _____

Father/Legal Guardian Name: _____

Use as Emergency Contact? YES NO **Cell Phone #:** _____

Home Phone #: _____ **Work Phone #:** _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

Mother/Legal Guardian Name: _____

Use as Emergency Contact? YES NO **Cell Phone #:** _____

Home Phone #: _____ **Work Phone #:** _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

Other Emergency Contact

Name: _____

Relationship to Student-Athlete: _____

Home Address: _____

City, State, Zip Code: _____

Cell Phone #: _____ **Alternate Phone #:** _____

Primary Insurance Information Sheet

Name of Student Athlete: _____ Sport: _____

If a student will be using their own primary insurance, the following information needs to be completed in full and returned to the St. Thomas University Athletic Training Staff along with a front and back copy of the primary insurance card. If a student will be using the St. Thomas University Primary insurance, please ONLY indicate and sign below.

*** PLEASE NOTE: THIS IS NOT A WAIVER FOR THE STU STUDENT INSURANCE PLAN!**

Will you be using the primary insurance provided by St. Thomas University?

- YES If yes, STU ID#: _____
- NO If no, please complete below.

Primary Insurance Holder's Full Name: _____

Primary Insurance Company Name: _____

Address: _____

Phone #: _____

Group # (if applicable): _____

Policy # (if applicable): _____

Member ID # (if applicable): _____

I certify that, to the best of my knowledge, the information provided above is complete and correct. Should any changes in insurance or demographic occur, it is my responsibility to notify the St. Thomas University Athletic Training Staff immediately. **Failure to do so may result in incurring out-of-pocket expenses. St. Thomas University will not be responsible for any medical bills resulting from the lapse or cancellation of a student athlete's primary insurance coverage.**

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____

ALL information provided will be stored in private files in the St. Thomas University Athletic Training Department and will only be disclosed if required by insurance company to file a claim.

Name: _____ Sport: _____

Pre-Participation Physical Screening Evaluation

Height: _____ Weight: _____ Blood Pressure: _____/_____ Heart Rate: _____

Left Eye: 20/____ Right Eye: 20/____ Corrected: Y / N Glasses/Contacts/NO Pupil: Equal ____ Unequal ____

General Medical History Update

**** SINCE YOUR LAST PHYSICAL EXAM, HAVE YOU HAD ANY OF THE FOLLOWING? ****

1. Had a serious illness/been hospitalized	YES	NO
2. Been diagnosed with any NEW medical problems or had any surgical procedures?	YES	NO
3. While exercising has your heart ever "skipped" a beat, have you suffered from "racing heart", severe chest pain, lightheadedness, fainting?	YES	NO
4. Have you felt dizzy, passed out, or "blacked out" during or after exercise?	YES	NO
5. Had frequent headaches?	YES	NO
6. Experienced coughing, wheezing, shortness, of breath, or difficulty breathing during or after exercise?	YES	NO
7. Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time/received special attention (IV fluids, etc.) for a heat related problem?	YES	NO
8. Do you take vitamins, amino acids, creatine, and/or any other dietary supplement on a daily basis and/or as needed?	YES	NO
9. Been recently diagnosed with infectious disease or viral infection (i.e. mononucleosis, staph infection)?	YES	NO
10. Been denied clearance by a medical professional to participate in any athletic activity?	YES	NO
11. Sudden death or serious illness of a parent?	YES	NO
12. Taking any medications?	YES	NO

****IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN IN DETAIL WITH THE QUESTION NUMBER BELOW****

MEDICAL STAFF USE ONLY

Internal medical clearance: YES/NO Additional testing required? YES/NO

Notes: _____

Physician/ATC Signature: _____ Date: _____

Reviewed By: _____ Date: _____
(STU Staff ATC Signature)

PRE-PARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date: _____ Male Female Sport: _____
 Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____
 Vision: R 20/ _____ L 20/ _____ Corrected? Y N If corrected, circle one: Glasses/Contacts?

MEDICAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat • Pupils equal, reactive to light		
Lymph nodes		
Heart • Murmurs		
Lungs		
Abdomen		
Skin • HSV, tinea corporis, lesions suggestive of MRSA • Scars/Incisions		
Neurologic		
MUSCULOSKELETAL		
Neck		
Shoulder		
Elbow		
Wrist/Hand/Digits		
Back		
Hip		
Knee		
Ankle		
Foot/Toes		
Reflexes		
Functional • Hop, jump, squat • Duck/toe/heel walk		

PARTICIPATION STATUS

_____ Full Unlimited Participation in Intercollegiate Sports
 _____ Conditionally Cleared with the Following Exceptions: _____
 _____ Participation withheld until: _____
 _____ Disqualifications (explain): _____

General Medical Physician Signature: _____ Date: _____

Orthopedic Physician Signature: _____ Date: _____

Reviewed By: _____ Date: _____
 (STU Staff Certified Athletic Trainer)

