**Florida Agricultural and Mechanical University**
Tallahassee, Florida 32307-4400

**M E M O R A N D U M**

TO: All Band Members

FROM: Dr. Shelby Chipman
Director of Marching and Pep Bands

DATE: May 1, 2024

**RE: PHYSICAL EXAMINATION**

YOU MUST SUBMIT PROOF OF PHYSICAL EXAMINATION FROM YOUR PHYSICIAN, WHICH STATES THAT YOU ARE PHYSICALLY ABLE TO PARTICIPATE IN MARCHING BAND. YOU MUST ALSO SUBMIT THE INSURANCE AND MEDICAL CONSENT AND LIABILITY RELEASE FORMS. YOU WILL NOT BE ABLE TO PARTICIPATE IN ANY BAND ACTIVITIES, TO INCLUDE MUSIC AND FIELD REHEARSALS WITHOUT THESE SIGNED FORMS.

**PLEASE COMPLETE AND SUBMIT THESE FORMS NO LATER THAN June 30, 2024.**

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# Florida A&M University
## Athletic Pre-Participation History

The National Collegiate Athletic Association's policies recommend that all student-athletes have a qualifying medical evaluation upon initial entrance into an institution's athletic program, and an annual "health status" review. Florida A&M University supports this NCAA policy. Further medical evaluations may be required for specific matters.

**Name** **FAMU ID #** **Date**

**Gender (M/F):** __________ **Age:** ______ **DOB:** ___________________ **Sport:** _____________________________

Year of Athletic Participation at Florida A&M University: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th

I consent to proceed with this athletic physical exam or screening. I certify that all information I give during the course of this examination is true and correct. I understand that passing the physical examination does not necessarily mean that an athlete is qualified to engage in athletics, but only that the medical evaluation did not find a medical reason to disqualify the athlete at the time of said examination. My signature affirms that I have read and understand the material above and have been given an opportunity to ask questions.

____________________________________________ ____________________________

**Athlete's Signature** **Date**

**Mark Yes or No and circle the questions you don't know the answer to:**

| | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 2. Have you ever been diagnosed or treated for high blood pressure or diabetes? | ☐ | ☐ |
| 3. Have you ever been told you have an irregular heart beat, heart murmur or other heart condition? | ☐ | ☐ |
| 4. Do you or any family member have Marfan's Syndrome? | ☐ | ☐ |
| 5. Has any family member died before the age of 50? | ☐ | ☐ |
| 6. Have you ever been diagnosed with asthma, other respiratory ailment or allergies? | ☐ | ☐ |
| 7. Do you cough, wheeze or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 8. Are you allergic to any medications, insect stings or insect bites? | ☐ | ☐ |
| 9. Have you ever been diagnosed with anemia or having an iron deficiency? | ☐ | ☐ |
| 10. Have you been diagnosed with hepatitis in the last 3 years? | ☐ | ☐ |
| 11. Have you been treated for any infectious virus in the last year? | ☐ | ☐ |
| 12. Have you ever felt faint or passes out with exercise or in the heat? | ☐ | ☐ |
| 13. Have you ever been knocked out or had a concussion within the past 3 years? | ☐ | ☐ |
| 14. Have you ever had any type of seizure or informed that you may have epilepsy? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 15. Have you had an illness or injury in the past year that required overnight hospitalization? | ☐ | ☐ |
| 16. Have you had any illness or injury that required surgery? | ☐ | ☐ |
| 17. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below. | ☐ | ☐ |
| 18. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, circle below. | ☐ | ☐ |

| Head | Neck | Shoulder | Upper Arm | Elbow | Fore-Arm | Hand/ Fingers | Chest |
|---|---|---|---|---|---|---|---|
| Upper back | Lower back | Hip | Thigh | Knee | Calf/ Shin | Ankle | Foot/ toes |

| | Yes | No |
|---|---|---|
| 19. Do you wear glasses or contact lenses when playing your sport? | ☐ | ☐ |
| 20. Do you wear protective eye wear, such as goggles or a face shield? | ☐ | ☐ |
| 21. Do you wear dental appliances or wear a hearing aid? | ☐ | ☐ |
| 22. Are you taking any prescribed or over-the-counter medication on a regular or continuous basis? | ☐ | ☐ |
| 23. Are you, your parents or grandparents of African American, African, Hispanic, Arab, Greek, Italian or East Indian descent? | ☐ | ☐ |
| 24. Have you ever been told you have sickle cell disease or trait? | ☐ | ☐ |
| **FEMALES ONLY**<br>25. Do you have or have you had any menstrual irregularities? | ☐ | ☐ |
| 26. Date of last menstrual period ___________________ | | |

Explain "Yes" answers here (use additional page if necessary):______________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Florida A&M University**
**Athletic Physical**

| **Athletic Physical Examination** | Name: ____________________<br>ID # ____________________<br>Incoming: ________ Returning: ________ |
|---|---|

Height: ________________ Weight: ____________ Pulse: ____________ BP: ______________
Vision: w/correction: R __________ L ___________ w/o correction R __________ L __________

| | NORMAL | ABNORMAL |
|---|---|---|
| **MEDICAL** | | |
| Skin | | |
| Head | | |
| Eyes | | |
| Ears | | |
| Nose | | |
| Throat & Mouth | | |
| Teeth | | |
| Neck | | |
| Lungs & Chest | | |
| Heart | | |
| Abdomen | | |
| Hernia (male athletes) | | |
| OB/GYN discussion | | |
| **MUSCULOSKETAL** | | |
| Neck | | |
| Back/Spine | | |
| Shoulders/arms | | |
| Elbows/forearms | | |
| Hips | | |
| Quadriceps/Hamstrings | | |
| Knees/Legs | | |
| Ankles | | |
| Feet/toes | | |
| **LABORATORY (please attach copies)** | | |
| Sickle cell screen | | |
| Other: | | |

☐ This athlete is cleared to participate in sport with no restrictions.
☐ This athlete is cleared to participate in sport with the following specifications: ____________________
☐ This athlete may not participate in sport for the following reasons:____________________________

______________________________________________________________

**Provider Signature**:__________________________________________ **Date:**______________

______________________________________________________________
**Physician Signature** **Date** **Office Stamp (Address/Phone/Fax # mandatory)**

05/08 TT