



STUDENT HEALTH

SANTA BARBARA, CA 93106-7002

### Designated Primary Care Provider

Dr. Elizabeth Downing is the designated primary care provider for the Recreational Sports Athletes on campus. As such, she is the treating physician of record whenever such designation is required for sharing of Protected Health Information. In her absence, any primary care physician at Student Health may assume this role.

Any Protected Health Information shared between treating physicians will become part of the Student Health medical record. Protected Health Information will not be shared with non-treating health care providers without specific written authorization. However, shared information may become the basis for rescinding the clearance for an athlete to participate in sports-related activities.

I understand and agree that this relationship will exist until I am no longer part of the Recreational Sports Program at the University of California, Santa Barbara.

Signature \_\_\_\_\_

Date \_\_\_\_\_ Perm \_\_\_\_\_

Pt. label

CLINIC RECORD CLUB SPORTS PHYSICAL EXAMINATION

Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_/\_\_\_\_ Vision: R \_\_\_\_\_ L \_\_\_\_\_ Glasses: YES  NO

Current Medications \_\_\_\_\_

Medical History Review: \_\_\_\_\_ Sport: \_\_\_\_\_

MEDICAL EXAM	WNL	ABN	comment
ENT (pupils, red reflex, nose, throat, teeth, glands, thyroid)			
CHEST (lungs, heart, chest wall)			
ABD (liver, spleen, masses)			
GU (hernia, testes)			
ORTHO (2 min exam)			
MARFAN'S (as needed)			
SPECIALTY	CL	NOT CL	COMMENT
ORTHOPEDIC CONSULTATION			SIG:
CARDIOLOGY CONSULTATION			SIG:

Clinician signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_

Perm no: \_\_\_\_\_

Page : \_\_\_\_\_

**CLUB SPORTS PREPARTICIPATION CLEARANCE HISTORY**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Perm #: \_\_\_\_\_

YES	NO	Do you now have or have you ever had:
		Chest pain or discomfort related to exertion/exercise/training?
		Fainting or nearly fainting related to exertion/exercise/training?
		Unusual or unexplained shortness of breath related to exertion/exercise/training?
		A heart murmur?
		Elevated blood pressure?
		A family member die or become disabled from cardiovascular disease before age 50?
		A family member with any heart abnormality?
		A family member with Marfan's syndrome?

**Other sudden death risks**

YES	NO	Do you now have or have you ever had:
		Undiagnosed, severe headaches?
		A diagnosis of sickle cell disease/trait or family member with sickle cell disease/trait?
		An allergic reaction severe enough to require hospital treatment?
		An injury to the chest (ex: hitting the steering wheel in a car accident)?
		Asthma?

**Risks related to sports participation**

YES	NO	Do you now have or have you ever had:
		Loss of kidney or eye?
		Skull fracture, concussion, or loss of consciousness due to head injury?
		Heat exhaustion or heat stroke?
		Visual or hearing impairment?
		Liver, kidney, or thyroid disease?
		Diabetes?
		Seizure disorder?
		Injury to an internal organ?
		Hemophilia?
		(Women only) Three or more months without a period?

**Injury assessment**

YES	NO	Do you now have or have you ever had:
		Neck or back pain or injury?
		Arm/finger/leg/foot numbness?
		Broken bones or joint dislocations?
		A need to tape a joint or joints for practice or games?
		Physical therapy?

**Miscellaneous**

YES	NO	
		Have you ever had surgery?
		Have you ever stayed over night in the hospital?
		In the past 2 weeks, have you had any illness or injury?
		In the past 12 months, have you had an illness or injury which prevented you from playing sports for 2 weeks or more? (If so, you must provide a clearance note from the treating health care provider before you will be cleared for participation.)

**You must bring a copy of your immunization record to the clearance exam.**

UCSB Recreational Sports  
**SPORTS PARTICIPATION CLEARANCE FORM**

By signing this Sports Participation Clearance Form, I acknowledge that I have performed a physical examination on the following patient:

\_\_\_\_\_

*(Please print patient's name)*

I acknowledge also that I have found this patient fit for participation in the following sport(s):

\_\_\_\_\_

*(Please print name(s) of sport(s))*

Signed: \_\_\_\_\_

*(Clinician signature)*

Date \_\_\_\_\_

Clinician name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

***Please note:*** The actual physical examination form should be filed with the patient's records at the clinic where the physical exam was performed.

***This form may be faxed to UCSB Recreational Sports at: (805) 893-5973***