MIT Health

MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, E23
Cambridge, MA 02139

# Varsity Student Athlete Physical Examination Form

**Only Needs to be Completed by Intercollegiate Varsity Student Athletes**

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

- **Keep a copy of the completed form for your records.**
- **To submit the form, visit 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 | ☐ | ☐ | Breasts | ☐ | ☐ | Genitourinary | ☐ | ☐ |
| HEENT | ☐ | ☐ | Cardiovascular | ☐ | ☐ | Extremities | ☐ | ☐ |
| Lymph nodes | ☐ | ☐ | Peripheral vascular | ☐ | ☐ | Reflexes | ☐ | ☐ |
| Thyroid | ☐ | ☐ | Heart murmur | ☐ | ☐ | Neurologic | ☐ | ☐ |
| Chest/lungs | ☐ | ☐ | Abdomen | ☐ | ☐ | | | |

Explain any abnormalities:

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

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:

## Physical Examination, continued

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

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

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

**Signature of physician/PA/NP/RN** ______________________ **Printed name** ______________________

**Date** ______ **Mailling address** ______________________ **Office phone** ______________________

**MIT Use Only** — Intercollegiate sports participation

☐ Approved ☐ Denied ☐ Requires sports med physician review INITIALS __________

**Continues on next page...**

## 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.
- If the student-athlete, and his or her parent/guardian if the student-athlete is a minor, does not desire sickle cell testing, a waiver must be signed. The Sickle Cell Waiver form is distributed to athletes by the Department of Athletics, Physical Education and Recreation (DAPER).

## 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** _______ **Mailling address**_________________________________________ **Office phone** ___________________________