



ALBANY STATE UNIVERSITY
STUDENT ATHLETE TRYOUT PACKET

Name (First & Last): _____ Sport: _____

ATTENTION HEAD COACH: All applicable documents below must be submitted to the Sports Medicine **AT LEAST 3 DAYS PRIOR TO TRYOUTS.** Incomplete or late packages will not be accepted by Sports Medicine Staff and student(s) will NOT be able to tryout, **NO EXCEPTIONS.**

TRYOUT APPROVAL PACKAGE CHECKLIST

Please review package and ensure all information is provided to the Sports Medicine Staff at least three days prior to the planned tryout date.

Items 1 – 7 are REQUIRED.

If prospective student athlete is under age 18, please ensure parent/guardian signature where required.

- _____ 1. ***Tryout Information Sheet***
- _____ 2. Signed ***Acknowledgement of Risk Form***
- _____ 3. Completed ***Pre-participation Medical History Form***
- _____ 4. Copy of the front/back of health insurance card
- _____ 5. Completed ***Albany State University Emergency/Insurance Form***
- _____ 6. Completed ***Sickle Cell Trait Form or Waiver***
- _____ 7. Completed documentation that the prospect has had a sports physical by a doctor licensed in the state.
**Must be an official physical form/documentation provided by the examining doctor. The physical must have been administered within the past six months UNLESS the prospective student-athlete is a high school senior AND the physical was completed less than one year ago and is accepted by their high school for athletics participation during their senior year.*
- _____ 8. If applicable: ***Completed Official Visit Form***
(AT: If this form is included in package, please forward to Compliance Office with copy of checklist.)



ITEM #1:

TRYOUT INFORMATION SHEET

Prospect's Name: _____ **Sport:** _____

Date of Tryout: _____ **Time of Tryout (begins and ends):** _____

Location: _____ **In-Season:** _____ **Out-Season:** _____

(Per NCAA legislation, tryouts must occur on campus or at a site normally used to conduct practice/competition)

Complete one:

_____ **ALBANY STATE UNIVERSITY WALK-ON**

_____ **HIGH SCHOOL PROSPECT**

* Name of High School: _____

* Date of Completion of High School Eligibility in Sport: _____

- If PSA has high school eligibility remaining, is the prospect enrolled in a term during which he/she is
NOT involved in the high school sport? _____ Yes _____ No

_____ **TWO-YEAR COLLEGE PROSPECT**

* Date of Completion of Prospect's College Sport Season: _____

_____ **FOUR-YEAR COLLEGE PROSPECT**

* Date of Completion of Prospect's College Sport Season: _____

* Is written permission to contact the prospect attached/on file in Compliance Office? _____ Yes _____ No

Signature of Head Coach

Date

Signature of Albany State Athletic Trainer

Date

Associate Athletics Director for Academics/Compliance

Date



13.11.1.5 Tryout Camps. A member institution or conference may not conduct a tryout camp devoted to agility, flexibility, speed and strength tests for prospective student-athletes. A member institution's staff members may not attend such a tryout camp sponsored by an outside organization if the camp invites only representatives from selected institutions or conferences to observe the camp.

13.11.2.1 Tryouts – Permissible Activities. A member institution may conduct a tryout of a prospective student-athlete only on its campus or at a site at which it normally conducts practice or competition and only under the following conditions:

- (a) Not more than one tryout per prospective student-athlete per institution per sport shall be permitted;
- (b) The tryout may be conducted only for high school seniors who are enrolled in a term other than the term(s) in which the prospective student-athlete's high school's traditional season in the sport occurs or who have completed high school eligibility in the sport; for a two-year college student, after the conclusion of the sport season or anytime, provided the student has exhausted his or her two-year college eligibility in the sport; and for a four-year college student, after the conclusion of the sport season, provided written permission to contact the prospective student-athlete (per Bylaw 13.1.1.2) has been obtained;
- (c)) Prior to participation in a tryout, a prospective student-athlete is required to undergo a medical examination or evaluation administered or supervised by a physician (e.g., family physician, team physician). The examination or evaluation must be administered within six months prior to participation in the tryout. The medical examination or evaluation may be conducted by an institution's regular team physician or other designated physician as a part of the tryout; (*Revised: 7/24/07 effective 8/1/07*)
- (d) The tryout may include tests to evaluate the prospective student-athlete's strength, speed, agility, and sport skills. Except in the sports of football, ice hockey, lacrosse and wrestling, the tryout may include competition. In the sport of football, the prospective student-athletes shall not wear helmets or pads;
- (e)) Competition against the member institution's team is permissible, provided such competition occurs during the academic year and is considered a countable athletically related activity;
- (f) The time of the tryout activities (other than the physical examination) shall be limited to the length of the institution's normal practice period in the sport but in no event shall it be longer than two hours; and
- (g) The institution may provide equipment and clothing on an issuance-and-retrieval basis to a prospective student-athlete during the period of the tryout.

13.11.2.3 Recreational Activities. A prospective student-athlete visiting a member institution may participate in physical workouts or other recreational activities during a visit to an institution's campus, provided such activities:

- (a) Are not organized or observed by members of the athletics department coaching staff; and
- (b) Are not designed to test the athletics abilities of the prospective student-athlete



ITEM #2:

ACKNOWLEDGEMENT OF RISK FORM

Acknowledgement of Warning/Risk

By signing below, you acknowledge that you are aware there is a possibility you may incur injury of varying temporary or permanent disability to any of the body's systems at any point during the workout. Additionally, you agree to release Albany State University from any liability with regards to injury sustained.

Acknowledgement of Physical (Please check one of the below)

_____ *High School Prospective Student-Athlete* – In order for you to participate in a tryout for Albany State University you must have undergone a physical administered by a physician. This physical must have been accepted by your high school for your participation in athletics. You must have received this physical within the past 6 months or within 6 months prior to your participation in practice during your senior year in high school. By signing this form you acknowledge that you did in fact receive a physical that meets these stipulations. That physical was performed in the month of _____ in the year _____.

_____ *Two Year or Four Year Transfers* – In order for you to participate in a tryout for Albany State University you must have undergone a physical administered by a physician. This physical must have been accepted by your collegiate institution for your participation in athletics. You must have received this physical within the past 6 months or within 6 months prior to your participation in practice, competition or out of season conditioning activities at your institution. By signing this form you acknowledge that you did in fact receive a physical that meets these stipulations. That physical was performed in the month _____ of in the year _____.

Printed Name of Prospect

Signature of Prospect

Date

Sport

Current HS/College

Grade

Emergency Contacts Name

Phone Number

Relationship

If prospect is a minor (under 18), a parent/legal guardian must sign below:

Printed Name of Parent/Legal Guardian

Signature

Date

**ITEM #3:****PRE- PARTICPATION MEDICAL HISTORY**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Pre-participation Physical Evaluation

Date of Exam _____ Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

**ITEM #3 Cont'd:****PRE- PARTICIPATION PHYSICAL***(Note: This form is to be filled out by the physician. The physician should keep this form in the chart.)***Pre-participation Physical Evaluation**

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none">Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat <ul style="list-style-type: none">Pupils equalHearing		
Lymph nodes		
Heart ^a <ul style="list-style-type: none">Murmurs (auscultation standing, supine, +/- Valsalva)Location of point of maximal impulse (PMI)		
Pulses <ul style="list-style-type: none">Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none">HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none">Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.^bConsider GU exam if in private setting. Having third party present is recommended.^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.☐ Cleared for all sports without restriction☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____☐ Not cleared☐ Pending further evaluation☐ For any sports☐ For certain sports _____

Reason _____ Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO



ITEM #4: PLEASE PROVIDE A COPY OF YOUR PRIMARY INSURANCE CARD

*** * * ATTACH COPY OF INSURANCE/MEDICAID CARD * * ***

FRONT OF CARD

BACK OF CARD

**ITEM #5:****EMERGENCY AND HEALTH INSURANCE INFORMATION****Athlete's Name** _____ **Sport(s)** _____**Date of Birth** _____ **Class** _____**Local Address** _____ **Phone # (____)** _____
Street City St. zip**Parent/Guardian Name** _____**Home Address** _____ **Phone # (____)** _____
Street City St. zip**EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED****Name** _____ **Phone # (____)** _____ **Relationship** _____**MEDICAL HISTORY**

Significant Medical Conditions _____

Surgical History (and date) _____

Known Allergies _____

Current Medications _____

Ins. Company Name _____ Subscriber Name _____

Policy/ID # _____ Group # _____

Member Services Hotline (e.g. 1-800 number) _____

Medical Authorization The above statements are true to the best of my knowledge. This athlete/parent gives consent for the certified athletic trainer, team physician, and/or consulting physician to examine records, or be in consultation concerning examination or treatment of the athlete for the express purpose of evaluating the medical and/or physical fitness for participation in, or continued participation in any athletic program at Albany State University. The athlete/parent also gives permission for acceptable diagnostic, therapeutic and emergency operative procedures to be carried out in the treatment of illness and injury sustained while a member or prospect of an Albany State University intercollegiate athletic team.

Athlete Signature _____ **Date** _____**Parent Signature (if athlete is under 18)** _____ **Date** _____



Sickle-Cell Trait Information and Policy

In January 2012, NCAA adopted legislation that requires all Division II student-athletes who are beginning their initial season of eligibility and student-athletes who are trying out for a team, including current students, transfers and new recruits have their Sickle-Cell Trait status documented.

Background:

Sickle-Cell Trait (SCT) is not a disease; rather it's generally a benign condition that allows individuals to live long, productive and active lives. SCT is the inheritance of one gene of sickle hemoglobin and one for normal hemoglobin. During intense or extensive "all-out" exertion, the sickle hemoglobin can change red blood cells from their usual round shape to a quarter-moon or "sickle" shape. This change, called "exertional sickling", can pose a grave risk for some athletes as the sickled red cells can accumulate in the blood vessels during intense exercise, blocking normal blood flow to the tissues or muscles. This "logjam" of sickled red cells can lead to ischemic rhabdomyolysis or the rapid breakdown of muscles starved for blood. Exertional sickling can begin as early as 2-3 minutes of any all-out exertion; athletes with SCT have experienced significant physical distress, collapsed and even died under these conditions. Heat, dehydration, altitude and asthma can increase the risk and exacerbate the complications associated with SCT, even in situations where the exercise is not intense.

SCT is a condition of inheritance, not race; centuries ago it offered protection against death from malaria. It can be found in all segments of the American population, African-Americans (8%), Hispanics (0.5%) as well as Caucasian Americans (0.2%). SCT is also present in people of Mediterranean, Middle Eastern, Indian, Caribbean and South and Central American decent. Thus, there is universal SCT screening for newborns across the US in all 50 states; some other countries have also adopted this same screening strategy. Therefore, this information should be a standard element of one's personal health information.

Student-athletes with SCT should not be, and generally are not, excluded from participation. Rather, the knowledge of SCT will allow simple precautions that may prevent collapse and give affected student-athletes the accommodation necessary to succeed in their athletic activity.

Sickle-Cell Trait Status Policy:

The NCAA and the Albany State University Department of Athletics encourages all student-athletes to confirm their SCT status, if unknown, via a sickle-cell solubility test. The University will comply with the NCAA Division II legislation (Bylaw 17.1.5.1) by requiring student-athletes, including all prospects (e.g., recruits), to have their SCT status documented* in ONE (1) of the following three (3) ways:

1. Provide documentation of their known SCT status (e.g., newborn test results).
2. If SCT status is unknown, provide results of a sickle cell solubility test.
 - This test would be at the student-athlete's own expense.
3. Sign the attached declination statement waiving the sickle-cell solubility test and releasing the College of any liability.

**This documentation must be on file with the Sports Medicine staff BEFORE participation will be allowed in any capacity, including weight training. A delay in the student-athlete's participation start date may occur if documentation is not received in a timely manner.*



ITEM #6 Cont'd:

SICKLE CELL TRAIT INFORMATION AND POLICY

After reading the Sickie-Cell Trait Information and Policy, please check one of the following:

☐

I have been screened for Sickie-Cell Trait in the past and my status is:

_____ Negative

_____ Positive

- I understand that I am required to submit a copy of my test results and will not be released to participate in any intercollegiate athletic activities (including weight lifting) until my results are received and accepted by the Sports Medicine staff.

☐

I acknowledge that I have read the Albany State University Department of Athletics Sports Medicine Sickie-Cell Trait Information and Policy and attest to the following:

- I completely understand the Statement and have had the opportunity to ask questions and have received adequate answers and explanations.
- **I willfully agree that it is in my best interest to confirm my Sickie-Cell Trait status and will obtain a sickie-cell solubility test.**
- I have been informed that such testing will be at my own expense.
- I must submit the test results to the Sports Medicine staff **BEFORE** I will be released to participate in any intercollegiate athletic activities, including wt. lifting.

☐

I acknowledge that I have read the Albany State University Department of Athletics Sports Medicine Sickie-Cell Trait Information and Policy and attest to the following:

- I completely understand the Statement and have had the opportunity to ask questions and have received adequate answers and explanations.
- I am fully aware of the risks associated with participation in strenuous and intense athletic activities if I have the Sickie-Cell Trait.
- I also understand that the Department of Athletics has encouraged all student-athletes to confirm their Sickie-Cell Trait status via a sickie-cell solubility test.
- **I voluntarily choose not to be tested for Sickie-Cell Trait at this time.**
- As such, I agree to accept all risk associated with strenuous and intense training and intercollegiate competition and being duly informed, release Albany State University, the Southern Intercollegiate Athletics Conference and the NCAA and all of their employees and representatives of any and all liability.

Student-Athlete Name (Print): _____

Student-Athlete Signature: _____ Date: _____

If Student-Athlete is under 18 years:

Parent/guardian Name (Print): _____

Parent/guardian Signature: _____ Date: _____



ITEM #7:

ATTACH PHYSICAL FROM PHYSICIAN

****If you have already had a physical in the past 12 months, please attached the documentation from your physician as proof that you have had a sports physical by a licensed physician and are cleared to participate in sports. The form must be an official physical form/documentation provided by the examining physician.*



ITEM #8:

ATTACH OFFICIAL VISIT REQUEST FORM

****If you are on an official request, please attach the official request form (if appropriate).*