

UNITED STATES LUGE ASSOCIATION

PHYSICAL EXAM FORM

35 Church Street, Lake Placid, NY 12946

All of this information is necessary before being allowed to participate in the sport of luge.
Please complete all information.

| | |
|----------------------|--|
| NAME: _____ | Home Phone: (____) _____ |
| ADDRESS: _____ | Day/Work Phone: (____) _____ |
| DATE OF BIRTH: _____ | (If minor please list parent day phone) |
| | Social Security # (last 4 digits): _____ |
| | <i>(required to access OTC facilities)</i> |

PASSPORT INFORMATION

Please enter exactly as it appears on passport.

Full Given Name: _____ Passport #: _____

Date & Place of Birth: _____ Nationality: _____

Date of Issuance: _____ Date of Expiration: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Policy #: _____

Policy Holders Name: _____ Policy Holder's Date of Birth: _____

On the back of this form is a request for medical information that is pertinent to the sport of luge. Please complete all information as accurately as possible. Please note that if the athlete is a minor, a parent signature is required. The examining physician must sign this form where applicable. **No other forms will be accepted.**

MEDICAL INFORMATION

ATHLETE HISTORY (If you answer **YES** to any of these questions, please explain below and include year)

- | | YES | NO |
|---|-------|-------|
| 1. Has this athlete ever had hospitalization, surgery, injury, or a serious medical illness? _____ | _____ | _____ |
| 2. Is this athlete currently taking <u>any</u> medications or under the care of a physician? _____ | _____ | _____ |
| 3. Does this athlete have any known allergies to medications? _____ | _____ | _____ |
| 4. Has this athlete ever blacked out or had a concussion as a result of physical activity? _____ | _____ | _____ |
| 5. Has this athlete ever been diagnosed or treated for asthma? _____ | _____ | _____ |
| 6. Has this athlete ever been diagnosed or treated for diabetes or high blood sugar? _____ | _____ | _____ |
| 7. Is there a history of heart problems in your family? _____ | _____ | _____ |
| 8. Is there a history of diabetes in your family? _____ | _____ | _____ |
| 9. Does this athlete wear glasses or contact lenses? If YES please give date of last exam. _____ | _____ | _____ |
| 10. Has any physician ever recommended or do you feel that there should be limitations placed on this athlete's participation in competitive sports? List: _____ | _____ | _____ |

PHYSICAL

Height: _____ Heart: _____ Blood Pressure: _____
Weight: _____ Pulse: _____ Neurological Reflexes: _____

Orthopedic Evaluation: _____

Abnormal Physical Findings: _____

New Problems: _____

Any Distinguishing Characteristics/Medical Problems/Conditions: _____

PATIENT PROFILE

Immunizations: _____

Medications: _____

Allergies: _____

Tetanus Toxoid: _____ Blood Type: _____

Hepatitis B Vaccination: YES or NO

Hepatitis A Vaccination: YES or NO

PHYSICIANS MAY ADD ADDITIONAL COMMENTS ON THE BACK OF THE LAST PAGE OF THIS FORM.

ATHLETE NAME: _____

OPTIONAL TESTS (Required at Physician's Discretion)

Urinalysis: _____ Albumin: _____ Hgb: _____ or HCT: _____
Sugar: _____ Blood Count: _____
Micro (if sugar test abnormal) _____

The examiner, by signing this form, agrees that he/she understands the danger for catastrophic injury inherent in the sport of luge and further, certifies that there is no current health condition, nor any item in the athlete's medical history, which may interfere with the athlete's participation in the sport of luge, or make it inadvisable for the athlete to participate in the sport of luge.

State Certified Health Examiner (e.g., Doctor) Signature: _____
Health Examiner's Name (PRINT): _____ DATE: _____
Health Examiner's Address: _____ PHONE: (____) _____

LIABILITY/MEDICAL RELEASE

If I am injured while residing at and/or participating in United States Luge Association (USLA) programs at either the United States Olympic Training Center (USOTC) or elsewhere, (1) I and my family agree to waive any legal claim against the USLA and those associated with the USLA; and (2) I give consent for the USLA to provide medical care and treatment, transportation, and emergency medical services as warranted. If the program in which I am participating includes Psychological, Physiological, and/or Biomechanical evaluations, I further consent to these evaluations, which pose no unusual risks or hazards when customary safeguards are observed; and (3) I authorize the USLA to disclose medical information about me to facilitate medical treatment or services by providers. The USLA may disclose medical information about me to providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of me.

If injured while traveling to or from any USLA program by public, private, or any other means of conveyance, I agree to waive any legal claims against the USLA. By signing this release, I swear that I am in good physical condition and I am not aware of any health condition, disease, or injury that would result in my being injured during any program's participation.

If I am less than 18 years of age or a minor under the laws of the state where I live, my parent or guardian shall sign this release as requested below.

DATE: _____

Signature of Athlete
DATE: _____

Signature of Parent/Guardian (if under 18 yrs. of age)

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DATE: _____

Signature of Parent/Guardian (if under 18 yrs. Of age)

This smaller Liability/Medical Release waiver is identical to the above waiver. Please sign appropriately as this will be attached to your Sliding Permit that will be issued to you as soon as all the appropriate paperwork has been recorded.

