Department of Physical Therapy
College of Health and Human Sciences
2410 Health Sciences Building | 600 Moye Boulevard | Mail Stop 668
East Carolina University® | Greenville, NC 27834-4354
252-744-6239 office | 252-744-6240 fax | https://pt.ecu.edu/

Raleigh Raptors/ECU Physical Therapy Hockey Screening Waiver

Testing Objectives: I understand that the tests that are about to be administered to the athlete are for the purpose of identifying the athlete's underlying movement compensation patterns, muscular or mobility deficets, and assessing power/agility/speed. The athlete will complete a series of tests aimed at understanding their mobility, strength, power, and endurance. Based on the data collected from each test, it can identify areas for improvement and establish a plan to optimize performance and decrease injury risk.

Explanation of Procedures: The hockey screening is composed of seven stations assessing ankle range of motion, hip range of motion, hip strength, counter movement jumps, pro agility test, 40m sprint, and 300 yard shuttle. These stations are implemented to assess available range of motion in the hips and ankles, hip strength, change of direction, leg power, sprint speed, endurance.

Description of Potential Risks: I understand that there exists a small possibility of injury to the athlete during these movements. The risk for injury during this screen does not exceed the risk of participating in a typical hockey practice. Professional care throughout the entire testing process should provide appropriate precaution against such problems.

Benefits to be Expected: I understand that the results of these tests will be shared with the coaching staff, the athlete and legal guardian. Based on the results of the tests, a suggested list of exercises that can be done as a warm-up, cool-down, and/or in conjunction with my strength training regimen will be provided. This does NOT replace any current sport-specific training set forth by any coaches, trainers, etc. If further evaluation or treatment of injury/weakness by physical therapist is warranted and the athlete/family is interested, further evaluation and treatment can be performed by a local provider. This is not required and you may decline or seek treatment at the clinic of your choice.

I have read the foregoing information and understand it. Questions concerning these procedures have been answered to my satisfaction. I also understand that I/the athlete is free to deny answering any questions during the evaluation process, or to withdraw consent and discontinue participating in any procedures. I have also been informed that the information derived from these tests is confidential and will not be disclosed to anyone other than the coaches, the athlete and legal guardian without my permission.

If you have any questions regarding the screening prior to the test date, do not hesitate to contact us with any concerns. This is a free screening provided by ECU Physical Therapy Department Faculty, Staff and Students.

In the last year have you missed more than one week due to muscle, joint or ligament pain? Y / N
In the last year have you been diagnosed by a medical provider with a concussion? Y / N

Athlete Printed Name:_____ Signature:_____Date:_____

Legal Guardian Printed Name:_____ Signature:_____Date:_____