

**WILMINGTON COLLEGE  
ATHLETIC TRAINING**

**MEDICAL STATUS UPDATE  
(Returning Athlete)**

This form must be completed and returned before the student athlete will be permitted to participate in any practices or games.

I. PERSONAL INFORMATION DATE \_\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
Last First MI.

Sport \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Year in School \_\_\_\_\_

II. MEDICAL INFORMATION

1. Do we have a physical examination by a Wilmington College Team Physician for you on file in the athletic training office?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Date provided \_\_\_\_\_.

2. Have you ever participated in Intercollegiate Athletics at Wilmington College? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, list sports and dates \_\_\_\_\_

3. Do you now or did you have any severe or chronic illnesses since your last physical exam?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes list illnesses: \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

4. Do you now or have you had any injuries since your last physical exam? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes list injuries: \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

5. Have you been under a physician's care for any extended time?  
Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain: \_\_\_\_\_

6. Have you been hospitalized since your last physical exam?  
Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain: \_\_\_\_\_  
\_\_\_\_\_ Dates \_\_\_\_\_

7. Have you been knocked unconscious or passed out during exercise at any time? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain how and when:  
\_\_\_\_\_ Dates \_\_\_\_\_

8. Do you have any problems with your hearing and/or eyesight?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain: \_\_\_\_\_

9. Have you had any surgeries since your last physical exam?  
Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain: \_\_\_\_\_  
\_\_\_\_\_ Dates \_\_\_\_\_

**\* If yes you must provide us with a written release to play.**

10. Does your family have a history of any sudden death, chronic illnesses, or Marfan Syndrome? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain:  
\_\_\_\_\_

11. Do you currently have any allergies including drugs, foods, and

insect bites or stings? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain:  
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12. Are you currently taking any medication on a regular basis?  
Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please list: \_\_\_\_\_  
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13. Do you have any other physical problems, which have not been  
mentioned? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, explain \_\_\_\_\_  
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14. Have you ever had shortness of breath or dizziness during exercise?  
Yes\_\_\_\_\_ No\_\_\_\_\_. If yes, explain:\_\_\_\_\_

15. Have you ever had any chest pain, racing heart beat, or heart palpitations during or after  
exercise? Yes\_\_\_\_\_ No\_\_\_\_\_  
If yes, explain:\_\_\_\_\_

16. Have you ever been told that you have cardiovascular problems, Heart murmur, or High  
blood pressure? Yes\_\_\_\_\_ No\_\_\_\_\_  
If yes, explain:\_\_\_\_\_

17. Have you or an immediate family member been diagnosed with sickle cell trait?  
Yes\_\_\_\_\_ No\_\_\_\_\_. If yes, explain\_\_\_\_\_

18. Blood Pressure \_\_\_\_\_/\_\_\_\_\_, Pulse Rate\_\_\_\_\_ HT\_\_\_\_\_ WT\_\_\_\_\_

\* Answering yes to any of these may require you to get a new physical exam. This will be determined when you arrive on campus.

The undersigned, Herewith, affirms that to the best of his/her knowledge, the above statements are correct and true, and he/she does not have any illnesses or injuries that would be detrimental to his/her participation in intercollegiate athletics.

-----  
Athletes Signature

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Date

**Return to the WC Athletic Training staff when you arrive on campus.**

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Physician remarks and recommendations.

\_\_\_\_\_ Cleared to participate in full activity

\_\_\_\_\_ Physical Re-examination Required

\_\_\_\_\_ Cleared with the restrictions (list below)

\_\_\_\_\_ Not cleared for participation (list below)

Reason(s) for restriction or disqualification:

WILMINGTON COLLEGE  
ATHLETIC TRAINING  
MEDICAL TRAVEL FORM

I. IDENTIFICATION

Today's Date \_\_\_\_\_

Sport(s) \_\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

Sports \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

Local W.C. Address \_\_\_\_\_  
Number & Street City, State, Zip

Spouse, Parent or Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_  
Number & Street City, State, Zip

Telephone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

II. INSURANCE (Please fill out completely. If you have an insurance card, attach a photo copy. If you have no insurance please write no insurance.)

Name of Parents Insurance Company \_\_\_\_\_

Address \_\_\_\_\_  
Number & Street City, State, Zip

Whose name is insurance policy in (Athlete, Mother, Father, etc.)?

SS# \_\_\_\_\_

Insured Parents Birthdate \_\_\_\_\_ Employer \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

**If you have an insurance card, attach a copy.**

\* DO NOT LEAVE INSURANCE INFO. BLANK. PLEASE PUT NO INSURANCE IF YOU ARE NOT COVERED BY ANYONES POLICY.

III. MEDICAL ALERT

**\* Please check yes or no as it applies and explain where appropriate.**

Medical Conditions      Yes No    If yes, please explain      Dates

ALLERGIES

ILLNESSES

TETANUS IMMUNIZATIONS

INJURIES (Recent)

MEDICATIONS

SURGERIES

CONTACT LENSES

**WILMINGTON COLLEGE ATHLETIC TRAINING**

**Information Release Authorization**

I, \_\_\_\_\_ hereby give my consent for the team physicians, athletic training staff, 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 for one year or 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 any 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

**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 \_\_\_\_\_

ATHLETE'S CELL 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 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 Wilmington College, 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.

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Name

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Date

## WILMINGTON COLLEGE - ATHLETIC MEDICAL FORM

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

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**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

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**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

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**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

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**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: \_\_\_\_\_