University of Vermont
On-Campus Evaluation (OCE) Medical Packet

Please submit all forms no later than three (3) business days before the OCE to:
Athletic Medicine Department ◊ 97 Spear St, 140 Patrick Gym ◊ Burlington, VT 05405
(802) 656-7751 ◊ Fax (802) 656-9578

UVM Prospective Student- Athlete Medical History Questionnaire

****Please provide proof of a physical examination by a physician completed within the previous year from date of on-campus evaluation.**
**** Per the NCAA, all prospective student-athletes must provide documentation and results of a Sickle Cell test in order to participate in any activity. This test is not offered by UVM for prospective student athletes.**

For prospective students: *Aside from providing immunization records, UVM encourages all student to be vaccinated against Covid-19, including boosters.*

Please read all questions carefully and respond by selecting the appropriate response. All questions must be answered.

Demographic Information

Last Name _____
First Name _____
Middle Initial _____
Date of Birth _____
Current Age _____
Height _____
Weight _____

Emergency Contact Information

Parent/Guardian _____
Phone # _____
Parent/Guardian _____
Phone # _____
Emergency Contact _____
Relationship _____
Phone # _____

Health Insurance Information

Type of Insurance Plan:

____ Traditional Medical and Hospitalization
____ Health Maintenance Organization (HMO)
____ Preferred Provider Organization (PPO)
____ Point of Service (POS)

Insurance Policy Information:

Insurance Company _____
Insurance Co. Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
Policy Number _____
Group # or Soc.Sec # _____
Policy Holder Name _____

Birthday of Policy Holder _____
Home Phone#/Policy Holder _____
Work Phone#/Policy Holder _____
Employer of Policy Holder _____
Employer Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____

Your Doctor:

Prospective Student-Athlete's
Primary Care Physician (Name) _____**Physician's Phone**_____

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Medical History

Section A: General **(Please answer all questions and explain YES responses/provide dates in the space provided**

Have you been treated for infectious Mononucleosis?
____ Yes (please specify date) _____
____ No

Have you been treated for Pneumonia?
____ Yes (please specify date) _____
____ No

Have you ever been hospitalized?
____ Yes (please specify date) _____
____ No

Are you presently taking any prescription or over the counter medications (albuterol inhalers, oral asthma medications, anti-inflammatories, anti-depressants, etc.)?
____ Yes (specify name of drug, reason for taking and usual dosage) _____
____ No

Are you allergic to any medications?
____ Yes (Please name) _____
____ No

Have you ever had a serious allergic reaction (i.e. anaphylaxis) to an insect bite or food source (e.g. peanuts)?
____ Yes (Please specify insect/food and reaction) _____
____ No

Do you have any other allergies?
____ Yes (Please specify) _____
____ No

Section B: Family Health History
Has anyone in your family (blood relatives) suffered from any of the following:

Sudden death from non-traumatic causes, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Cancer, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Diabetes, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Heart Trouble, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No
Sickle Cell Disease?
____ Yes (Please indicate relationship to you) _____
____ No

High Blood Pressure, before the age of 50?
____ Yes (Please indicate relationship to you) _____
____ No

Marfan Sydrome?
____ Yes (Please indicate relationship to you) _____
____ No

Section C: Detailed Health History

Have you ever had a heat-related illness (heat exhaustion, heat stroke, etc.)?
____ Yes (Please give date and details) _____
____ No

Do you have problems with muscle cramps?
____ Yes
____ No

Do You have any disorders involving:
Eyes/Vision?
____ Yes (Please describe) _____
____ No

Ears/Hearing?
____ Yes (Please describe) _____
____ No

Kidneys?
____ Yes (Please describe) _____
____ No

Liver?
____ Yes (Please describe) _____
____ No

Spleen?
____ Yes (Please describe) _____
____ No

Heart?
____ Yes (Please describe) _____
____ No

Lungs?
____ Yes (Please describe) _____
____ No

Testicles?
____ Yes (Please describe) _____
____ No

Gastrointestinal Tract?
____ Yes (Please describe) _____
____ No

Other?
____ Yes (Please describe) _____
____ No

Have you ever had a concussion, had your "bell rung" or been knocked out?
____ Yes (Please give dates) _____
____ No

Do you wear eyeglasses or contacts?
____ Yes
____ No

Have you ever experienced a seizure or been informed that you have epilepsy?
____ Yes (Please give dates) _____
____ No

Have you had hepatitis at any time?
____ Yes (Please provide details including type of hepatitis) _____
____ No

Do you have any type of blood disorder (hemophilia, anemia, sickle cell trait, etc.)?
____ Yes (Please provide details) _____
____ No

Do you have any diabetes or have you ever been treated for diabetes?
____ Yes (Please give dates and details) _____
____ No

Have you ever been treated for kidney stones?
____ Yes (Please give dates and details) _____
____ No

Section D: Cardiopulmonary

Have you ever been told by a physician that you have asthma?
____ Yes (Please specify date) _____
____ No

Have you ever been told that you have a Heart Murmur or any other heart condition?
____ Yes (Please provide date) _____
____ No

Have you ever been held from competition for a heart murmur or condition?
____ Yes (Please specify date) _____
____ No

Have you ever had any tests done for a heart murmur?
____ Yes (Please list tests and dates) _____
____ No

Have you ever experienced and "irregular" heartbeat, dizziness, or chest pain with exercise?
____ Yes (Please provide date and details) _____
____ No

Have you ever been told that you have high blood pressure?
____ Yes (Please provide date and indicate if you have taken meds for this condition) _____
____ No

Have you ever fainted, passed out, or "blacked out" during exercise?
____ Yes (Please specify date) _____
____ No

Section E: Musculoskeletal

Please indicate if you have had any major injuries to the following areas within the last 3 years. A major injury for this purpose is one that required medical attention or held you out of practice/competition (i.e. a broken bone, surgery, concussions, major ligament sprain or muscle strain, etc.)

If yes, please indicate the body part, whether left (L) or right ®, and the type of injury in the space provided:

Head / Neck?
____ Yes (specify date) _____
____ No

Shoulder/ Elbow / Arm?
____ Yes (specify date) _____
____ No

Wrist / Hand?
____ Yes (specify date) _____
____ No

Back / Spine?
____ Yes (specify date) _____
____ No

Knee / Hip / Leg?
____ Yes (specify date) _____
____ No

Foot / Ankle?
____ Yes (specify date) _____
____ No

Have you had any surgical procedure to correct an injury or condition?
____ Yes (specify dates and details) _____
____ No

Do you have a pin, screw, plate, etc. somewhere in your body because of surgery?
____ Yes (please specify) _____
____ No

Section F: Other

Do you now or have you ever used illegal drugs?
____ Yes (please provide details) _____
____ No

Have you ever used anabolic steroids?
____ Yes (please provide details) _____
____ No

Do you now or have you ever had a drug or alcohol abuse, dependency or addiction problem?
____ Yes (please provide details) _____
____ No

Have you ever had any additional illnesses or injuries not covered by the previous questions?
____ Yes (please provide details) _____
____ No

Are you presently under a physician's care for a condition not covered by the previous questions?
____ Yes (please provide details) _____
____ No

Do you consider yourself in good physical shape and prepared to participate in this tryout?
____ Yes
____ No

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The Fine Print (Read Carefully)

Please read the above over again carefully before signing below. By signing below you…

- ***Certify that the above answers are complete, correct and truthful to the best of your knowledge.***
- ***Fully realize that the University of Vermont cannot be held responsible for any previous medical condition(s) that you might have.***
- ***Fully realize that misrepresentation of information could have serious medical implications leading to injury and, in extreme circumstances, death.***

By submitting this, I agree to the terms set forth above:

_____ _____
Prospective student-athlete **Date**

_____ _____
Parent/Guardian if PSA under 18 **Date**

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Medical Requirements for On-Campus Evaluation

Prior to participation in an on-campus evaluation, a perspective student-athlete is required to provide the following documentation:

_____ Proof of insurance
_____ Proof of a physical examination by a physician completed within the previous year from date of on-campus evaluation.
_____ Completed Medical Questionnaire
_____ Documentation of Sickle Cell test and results

UVM ATHLETICS – OFFICIAL VISIT PARTICIPATION WAIVER

I, _____ (Prospective Student), certify that I am participating in an official visit at the invitation of the University of Vermont and State Agricultural College ("UVM") Department of Athletics.

I acknowledge that I am completely aware of the inherent risks associated with playing basketball. I understand that, in addition to the risks of injury, which may include death, my participation in basketball may cause aggravation of pre-existing injuries. Knowing this, I take full responsibility for any injury that may occur because of my participation in basketball activities during my official visit at UVM.

I understand that to participate in basketball activities during my official visit at UVM, I must provide written consent and clearance from a qualified health care provider, as well as proof of health insurance coverage.

It is my understanding that UVM Athletics and the Athletic Medicine Department may deny my participation because of a medical condition in my health history or for any other valid reason.

All costs associated with any tests, consultations, and/or medical procedures needed to gain approval/certification for participation are the responsibility of myself, and/or my parent(s)/guardian(s).

I further acknowledge that I am signing this consent voluntarily, with complete understanding of the terms and conditions herein, and that, as applicable, I have discussed my participation and the related risks with my parents and/or guardians.

Prospective Student Signature _____ Date: ___/___/_____
Parent / Guardian Signature (if under 18 years of age): _____
Parent / Guardian Printed Name: _____ Date: ___/___/_____