

# Olympia Area Rowing Junior Program

## Physical Examination Form

*(This 1 page form must be completed in its entirety or a substitute form provided by a physician may be provided in lieu of this form.)*

### Participant's Information (to be completed by parent):

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Address Street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physical Examination (to be completed by licensed practitioner/physician):** Rowing is a strenuous sport and places strong demands on the cardiovascular system, back, shoulders and knees. Please note any abnormalities that may limit the athlete's participation or make this athlete susceptible to injury.

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

1. HEENT
2. Lungs
3. Heart
4. Abdomen
5. Neuro
6. Skin
7. Spine/Back
8. Shoulders/Upper Extremity
9. Legs, Knees

ASSESSMENT: Participation:                      Full                      Limited                      May Not Participate

Limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Examiner's Signature: \_\_\_\_\_

Examiner's Phone: \_\_\_\_\_ Examiners Name (Print): \_\_\_\_\_

**OAR Jr Program Medical History and Permission Form – Page 1 of 2**

ROWER FULL NAME \_\_\_\_\_

Date of Application: \_\_\_\_\_ ... for Season (circle one): Fall, Winter, Spring, Summer

**Parent Information (Please fill out for one or two Parent/Guardians, for Emergency Contact if needed)**

Mother/Guardian	Father/Guardian
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Preferred Phone # to Use In Emergency: _____	Preferred Phone # to Use In Emergency: _____
_____	_____

**Emergency Contacts:** Alternative person (s) to whom students may be released in case of emergency:

<p>1.</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Home Phone: _____</p> <p>Work Phone: _____</p>	<p>2.</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Home Phone: _____</p> <p>Work Phone: _____</p>
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**Authorization to Treat a Minor**

I (we) the undersigned parent (s), or legal guardian of \_\_\_\_\_ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room of any acute general hospital holding a current license to operate and that I (we) agree to be responsible for the cost of such treatment. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide the authority and power to render care which the aforementioned medical staff in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned before rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: \_\_\_\_\_

It is understood that Olympia Area Rowing is not liable for any accident or incident related to transportation by a public carrier.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name (Type or Print): \_\_\_\_\_

**Insurance Information**

(Name) _____ is covered for accident and medical insurance benefits:	
Insurance Carrier and #: _____	Preferred Hospital: _____
Phone: _____	Phone: _____
Primary Care Physician: _____	Prior/Current Medical Risks: _____
Phone: _____	

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

# OAR Jr Program Medical History and Permission Form – Page 2 of 2

Please circle “yes” or “no,” and provide additional details where requested.

1. Are you allergic to any medication (aspirin, sulfa, penicillin, etc)? No/Yes  
2. Do you have any other allergies (animals, insects, bees, foods, etc.)? No/Yes

If you answered yes to any of the above please describe allergic reaction and treatment:

3. May sunscreen be applied during the day? No/Yes  
4. Do you have any of the following conditions? No/Yes

(circle those that apply): ADD/ADHD/Blood Disorder/Diabetes/Hearing Problems/Headaches/Frequent Nosebleeds/Kidney or Bladder Problems/Mental Health Concerns/Eating Disorders/Vision Problems/Speech Problems

Please describe any of the condition (s) circled above:

5. Have you ever been told by a doctor that you have asthma or exercise-induced asthma? No/Yes  
Do you use an inhaler (Albuterol, etc.)? No/Yes  
List all asthma medications, and frequency of use:

6. Have you ever had epileptic seizures or been told by a doctor that you have epilepsy? No/Yes  
7. Do you have any medical conditions for which you are currently under treatment? No/Yes

8. Do you take any prescribed or over-the-counter medications on a regular basis (steroids, birth control pills, anti-inflammatory, antibiotics, dietary supplements, herbal, etc.)? No/Yes

9. Do you wear glasses or contacts during practice or competition? No/Yes

10. Have you ever had surgery for any reason: No/Yes  
List:

11. Have you ever had a shoulder injury that disabled you for a week or longer (dislocation, separation)? No/Yes  
Right or Left? Type of injury

12. Have you ever injured your back? No/Yes  
Type of Injury: Dates:

13. Do you have back pain (neck/upper back/lower back)? No/Yes  
Circle those that apply: seldom/occasionally/frequently with vigorous exercise or heavy lifting

14. Do you have buttock or leg pain associated with low back pain? No/Yes

15. Have you had an x-ray, CT scan, MRI of your lower back? No/Yes  
Results:

16. Have you ever been treated for low back pain? No/Yes  
Please describe treatment:

17. Have you ever been told by a doctor/athletic trainer that you injured the cartilage in your knees? No/Yes  
Right or Left: Dates:

18. Do you have any other conditions of which we should be aware? No/Yes

Date of Last Medical Exam: \_\_\_\_\_ By Dr. \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

The questions on this form have been answered completely and truthfully to the best of my knowledge.

(signature of athlete) \_\_\_\_\_

(type or print athlete name) \_\_\_\_\_ (date) \_\_\_\_\_

(signature of parent) \_\_\_\_\_

(type or print parent name) \_\_\_\_\_ (date) \_\_\_\_\_

**This Form Is Required Yearly**