



Prestige Worldwide Sports Academy

4302 Hollywood Blvd. #144

Hollywood, FL 33021

Phone 1 (863) 703-4644

Email: info@pwsportsacademy.com

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** **Tennis** **Soccer** **Basketball** **Baseball**

Session Registering for:
(circle ALL sessions you will attend) **Spring 2021** **Fall 2021** **Spring 2022** **Fall 2022**

Country of Citizenship: _____

Parent's Information

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

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____

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

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____

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 PWSA.

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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Epilepsy/ Seizures | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Gout | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • High Cholesterol | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Kidney Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Liver Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Lung Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Marfan's Syndrome | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Mental Illness | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Phlebitis/Blood Clots | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Stomach Ulcers | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Thyroid Trouble | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |
| • Urinary Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | If Yes, Who: _____ |

Personal History

Have you ever had:

- | | | | |
|----------------------------------|--|-------------------------------|--|
| Measles/ German Measles | <input type="checkbox"/> YES <input type="checkbox"/> NO | High/Low Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Infectious Mononucleosis | <input type="checkbox"/> YES <input type="checkbox"/> NO | Polio/Meningitis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO | Gallbladder Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Whooping Cough | <input type="checkbox"/> YES <input type="checkbox"/> NO | Bladder/Urinary Tract Issue | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chicken Pox | <input type="checkbox"/> YES <input type="checkbox"/> NO | Frequent Diarrhea | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mumps | <input type="checkbox"/> YES <input type="checkbox"/> NO | Constipation | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pneumonia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Colitis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rectal Bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent Colds/Sore Throats | <input type="checkbox"/> YES <input type="checkbox"/> NO | Enlarged Glands | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent/Severe Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO | Temporary/Permanent Paralysis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Nervous Breakdown | <input type="checkbox"/> YES <input type="checkbox"/> NO | Birth Defects | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Palpitations/Irregular Heartbeat | <input type="checkbox"/> YES <input type="checkbox"/> NO | Night Sweats | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO | Skin Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO | Frequent Skin Infections | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Dizziness or Fainting | <input type="checkbox"/> YES <input type="checkbox"/> NO | MRSA/Staph Infection | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Shortness of Breath/Wheezing | <input type="checkbox"/> YES <input type="checkbox"/> NO | Gonorrhea/Syphilis/Herpes | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Problems with Nose/Sinuses | <input type="checkbox"/> YES <input type="checkbox"/> NO | Eating Disorders | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sickle Cell Anemia/Trait | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hernia | <input type="checkbox"/> YES <input type="checkbox"/> 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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Concussion or Severe Head Injury | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Loss of Memory or Amnesia | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Poor Vision in One Eye | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Temporary Loss of Vision | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Wear Glasses or Contact Lenses | <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, when? _____ |
| • Orthodontic Work (Braces) | <input type="checkbox"/> YES <input type="checkbox"/> 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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | Bee Stings | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sulfa | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mold/Dust | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Aspirin | <input type="checkbox"/> YES <input type="checkbox"/> NO | Pollen | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mycins / Other Antibiotics | <input type="checkbox"/> YES <input type="checkbox"/> NO | Adhesive Tape | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Tetanus Antitoxin/Serums | <input type="checkbox"/> YES <input type="checkbox"/> NO | Latex | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Codeine | <input type="checkbox"/> YES <input type="checkbox"/> NO | Cold Treatment | <input type="checkbox"/> YES <input type="checkbox"/> 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 Prestige Worldwide Sports Academy. I hereby authorize the Athletic Training Staff and/or Coaching Staff of the Prestige Worldwide Sports Academy to secure all medical treatment and medical records, including diagnostic testing, physical exams, and hospital procedures. I authorize the Prestige Worldwide Sports Academy 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 Prestige Worldwide Sports Academy

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):

Prestige Worldwide Sports Academy (Home Court Consulting LLC) 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 PWSA. 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 PWSA 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 PWSA 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 Prestige Worldwide Sports Academy, acknowledge the NCAA requirement that student-athletes at the Prestige Worldwide Sports Academy accept responsibility for reporting their personal injuries and illness to the Prestige Worldwide Sports Academy 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)