

**UNIVERSITY OF WASHINGTON ATHLETIC TRAINING ROOM  
REQUIREMENTS FOR ALL CREW TRY OUTS**

In order for the tryout procedure to run smoothly we have provided the following three forms:

- 1. CRITERIA FORM**
- 2. WAIVER FORM**
- 3. BLANK PHYSICAL FORM**

Please read the criteria form and then fill out the waiver form. Some physicians may ask for a blank physical form. We have provided one if you need it. If you are using their form make sure all the required information is on it.

**Scroll Down**



UNIVERSITY OF WASHINGTON ATHLETIC TRAINING ROOM  
CRITERIA FOR ALL "CREW" TRY OUTS

1. Proof of physical within the last six months by one of these providers, an MD (Medical Doctor), a Physician Assistant (PA), a Nurse Practitioner (LNP), or a DO (Doctor of Osteopathy) indicating you are cleared to participate without restriction(s). It needs to have the name, address, phone number of the clinic and the provider's name on the form. It needs to be signed and dated by him/her. If he/she requests a blank physical form from us prior to your physical see attached.
2. Proof of medical insurance. Proof of medical insurance includes:
  - a. A legible copy of your insurance card front and back **(the actual card is preferable)**  
**OR**
  - b. The following information: Insurance Plan Name, Subscriber Name (Subscriber means the person who the plan is under - ie. mom, dad, you, etc), Subscriber's Phone Number, Subscriber ID Number, Group Number, and Insurance Plan Phone Number.
3. Sickle Cell Trait Status: 1) documentation of sickle cell trait status, 2) or signature on waiver declining a sickle cell blood test.
4. Fill out the waiver form completely. If you have a legible copy (front and back) of your insurance card or the actual card for us to copy then you will not need to fill out the insurance information section. In the section "Check the following:" under "I have disclosed all medical conditions that may impact my ability to participate in rigorous athletic activities. They are the following:" Here are some examples that may apply to you:
  - a. If you are asthmatic and use an inhaler
  - b. Allergic to bees and require an epi pen (indications for use)
  - c. Require glucose for diabetes
  - d. Or any other medical conditions we need to be aware of.

**If you don't have any medical conditions we should be aware of check the first line.**

**If you are under the age of eighteen a parent or legal guardian must also sign the waiver.**

The try out period for men's and women's crew is one month.

If you make the team and are added to the official roster you will then be required to have an official pre-participation examination by a University of Washington Team Physician. These exams must be scheduled through the athletic training room. After passing the pre-participation physical exam you will be eligible to compete as a University of Washington student-athlete.

**ALL FORMS MUST BE FILLED OUT AND SIGNED IN BLUE/BLACK INK.**



## Preparticipation Physical Evaluation

Name _____	Date of Birth _____
Height _____	Weight _____
Pulse _____	BP ____/____ (____/____, ____/____)
Vision R 20/____ L 20/____ Corrected: Y____ N____ (contacts/ glasses)	
List any known allergies: _____	

**NORMAL**

**ABNORMAL FINDINGS**

**INITIALS**

<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/ Arm			
Elbow/ Forearm			
Wrist/ Hand			
Hip/ Thigh			
Knee			
Leg/ Ankle			
Foot			

<input type="checkbox"/> Cleared	
<input type="checkbox"/> Cleared after completing evaluation/ rehabilitation for:	
_____	
_____	
<input type="checkbox"/> Not cleared for (Reason/ Recommendations):	
_____	
_____	
Name of physician (print/type) _____	Date _____
Clinic Name & Address _____	
_____	
Phone# _____	
Signature of physician _____, MD or DO	

**UNIVERSITY OF WASHINGTON  
ASSUMPTION OF RISK RESPONSIBILITY WAIVER FOR:**

**WOMEN'S NOVICE CREW**

\_\_\_\_\_  
**Print Legal Name Of Athlete**

**Sport**

I have been informed and fully understand that the University of Washington is **not** responsible in the event of an injury or illness incurred as a result of/or during an athletic tryout. I hereby waive all future claims against the University of Washington and specifically the Department of Intercollegiate Athletics, arising out of such an athletic tryout. I am aware that if medical care arising out of such an athletic tryout becomes necessary, it is my own responsibility to seek such care and I agree to assume full responsibility for any financial charges incurred.

I have been examined by a by a licensed Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (LNP), or Doctor of Osteopathy (DO) and **will submit, prior to tryout**, a signed physical examination document. This document will verify that I am in good health and may participate without any restrictions.

My tryout period for **WOMEN'S NOVICE CREW** starts **SEPTEMBER 29<sup>th</sup>, 2011** and ends **OCTOBER 31<sup>st</sup>, 2011**. I do understand that if I am selected to become a member of a University of Washington team, I must undergo an Intercollegiate Athletic physical examination which will be administered by the ICA Medical Staff.

**Check the following:**

- \_\_\_\_\_ I have no known medical conditions that would prevent me from participating in rigorous athletic activities.
- \_\_\_\_\_ I have provided documentation of my Sickle Cell Trait status to the University of Washington Sports Medicine staff.
- \_\_\_\_\_ I have been made aware of the necessity of sickle cell trait testing and decline a blood test .
- \_\_\_\_\_ I have disclosed all medical conditions that may impact my ability to participate in rigorous athletic activities. They are the following:

\_\_\_\_\_  
\_\_\_\_\_

In the unlikely event that I might be unable to provide information to the proper authorities, I wish it to be known that the name of my insurance company is:

Insurance Plan Name: \_\_\_\_\_  
\*Subscriber Name: \_\_\_\_\_  
\*Subscriber's Phone Number: \_\_\_\_\_  
\*Subscriber ID#: \_\_\_\_\_  
Group#: \_\_\_\_\_  
Insurance Plan Phone#: \_\_\_\_\_

\*Subscriber means the person who the plan is under (ie. mom, dad, you, etc)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

If under the age of 18, this form must be signed by a parent or legal guardian.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Athlete

\_\_\_\_\_  
Authorized by UW Training Room Staff