

WILMINGTON COLLEGE
PREPARTICIPATION MEDICAL HISTORY EVALUATION

NAME _____ BIRTHDATE _____ DATE _____
 SPORTS _____ YEAR IN SCHOOL _____ SS# _____
 PERSONAL PHYSICIAN _____ PHYSICIAN'S PHONE # _____

EXPLAIN ALL YES ANSWERS ON THE SPACE PROVIDED ON THE NEXT PAGE.

- | | | YES | NO |
|---|--|-----|-----|
| 1. Are you under a physician's care for any reason now? | | ___ | ___ |
| 2. Have you ever had shortness of breath during exercise..... | | ___ | ___ |
| 3. Have you ever passed out(Unconscious) during or after exercise? | | ___ | ___ |
| 4. Have you ever been dizzy during or after exercise? | | ___ | ___ |
| 5. Have you ever had chest pain during or after exercise? | | ___ | ___ |
| 6. Do you tire more quickly than your friends during exercise? | | ___ | ___ |
| 7. Have you ever had high blood pressure? | | ___ | ___ |
| 8. Have you ever experienced or been told you have cardiovascular problems... | | ___ | ___ |
| 9. Have you ever been told you have a heart murmur or irregular rhythm? | | ___ | ___ |
| 10. Have you ever had racing of your heart or skipped beats? | | ___ | ___ |
| 11. Do you have any family (immediate) history of sudden death, cardiac disease, valvular heart disease, Marfans syndrome, asthma, or fainting spells?..... | | ___ | ___ |
| 12. Have you ever taken medication for high blood pressure?..... | | ___ | ___ |
| 13. Are you presently taking any medications or pills? | | ___ | ___ |
| 14. Are you missing any organs (kidney, spleen, eye, testicle, etc)? | | ___ | ___ |
| 15. Have you ever been hospitalized? | | ___ | ___ |
| 16. Have you ever had surgery (i.e. tonsillectomy, arthroscopy, etc.)?..... | | ___ | ___ |
| 17. Do you have any allergies (hayfever, hives, and eczema | | ___ | ___ |
| medicines, stinging insects, etc.)? | | ___ | ___ |
| 18. Do you have asthma or do you have trouble breathing or cough | | | |
| during or after activity? | | ___ | ___ |
| 19. Do you have, or have you had in the last six months, skin rashes? | | ___ | ___ |
| 20. Have you ever had a head injury? | | ___ | ___ |
| 21. Have you ever been knocked out or unconscious? | | ___ | ___ |
| 22. Have you ever had a memory loss from any cause? | | ___ | ___ |
| 23. Have you every had a seizure? | | ___ | ___ |
| 24. Have you ever had a stinger or burner or pinched nerve? | | ___ | ___ |
| 25. Have you ever had heat or muscle cramps? | | ___ | ___ |
| 26. Have you ever been dizzy or passed out due to the heat? | | ___ | ___ |
| 27. Do you use any special equipment (pads, braces, neck rolls, | | | |
| mouth guard, eye guards, etc.)?..... | | ___ | ___ |
| 28. Have you had any problems with eyes or vision? | | ___ | ___ |
| 29. Do you wear glasses or contacts or protective eyewear? | | ___ | ___ |
| 30. Have you ever sprained/strained, dislocated, broken or had repeated | | | |
| swelling of any of the following? | | ___ | ___ |
| ___Head ___ Shoulder ___ Thigh ___ Neck ___ Elbow ___ Knee ___ Chest ___ Forearm | | | |
| ___Shin/Calf ___ Back ___ Wrist ___ Ankle ___ Hip ___ Hand ___ Foot | | | |
| 32. Have you ever missed practice three or more days? (explain)..... | | ___ | ___ |
| 33. Do you wear any dental appliances (braces, false teeth)? | | ___ | ___ |
| 34. Do you have ear drum tubes or a perforated ear drum? | | ___ | ___ |
| 35. Have you had any other medical problems (i.e. infectious mononucleosis, | | | |
| diabetes, etc.)? | | ___ | ___ |
| 36. Have you had a medical problem or injury since your last evaluation? | | ___ | ___ |
| 37. When was your last tetanus shot? _____ | | | |
| 38. When was your last measles immunization? _____ | | | |
| 39. Have you ever been told not to participate in any sport? | | ___ | ___ |
| Which sport and when? _____ | | | |
| 40. Have you or an immediate family member been diagnosed with sickle cell trait? | | ___ | ___ |

EXPLAIN ALL YES ANSWERS IN THE AREA BELOW. MARK EACH EXPLANATION WITH THE NUMBER OF THE QUESTION YOU ARE RESPONDING TO. BE AS DETAILED AS POSSIBLE AND INDICATE DATES OF EACH OCCURRENCE.

Are there any other medical conditions that was not mentioned above? _____

CERTIFICATION OF MEDICAL HISTORY

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

Signature (Participant) _____ Date _____

I hereby state that I have reviewed this medical history and find the answers to the questions correct to the best of my knowledge. (Required for legal minors.)

Signature (Parent or Guardian) _____ Date _____

I hereby state that I have reviewed this medical history and find the answers to the questions correct to the best of my knowledge.

Signature (Wilmington College Licensed Medical Physician) _____ Date _____

ATHLETE INFORMATION

S.S. # ____ / ____ / ____ SCHOOL ID # _____ SPORT(S) _____

ATHLETES NAME _____ DATE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT'S NAME _____ SAME ADDRESS ___ YES ___ NO

PARENT'S HOME PHONE _____ PARENT'S BUSINESS PHONE _____

IN CASE OF AN EMERGENCY, WHO COULD BE CONTACTED IF YOUR PARENTS SHOULD NOT HAPPEN TO BE HOME:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

**WILMINGTON COLLEGE ATHLETIC DEPARTMENT
PHYSICAL EXAM**

NAME _____ Sports _____ Yr in School _____ Date _____

AGE _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____ PULSE _____

BLOOD PRESSURE(Sitting) _____

Normal Abnormal Findings _____

1. Eyes (Pupils Equal?) _____

2. Ears, Nose, Throat _____

3. Mouth and Teeth _____

4. Neck _____

5. Chest and Lungs _____

6. Cardiovascular: **As per NCAA Recommendations.*

A. Precordial Auscultation:

 Sitting and Standing: _____

B. Femoral Artery Pulses: _____

C. Physical Stigmata of Marfan Syndrome: _____

7. Abdomen _____

8. Skin _____

9. Genitalia _____

10. Musculoskeletal:

 ROM, Strength, etc. _____

 a. Neck _____

 b. Spine _____

 c. Shoulders _____

 d. Arms/Hands _____

 e. Hips _____

 f. Thighs _____

 g. Knees _____

 h. Ankles _____

 i. Feet _____

11. Neurological Assesment _____

12. Urinalysis(Optional) _____

13. Laboratory (If needed) _____

Comments _____

Can this person participate in NCAA Intercollegiate Athletics? YES _____ NO _____

Participation Recommendations or Restrictions: _____

Date of Examination _____ Signed _____

(Wilmington College Physician, MD or DO)

Physician Name (Printed) _____ Phone _____

Address _____

WILMINGTON COLLEGE ATHLETIC TRAINING

Protecting Health Information

The Wilmington College Athletic Training Department maintains the confidentiality of protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA), and we will follow the terms of our Notice of Privacy Practices. A copy of the Notice is posted in the training room and a paper copy is available upon request.

Information Release Authorization

I, _____ hereby give my consent for the team physicians, athletic training staff, campus clinic, coaches or other medical personnel of Wilmington College to release such information regarding my medical history, record of injury or surgery, record of illness, and rehabilitation results to each other in order to coordinate medical care and athletic training services. This information is normally confidential and, except as provided in this RELEASE, will not be otherwise released by the parties in charge of the information. This RELEASE remains valid until revoked in writing by me.

Student Athlete Signature

Date

Assumption of Risk

I, _____ understand that there are risks in participating in the sport (s) of _____ and I will be liable for any athletic injury that may occur to me. I do understand that there is a small risk of potentially catastrophic injury by participating in intercollegiate athletics. I assume financial and legal responsibility for any injury or injuries I suffer during tryouts/practices/ games of the above mentioned sports. I am aware of the risks and assume the responsibilities associated with participation in the sports listed above.

Student Athlete Signature

Date

Medical Treatment Consent

I, _____ hereby consent to receive medical treatment deemed necessary by the Athletic Training staff at Wilmington College. Any such treatment in no way confers liability to Wilmington College. Permission is hereby granted to the attending team physician, athletic training staff, or other medical personnel associated with Wilmington College to proceed with any medical or minor surgical treatment, x-ray examination and immunizations. In the event of serious illness or injury, I understand that an attempt will be made by the appropriate medical personnel to contact the parents or legal guardian. If medical personnel are not able to communicate with responsible parties the treatment necessary in the best interest of the student athlete may be given.

Student Athlete Signature

Date

Parent/Guardian Signature (If a minor)

Date

Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

I, _____ hereby authorize _____
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers and health care personal to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and :as employees or agents.

I understand that my protected health information will be used only by the NCAA S Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides WC, NCAA; NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identity individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injury/illness information is protected by federal regulations under either the Health Information portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and nay not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted Goon my institution to the NCAA and that neither the NCAA nor the ISS will identity me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office it. Indianapolis, Indiana.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete

Signature

Date

WILMINGTON COLLEGE
SUPPLEMENT SURVEY

Name _____
Birthdate _____

Wilmington College Sport _____
Current Weight _____

1. What supplements have you used in the past three years?

2. Are you currently taking a multivitamin? _____
3. During which training season have you used these supplements? (Pre, post, off season) _____
4. What was the deciding factor in using these supplements? (weight loss, increase in muscle mass, etc.) _____
5. Have you investigated the legality of these supplements and NCAA competition? _____
6. What supplement(s) are you currently taking?

7. Would you like to continue using these supplements while competing at Wilmington College? _____
8. List any injuries, illnesses, or detrimental effects you have experienced while using a performance enhancing supplement.

9. *******You must list all supplements on this form and present them to your Certified Athletic Trainer during the first week of your teams practice*******

Athlete Signature

ATC signature

Date

Date

WILMINGTON COLLEGE
HEAT ACCLIMATIZATION QUESTIONNAIRE

Please answer the following questions with at least a yes or no answer.

1. Have you ever had any form of heat stress problem (heat exhaustion, heat stroke, dizziness, fainting) before? If yes, circle the one that it was.
2. If you answered yes to the above question, how many times did that particular problem occur and when did it happen?
3. Were you on any form of conditioning program during the summer? If the answer is yes, briefly explain your program.
4. Did you work in an air-conditioned building this summer?
5. Are you presently on a diet? If yes, what kind of diet? Who designed it?
6. Have you been restricting your water intake for any reason? If yes explain why.
7. Have you recently (last 2 weeks) had a cold, problem with vomiting, or diarrhea? If yes, please explain.
8. Are you currently using any medication? If yes, list the name and purpose of the medication.

Name

Date

WILMINGTON COLLEGE - ATHLETIC MEDICAL FORM

This form must be fully completed prior to student's participation in athletics.

ATHLETE INFORMATION:

School Year _____ Sports _____

Last Name First Name MI Sex Date of Birth

Room/Local Phone Number Cell Phone Number Social Security Number

Room/Local Address

PARENT / GUARDIAN EMERGENCY INFORMATION:

Name of Parent/Guardian Relationship to Athlete Date of Birth

Home Address (include State & Zip Code) Home Phone Number

Emergency Phone Number Business Phone Number

ATHLETE INSURANCE COVERAGE INFORMATION: (Copy of front and back of covered parent/guardian insurance card must be included. Athlete must be covered by Wilmington College athletic policy in order to participate in athletics.)

Name of Covered Parent/Guardian Relationship to Athlete Date of Birth Sex

Insurance Company Name & Claims Address

Policy/Member Number Group Number Covered Parent/Guardian SS#

Insurance Company Phone Number Covered Parent/Guardian Employer Name

Athlete Covered by Wilmington College Athletic Policy ONLY.
(Signature of Parent/Guardian Required) _____

College Insurance: Special Risk Claims, Commercial Travelers Mutual Insurance Company, 70 Genesee St., Utica, New York 13502. Phone: 1-800-756-3702

MEDICAL HISTORY/ALERTS: (Indicate yes or no for each category, explaining where necessary.)

Allergies: _____

Illnesses: _____

Current Medications: _____

Injuries: _____

Surgeries

Contact Lenses: Yes No

Tetanus Immunizations: Yes No Date of last Tetanus immunization: _____