Omega Sports Academy International

Thomasville, GA 31792
Phone: 1-229-598-7176
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Athlete Physical Form

Athlete's Information

Full Name: _____ Date:__
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email__

Sport Program:
(circle Sport you want to participate in) **Football** **Women's Basketball** **Men's Basketball** **Softball**

Session Registering for:
(circle ALL sessions you will attend) **Spring 2024** **Fall 2024** **Spring 2025** **Fall 2025**

Country of Citizenship: _

Parent's Information

Father: _____ Date:__
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

Phone:__
City *State* *ZIP Code*

Mother: _____ Date:_____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

Phone:__
City *State* *ZIP Code*

Person to Contact other than Parents in an Emergency

Full Name:_____ Relationship:_____ **Phone:__**

Insurance Information

It is mandatory to show proof of medical insurance to attend the Academy. Failure to show proof or submit false information will forfeit roster spot and all fees and deposits paid.

Insurance Company Name: _____ Policy #: _

Name of Policy Holder: _____ Group #: _

Address:_____
Street Address

_____
City *State* *ZIP Code*

Type of Insurance: HMO ☐ PPO ☐ Other ☐

Dental Benefits: Yes ☐ No ☐

Vision Benefits: Yes ☐ No ☐

I understand that false or misleading information in my application may result in my release from OSAI.

Athlete Signature: _____ Date:__

Parent/Guardian Signature:_____ Date:__
(required if athlete is under 18 years old)

Medical History and Information

Family Medical History:

- Mother Deceased? ☐ YES ☐ NO If Deceased, Age of Death: _____
  Cause: _____
- Father Deceased? ☐ YES ☐ NO If Deceased, Age of Death: _____
  Cause: _____
- Brother Deceased? ☐ YES ☐ NO If Deceased, Age of Death: _____
  Cause: _____
- Sister Deceased? ☐ YES ☐ NO If Deceased, Age of Death: _____
  Cause: _____

*Have YOU or any Blood Relative (*Parents, Grandparents, Brothers/Sisters) *ever had any of the following:*

- Anemia ☐ YES ☐ NO If Yes, Who: _____
- Arthritis ☐ YES ☐ NO If Yes, Who: _____
- Asthma ☐ YES ☐ NO If Yes, Who: _____
- Bleeding Disorder ☐ YES ☐ NO If Yes, Who: _____
- Cancer ☐ YES ☐ NO If Yes, Who: _____
- Depression ☐ YES ☐ NO If Yes, Who: _____

*Have YOU or any Blood Relative (*Parents, Grandparents, Brothers/Sisters) *ever had any of the following: (Cont.)*

- Diabetes ☐ YES ☐ NO If Yes, Who:_____
- Epilepsy/ Seizures ☐ YES ☐ NO If Yes, Who: _____
- Gout ☐ YES ☐ NO If Yes, Who: _____
- Heart Disease ☐ YES ☐ NO If Yes, Who: _____
- High Blood Pressure ☐ YES ☐ NO If Yes, Who: _____
- High Cholesterol ☐ YES ☐ NO If Yes, Who: _____
- Kidney Problems ☐ YES ☐ NO If Yes, Who: _____
- Liver Problems ☐ YES ☐ NO If Yes, Who: _____
- Lung Disease ☐ YES ☐ NO If Yes, Who: _____
- Marfan's Syndrome ☐ YES ☐ NO If Yes, Who: _____
- Mental Illness ☐ YES ☐ NO If Yes, Who:_____
- Phlebitis/Blood Clots ☐ YES ☐ NO If Yes, Who: _____
- Stomach Ulcers ☐ YES ☐ NO If Yes, Who: _____
- Stroke ☐ YES ☐ NO If Yes, Who: _____
- Thyroid Trouble ☐ YES ☐ NO If Yes, Who: _____
- Tuberculosis ☐ YES ☐ NO If Yes, Who: _____
- Urinary Problems ☐ YES ☐ NO If Yes, Who: _____

Personal History

Have you ever had:

Measles/ German Measles	☐ YES ☐ NO	High/Low Blood Pressure	☐YES ☐NO
Infectious Mononucleosis	☐ YES ☐ NO	Polio/Meningitis	☐YES ☐NO
Rheumatic Fever	☐ YES ☐ NO	Gallbladder Problems	☐YES ☐NO
Whooping Cough	☐ YES ☐ NO	Bladder/Urinary Tract Issue	☐YES ☐NO
Chicken Pox	☐ YES ☐ NO	Frequent Diarrhea	☐YES ☐NO
Mumps	☐ YES ☐ NO	Constipation	☐YES ☐NO
Pneumonia	☐ YES ☐ NO	Colitis	☐YES ☐NO
Hepatitis	☐ YES ☐ NO	Rectal Bleeding	☐YES ☐NO
Frequent Colds/Sore Throats	☐ YES ☐ NO	Enlarged Glands	☐YES ☐NO
Frequent/Severe Headaches	☐ YES ☐ NO	Temporary/Permanent Paralysis	☐YES ☐NO
Nervous Breakdown	☐ YES ☐ NO	Birth Defects	☐YES ☐NO
Palpitations/Irregular Heartbeat	☐ YES ☐ NO	Night Sweats	☐YES ☐NO
Heart Murmur	☐ YES ☐ NO	Skin Problems	☐YES ☐NO
Chest Pain	☐ YES ☐ NO	Frequent Skin Infections	☐YES ☐NO
Dizziness or Fainting	☐ YES ☐ NO	MRSA/Staph Infection	☐YES ☐NO
Shortness of Breath/Wheezing	☐ YES ☐ NO	Gonorrhea/Syphilis/Herpes	☐YES ☐NO
Problems with Nose/Sinuses	☐ YES ☐ NO	Eating Disorders	☐YES ☐NO
Sickle Cell Anemia/Trait	☐ YES ☐ NO	Hernia	☐YES ☐NO

Have you passed out during or after exercises? ☐YES ☐NO If yes, when?_____

Have you been a doctor's care in the past 12 months? ☐YES ☐NO If yes, when? _____

Have you had or do you have now:

- Heat Stroke or Heat Exhaustion ☐YES ☐NO If yes, when? _____
- Concussion or Severe Head Injury ☐YES ☐NO If yes, when? _____
- Loss of Memory or Amnesia ☐YES ☐NO If yes, when? _____
- Poor Vision in One Eye ☐YES ☐NO If yes, when? _____
- Temporary Loss of Vision ☐YES ☐NO If yes, when? _____
- Wear Glasses or Contact Lenses ☐YES ☐NO If yes, when? _____
- Orthodontic Work (Braces) ☐YES ☐NO If yes, when? _____

- Hearing Loss ☐ YES ☐ NO If yes, when? _____
- Discharge from Ear ☐ YES ☐ NO If yes, when? _____
- Trouble with Gums or Teeth ☐ YES ☐ NO If yes, when? _____
- A Reaction to Insect Bites or Stings ☐ YES ☐ NO If yes, when? _____
- A Reaction to any Medications ☐ YES ☐ NO If yes, when? _____
- Tendency to Bleed or Bruise Easily ☐ YES ☐ NO If yes, when? _____
- Loss of Testicle Function ☐ YES ☐ NO If yes, when? _____

Allergies

Are you allergic to:

Penicillin	☐ YES ☐ NO	Bee Stings	☐ YES ☐ NO
Sulfa	☐ YES ☐ NO	Mold/Dust	☐ YES ☐ NO
Aspirin	☐ YES ☐ NO	Pollen	☐ YES ☐ NO
Mycins / Other Antibiotics	☐ YES ☐ NO	Adhesive Tape	☐ YES ☐ NO
Tetanus Antitoxin/Serums	☐ YES ☐ NO	Latex	☐ YES ☐ NO
Codeine	☐ YES ☐ NO	Cold Treatment	☐ YES ☐ NO

Please List All Other Allergies

Can you take Aspirin? ☐ YES ☐ NO

Have you had a Tetanus Shot ☐ YES ☐ NO When: _____

Social History

Smoke Cigarettes ☐ YES ☐ NO If yes, Packs per day _____

Drink Alcohol ☐ YES ☐ NO If yes, Social ☐Daily ☐Heavy ☐

Substance Abuse ☐ YES ☐ NO If yes, Social ☐Daily ☐Heavy ☐

Athletic Injuries and Surgeries

Have you ever had an athletic injury and/or surgery to the following?

- Head/Face ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Neck ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Shoulder ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Elbow/Forearm ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Chest/Abdomen ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Back/Spine ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Wrist/Hand ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Finger ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Hip/Pelvis ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Thigh ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Knee ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Lower Leg ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Ankle ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Foot ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____
- Toes ☐ YES ☐ NO Date of Injury:_____Type of Injury: _____

List any Surgeries, Illnesses, and/or Hospitalizations in the Past 2 Years:

Medical Reason	Date

Type of Surgery	Date

Medication

Please List all Medications That are Being Taken. Include Name, Dosage, and Frequency

None □

Women's Health History

Is your menstrual cycle regular? ☐YES ☐NO

Age of onset _____

Date of last Gynecological exam ----------_____

Have you ever had an abnormal pap smear? ☐ YES ☐ NO

Is heavy bleeding an issue? ☐ YES ☐ NO

Do you experience bleeding between periods? ☐ YES ☐ NO

Is severe cramping an issue? ☐ YES ☐ NO

Have you ever been pregnant? ☐ YES ☐ NO

Are you currently on birth control medication? ☐ YES ☐ NO

Do you experience frequent urinary tract infections? ☐ YES ☐ NO

ALL STUDENT-ATHLETES MUST SIGN BELOW

I do hereby state that, to the best of my knowledge and belief, the medical history that I have provided is correct and accurate. I fully understand that any attempts to mislead the medical staff about my medical history may result in revocation of my privilege to be an athlete at the Omega Sports Academy International. I hereby authorize the Athletic Training Staff and/or Coaching Staff of the Omega Sports Academy International to secure all medical treatment and medical records, including diagnostic testing, physical exams, and hospital procedures. I authorize the Omega Sports Academy International staff to secure all medical treatment and I authorize any hospital and/or attending medical personnel to render medical treatment for my son/daughter.

Athlete Signature: _____ Date:__

Parent/Guardian Signature:_____ Date:__
(required if athlete is under 18 years old)

Doctors Physical Examination

Date: _____

Name:_____ Date of Birth:_____ Sex: M / F

Age:_____Sport:_____

Height:_____ Weight:_____lbs BP:_____ Pulse:_____

Vision: R 20/_____L 20/_____Corrected: Y / N Contacts:_____Glasses:_____

FINDINGS	NORMAL	ABNORMAL FINDINGS
1. APPEARANCE	_____	_____
2. EYES/EARS/NOSE/THROAT	_____	_____
3. LYMPH NODES	_____	_____
4. HEART	_____	_____
5. PULSE	_____	_____
6. LUNGS	_____	_____
7. ABDOMEN	_____	_____
8. GENITALIA (MALES ONLY)	_____	_____
9. SKIN	_____	_____

GENERAL ORTHOPEDIC SECTION (PLEASE CHECK FOR NORMAL EXAM & DESCRIBE ABNORMALITIES IN SPACE PROVIDED)

1. Cervical Spine: NROM_____NT_____ _____
2. Thoracic Spine: NROM_____NT_____ _____
3. Lumbar Spine: NROM_____NT_____ _____
4. Sacroiliac: NROM_____NT_____ _____
5. Shoulder (R): NROM_____NT_____ _____
6. Shoulder (L): NROM_____NT_____ _____
7. Elbow (R): NROM_____NT_____ _____
8. Elbow (L): NROM_____NT_____ _____
9. Wrist/Hand (R): NROM_____NT_____ _____
10. Wrist/Hand (L): NROM_____NT_____ _____
11. Hip (R): NROM_____NT_____ _____
12. Hip (L): NROM_____NT_____ _____
13. Knee (R): NROM_____NT_____ _____
14. Knee (L): NROM_____NT_____ _____
15. Ankle/Foot (R): NROM_____NT_____ _____
16. Ankle/Foot (L): NROM_____NT_____ _____

Assessment: _____

ATHLETE: (MAY) (MAY NOT) participate at the Omega Sports Academy International

Additional Workup / Testing / Rx / Referral Necessary? No / Yes_____

Clearance pending release for: _____

Primary Care/ Sports Medicine Physician Signature: _____

Print Name:_____**Date:**____/____/____ Ph:_____

Doctor's Office Stamp (Must be Stamped to prevent fraud):

Omega Sports Academy International Inc. Shared Responsibility for Sport Safety Acknowledgement (the "Acknowledgement")

While benefits from athletic participation may be great, there are also serious risks involved in competition and preparation for competition. The responsibility for sport safety is a shared effort between administrators, coaches, physicians, athletic trainer, and student-athletes. Both participants and parent(s) are hereby advised that participation in athletics may lead to serious injuries and bodily harm, including the possibility of permanent physical or mental disability, partial or complete paralysis, or death. By signing below, I acknowledge that I have been informed of the risks associated with sports participation, and that it is my responsibility to help prevent injuries, comply with directions and instructions given by the Academy athletic staff, and constantly being aware of such risks and the prevention of injury to myself and to others.

I have read this acknowledgement and agree to assume responsibility for such risks while participating in athletics all or in connection with the OSAI. In the event that I am in need of medical care, I have primary insurance coverage in effect and will take full and complete responsibility to keep my insurance policy premiums paid while I am a student athlete. I understand that the OSAI offers supplementary insurance that can be billed for remaining medical expenses After my primary insurance has been processed. I also understand that any medical care balance remaining after all applicable insurance has been processed is solely my responsibility to pay, and that the OSAI has no liability therefore, I am aware that if let my primary insurance lapse for any reason, I will be ineligible to participate in practice or collegiate competitions.

Athlete Signature: _____ Date:__

Parent/Guardian Signature:_____ Date:__
(required if athlete is under 18 years old)

What is a concussion?

A concussion is a type of traumatic brain injury. It follows a force to the head or body and leads to a change in brain function. It is not typically accompanied by loss of consciousness.

How can I tell if an athlete has a concussion?

You may notice the athlete …

- Appears dazed or stunned
- Forgets an instruction
- Is confused about an assignment or position
- Is unsure of the game, score or opponent
- Appears less coordinated
- Answers questions slowly
- Loses consciousness

Note that no two concussions are the same. All possible concussions must be evaluated by an athletic trainer or team physician.

The athlete may tell you he or she is experiencing …

- A headache, head pressure or that he or she doesn't feel right following a blow to the head
- Nausea
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy or foggy
- Confusion, concentration or memory problems

What can I do to keep student-athletes safe?

	Preseason	In-Season	Time of Injury	Recovery
What can I do?	Create a culture in which concussion reporting is encouraged and promoted.	Know the signs and symptoms of concussions.	Remove athletes from play immediately if you think they have a concussion and refer them to the team physician or athletic trainer.	Follow the recovery and return-to-play protocol established by team physicians and athletic trainers.
Why does it matter?	Athletes who don't immediately seek care for a suspected concussion take longer to recover.	The more people who know what to look for in a concussed athlete, the more likely a concussion will be identified.	Early removal from play can mean a quicker recovery and help avoid serious consequences.	Team physicians and athletic trainers have the training to follow best practices related to the concussion recovery process.
Tips and strategies	Be present when your team physician or athletic trainer provides concussion education material to your team. Tell your team that this matters to you.	Check in with your team physician or athletic trainer if you want to learn more about concussion safety.	Provide positive reinforcement when an athlete reports a suspected concussion.	Tell athletes that decisions related to their return to play and health are entirely in the hands of the team physician and athletic trainer.

Concussion and Injury Reporting Acknowledgement

Concussion Fact Sheet (please read first before signing):

_____ ⟪ Initial ⟫ I understand that it is my responsibility to report all injuries and illnesses to my Athletic Trainer and/or Team Physician.

_____ ⟪ Initial ⟫ I have read and understand the NCAA Concussion Fact Sheet.

After reading the NCAA Concussion Fact Sheet, I am aware of the following information:

_____ ⟪ Initial ⟫ A concussion is a brain injury, which I am responsible for reporting to my Athletic Trainer and/or team Physician.

_____ ⟪ Initial ⟫ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

_____ ⟪ Initial ⟫ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_____ ⟪ Initial ⟫ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my Athletic Trainer and/or Coach.

_____ ⟪ Initial ⟫ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

_____ ⟪ Initial ⟫ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

_____ ⟪ Initial ⟫ In rare cases, repeat concussions can cause permanent brain damage, and even death.

I, the undersigned athlete at the Omega Sports Academy International, acknowledge the NCAA requirement that student-athletes at the Omega Sports Academy International accept responsibility for reporting their personal injuries and illness to the Omega Sports Academy International Athletic Training Staff, which may include, but is not limited to, signs and symptoms of concussions. Furthermore, I acknowledge that I have received the NCAA concussion education materials.

Athlete Signature: _____ Date:__

Parent/Guardian Signature:_____ Date:__
(required if athlete is under 18 years old)