

To: All Returning Intercollegiate Athletes
From: Michael S. Weller, M.S.,ATC/LAT, Head Athletic Trainer
Wilmington College Athletic Training Department
Date: 2009-2010 Intercollegiate Sports Seasons
Re: Intercollegiate Pre-participation Forms

This letter is to inform you of the Pre-participation medical eligibility forms you must complete in order to participate in athletics at Wilmington College. Enclosed you will find forms that you and your parents must fill out. **All forms must be filled out completely.** Please bring the completed forms with you when your team reports for the physical exam. **ONLY fall athletes that live 3 or more hours away from campus may have their returning physical completed at a later date than August 12th.** Please make arrangements with your Certified Athletic Trainer. There will no exemptions!

Our summer physical exam day will be Wednesday August 12, 2009 Each team will be given a specific time to report. All fall sport participants are required to attend this first round of physical exams you are expected to come to the August 12th physical day. **The second round of physical exams will be held once all athletes return to campus for classes. All winter and spring sport athletes will be required to attend this physical exam (Wrestling, M/W Golf, M/W indoor and outdoor track, M/W Tennis, M/W Basketball, Baseball, Softball, M/W Swimming).**

It is very important that you read this information and fill it out properly. Below you will find the dates and times for each sports physical exam period. **No athlete will be allowed to practice or compete until all of the required information is submitted and signed by our medical staff.** Information that is incomplete will be treated as non-compliant. If you have any questions, call 937-382-6661, ext. 252.

FALL PHYSICAL EXAM TIMES

August 12, 2009 – Meet in the Auxiliary Gym in Hermann Court

| | |
|--|---------|
| Football | 1:30 PM |
| M-Soccer, M-Cross Country | 2:45 PM |
| W-Soccer, W-Cross Country, Volleyball, | 3:30 PM |
| Cheerleading, M, W Tennis | 4:00 PM |

Reminders

- All information must be filled out completely.
- Do not leave insurance information blank. Provide a copy of your insurance card.
- All WC student athletes are required to purchase the school insurance.
- All physicals must be completed on campus by one of our team physicians.
- Please wear shorts and T-shirt to the physical exam

**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:

12. Are you currently taking any medication on a regular basis?
Yes _____ No _____. If yes, please list: _____

13. Do you have any other physical problems, which have not been
mentioned? Yes _____ No _____. If yes, explain _____

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

Date

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

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.

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: _____