Athletic Training Department
Exit Physical

Name:_____________________________ Sport:_________________

Please answer the following questions by checking the appropriate box (Yes or No)

Question	YES	NO
1. Have you been hospitalized or had a major illness during your sports career at SUNY Potsdam?		
2. Have you had any operations or surgery during your career at SUNY Potsdam?		
3. Have you broken ANY bones during your athletic career at SUNY Potsdam?		
4. Did you develop or were you diagnosed with a medical illness since coming to SUNY Potsdam that you still have, such as diabetes, asthma, heart condition?		
5. Are you currently ill in any way?		
6. Are you currently taking any medication for current illness, injury, etc?		
7. Do you currently have any injury that bothers you in any way?		
8. Did you receive any injury in practice or a game that you are still bothered by?		
9. Are you currently under the care or supervision of any doctors, athletic trainers, or therapists? If yes, whom and for what reason? (Explain on back side of form?		
10. Do you expect to continue to play athletes at a high level of competition? (University, Professional level sports, Olympic competition, etc)		
11. Would you like to discuss any health concerns with the Team Physician?		

EXPLAIN ALL "YES" ANSWERS IN THE SPACE PROVIDED ON THE BACK SIDE OF THE FORM.

In signing this document I certify that the answers to the above questions are correct and true. The questions have been explained to me fully and to my satisfaction. **I further certify that I have listed all existing medical conditions and injuries to the best of my knowledge.** Charges occurring as a result of injury are my financial responsibility. I recognize that any injuries sustained after the signed date below, which are not listed on this form, will not be the responsibility of SUNY Potsdam. I may not have access to the Athletic Training Department's training facilities or Athletic Training staff for such injuries. I understand this policy clearly and I freely sign this document. I understand I may be given a copy of this document for my own records upon request.

SIGNATURE:____DATE:_____________________

ATHLETIC TRAINER:____________________________________DATE:_____________________

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Please check all that apply

Athlete referred to:

Team Physician _______________
Other _______________
No Referral Necessary _______________

(REFER TO BACK SIDE OF FORM FOR ANY "YES" ANSWERS)

Please use the space provided below to explain all questions that were answered “YES” on the previous page.