

UNITED STATES LUGE ASSOCIATION

PHYSICAL EXAM FORM

57 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. Page 4 is an authorization for the release or disclosure of health information. We request this information because it is pertinent to the sport of luge and its administration and organization. Please complete all information as accurately as possible. Please note that if the athlete is a minor, a parent or guardian's 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 this athlete or the athlete's family? | _____ | _____ |
| 8. Is there a history of diabetes in this athlete or the athlete's 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 APPEND ADDITIONAL COMMENTS
TO THE BACK OF THE LAST PAGE OF THIS DOCUMENT.***

ATHLETE NAME: _____

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 that 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 medical 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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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.

**AGREEMENT TO SUBMIT TO MEDICAL EXAMINATIONS AND TESTS
AND
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

As an express condition of my residing at or participating in a United States Luge Association (USLA) program, I agree to submit to medical examination(s) and/or test(s) as directed by USLA if USLA suspects I have an injury or a medical condition that could affect or impair my athletic performance. I acknowledge that the results of such medical examination(s) and test(s) are pertinent to the USLA's administration and organization of the sport of luge, and that the failure to submit to such examination(s) or test(s) as directed by USLA is grounds for my removal from my current team status or a USLA program.

I hereby authorize any physician or any health care provider who participates in my examination or treatment of me to disclose to USLA, and to the United States Olympic Committee (USOC) in the case of any Olympic Team, any protected health information pertaining to me, including the results of any examination or treatment, for the purpose of permitting USLA, and the USOC in the case of any Olympic Team, to determine my fitness for participation in the sport of luge and my team status. This authorization shall expire in one year, on the last day of the calendar month in which you have signed this authorization.

I understand that I may revoke this authorization by sending a written revocation to the offices of the USLA, attention of the Executive Director. Such authorization shall be effective on receipt, except to the extent that action has been taken in reliance on this disclosure. I further understand that if I revoke this authorization, or refuse to authorize disclosure as provided in this paragraph, then I may be expelled from USLA programs, I may lose health benefits as a USLA athlete, and I may be removed from current team status. I further understand that any protected health information disclosed pursuant to this authorization is subject to redisclosure by the USLA and/or the USOC, and is no longer protected by the provisions of 45 CFR Parts 160 and 164.

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DATE: _____
Signature of Athlete

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

(Please do not write below this line)