The term: athlete(s) and intercollegiate athletics/sport applies to (aka) student-athlete, cheerleaders, managers (cheer and competitive)

Name____
(last) (first) (m)

B-Date _____________Sport(s)_______________________

Y N Are you a transfer student? Y N Are you adopted?

(2018-19)

Medical History Form : Please complete pages # 1/2/4 prior to your physical examination appointment:

(Please complete this form if you intend to partipate in intercollegiate athletics)

Medical and Injury Information: if yes, please supply information, dates, etc…

if yes, dd/mm/yy & answer (e.g. knee, albuteral, etc) also include left or right

		*Disease and Illness: Have you ever……	
Yes	No	1. Experienced a seizure or been informed you may have epilepsy or seizure(s)?	
Yes	No	2. Been treated for an infectious disease? (please circle)	
		mononucleosis viral pneumonia hepatitis staph MRSA or any other infectious disease?	
Yes	No	3. Been or are you being treated for diabetes? if yes, when diagnosed?	
		3a) Yes No insulin dependent? 3b) if yes, last diabetic medical check-up:	
Yes	No	4. Been treated for scarlet fever and/or rheumatic fever?	
Yes	No	5. Had any heart problems, exertional chest pain, and/or unexplained shortness of breath?	
		6. Been told you have high or low blood pressure? Have had heart tests? (EKG/ECHO etc)? Results attached	
Yes	No	7. Had heat illness, stroke, cramps, rhabdomyolysis?	
Yes	No	8. Had an illness requiring one week or longer of hospitalization/bed rest?	
Yes	No	9. Do you have asthma? list medications:	
Yes	No	10. Do you have Exercise Induced Asthma? list medications:	
		10a) When was your last medical check-up for your asthma?	
Yes	No	11. Been told you have Marfan syndrome?	
		***Head and Neck and Back: Have you ever……**	
Yes	No	1. Experienced an head injury- concussion, contusion been "knocked out, memory loss, confusion " etc?"	
		1a) if yes, where you hospitalized? Length?	
Yes	No	2. Had any injury to the neck/back involving muscle, nerves, vertebras, discs, etc?	
Yes	No	3. Been told you have stenosis? if yes, dates:	
Yes	No	4. Had paralysis? Or sustained limb weakness for a period of time?	
Yes	NO	5. Treated for: spondylolysis spondylolisthesis scoliosis bulge/herniated disc	
Yes	No	5. Been told you have migraines? Chronic headaches?	
		***Eyes and Dental:**	
Yes	No	1. Do you wear? eyeglasses hard contacts soft contacts tinted contacts goggles face shield	
Yes	No	2. Had eye injury requiring medical attention?	
Yes	No	3. Do you wear any dental appliance?	
Yes	No	4. Ever injured your teeth, jaw, nose, etc?	
		***Bones/Joints/Muscles: (please give dates and indicate right or left) Have you ever….**	
Yes	No	A. Have you ever had an injury, e.g sprain, muscle, ligament tear, tendinitis, etc. If yes, complete below	
Yes	No	B. Have you had any fractured (broken) bones, dislocation or subluxation of bones or jointes? Circle below	
Yes	No	C. Have you had a injury/illness that required xray, MRI, CT Surgery, injections, rehabilitation, physical therapy, brace, cast or crutches, If yes, complete below	
Yes	NO	D. Have you had any stress fractures? If yes, complete below	
		If yes, to A,B, C, D: please explain circle injury site and give Type of Injury, Date of Injury, and any other details in space below	
		Shoulder , Arm, Elbow, Hand/fingers, Chest/ribs, Hip, Leg, Knee, Ankle, Foot/toes	
Yes	No	1. Do you wear orthotics/prosthesis?	

CONTINUED …………..

The term: athlete(s) and intercollegiate athletic/sport applies to (aka) student-athlete, cheerleaders, managers (cheer and competitive)

UNIVERSITY of DUBUQUE

Name (last)______________________(first)_________________

(2018-19)

Medical History Form continued:

General Questions:

Yes	No	Anxiety/ Depression	Yes	No	Disease: Meningitis	Yes	No	Metal exposure: Shavings/shrapnel
Yes	No	Appendix or Spleen – Gall Bladder- removed?	Yes	No	Disease: Shingles	Yes	No	Menstrual Irregularities
Yes	No	Cancer	Yes	No	Disease: TB	Yes	No	Paralysis - weakness
Yes	No	CLAUSTROPHOBIC	Yes	No	Disease: other:	Yes	No	Pregnancy, history
Yes	No	Vitamin D Deficiency	Yes	No	Do you smoke?	Yes	No	Stomach –Chronic problems
Yes	No	Dietary restrictions	Yes	No	Vapor/E-cigarette?	Yes	No	Thyroid condition(s)
Yes	No	Dizziness/fainting	Yes	No	ENT chronic tonsillitis	Yes	No	Urinary/Bladder Conditions
Yes	No	Disease: Chicken Pox	Yes	No	ENT chronic Sinusitis, etc…	Yes	No	Urine - sugar/blood
Yes	No	Disease: Crohn's/Celiac	Yes	No	Headache - migraines	Yes	No	Vision problems
Yes	No	Disease: Measles	Yes	No	Hemophilic	Yes	No	Wt Gain/Loss - recent
Yes	No	Disease: Mumps	Yes	No	Hernia	Yes	No	Other:
Yes	No	Disease: Rubella	Yes	No	Insomnia/Sleep prob.	Yes	No	Other:

Yes	No	1. Do you have allergies? 1a) Insects, e.g. Bees, Wasps other, ____________ 1b) allergies to medications/food etc (circle), aspirin, gluten, lactose, latex, penicillin, sulfa, peanuts, etc
		* List
Yes	No	2. Are you currently on prescribed or non-prescribed (OTC) medication(s)? If yes, list & why?
Yes	No	3. Have you been tested for sickle cell? (see physical examination)
		3a) Do you have Sickle Cell Anemia? 3b) Sickle Cell Trait? 3c) Sickle Cell Disease?
Yes	No	4. Where you born without an organ or have an impaired organ? (e.g. one kidney, one testicle) if yes, list:
Yes	No	5. Have you ever had any operation(s)? If yes, why/when?
Yes	No	6. Has your physical activity been restricted during the past 3 years? If yes, why?
Yes	No	7. Have you received treatment &/or counseling for an Eating Disorder? If yes, when?
Yes	No	8. Have you received treatment &/or counseling for a Mental Health/Psychological Disorder?
Yes	No	9. Do you have a disability or condition which may limits your mental or physical functioning or acquire accommodations: (e.g. ADHD/ADD etc) please state and have medical provider complete accommodation form.
Yes	No	10. Are you taking any supplements, or have taken any kind of supplements, please list products and when:
Yes	No	11. Do you have any problems other than those mentioned or on page 1? If yes, explain:
Yes	No	12. Have you ever been advised by a physician NOT to participate in sports? If yes, explain:
Yes	No	13. How many years have you participated in present sport? SrHigh: ____ JC/Univ: ____

Family History:

Please indicate which immediate family/grandparents members have or had the following conditions:

Arthritis		Heart Disease (including premature death)	
Asthma/COPD		High Blood Pressure (HBP)	
Cancer		Sickle Cell Trait &/or Disease	
Diabetes		Marfan Syndrome	
Epilepsy/Seizures		Other	

The undersigned, herewith,
1) Certifies that the answers to the information, on all questions, is correct and true. 2) I understand I must refrain from participation while ill or injured, whether or not receiving treatment and during medical treatment until I am discharged from treatment or given permission by UD Certified Athletic Training staff/Team Physician/or designee despite continuing treatment. 3) I understand that having passed a medical examination does not necessarily mean I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me at the date of the physical examination.

____ ________________________________

Student's Signature Date (Parent/Guardian signature, if under 18yrs age)

UNIVERSITY *of* DUBUQUE

Intercollegiate Athletic Pre-Participation Physical Examination (PPE) must be completed by a physician(MD/DO), physician's assistant or nurse practitioner (under the direction of a physician) AFTER JUNE 1ST, 2018

Name____
(last) (first) (m)
B-Date ______________ **Sport(s)**______________________
(2018-19)

Physical Examination must be completed on this form and clarify any abnormal findings and recommendations.

(NOT ACCEPTABLE: high school, chiropractor, and other medical physicals and/or forms will NOT be accepted)

Height [ ] **Weight** [ ] **Pulse** [ ] (sitting) **BP** [ ]

Vision:

Right: 20/ _____ Left: 20/ ______

Y N Contact Lens Y N Color Blind

Pupils: Y N R Eye Equal/Reactive Y N L Eye Equal/Reactive if no? ___________

Blood Labs ~ FOR ALL, not just specific individuals ATTACH RESULTS

HGB/HCT: [ ] **Anemic:** Y N

Sickle Cell*: [ ] Trait [ ] Disease [ ] NO

*****Required -ATTACH: Examination to include a sickle cell screen; unless results of a prior test are provided & attached. (check birth records, if possible)

Hearing: (whispered voice at 10ft) Y N : R Hearing WNL Y N: L Hearing WNL if no? ____________________

Urinalysis (if indicated by MD) :

Check each item evaluated in appropriate column.	Normal/WNL	Abnormal Findings/Notes
Scalp, Face, Head, Concussion-Head Injury*attach baseline testing results		
ENT		
Eyes, (pupils, conjunct, peripheral)		
Endocrine System		
Lungs, Chest		
Heart: *(14- Element Cardiovascular Screening checklist for congenitial Heart disease for Competitive Athletes, Bethesda, AAFP, ACSM, AMSSM, AOSSM, AOASM)		
Abdominal, Hernia, GI etc		
Endocrine System		
Skin		
Upper Extremities		
Lower Extremities		
Ankles/Feet/Toes		
Neurological		
Reflexes		
Pelvic-Menstrual (females only) Genitalia (males only)		
Surgery(ies)		
Other		

***** PLEASE REVIEW STUDENT MEDICAL QUESTIONNAIRE WITH PATIENT (page 1 and 2) *****

Allergies (medication/drugs, etc) ________________________________ Prescribed Medication(s): ________________________

(UD is a NCAA DIII University and is governed by specific rules, regulations & guidelines, including, but not limited to prescribed medications, OTC's, supplements , etc)

"Supplement" Usage: ____

if medication for ADHD/ADD/Asthma etc, must be documented, enclosed accommodations form: completed and attach by appropriate medical personnel*

Check regarding intercollegiate participation: [ ] Cleared w/out RESTRICTIONS [ ] NOT Cleared- COMPLETE RESTRICTION

[ ] Specific Restrictions: ________________________________ [ ] Only specific sports(list) ____________________

To my knowledge, as the medical evaluator, the above information is accurate and complete:

Physician's Signature:____ **Date:** ________

Print/Stamp: **Physician's Name:** ____

Physician's Address: ____

The NCAA list of banned-drug classes is subject to change by the NCAA Executive Committee. **Contact NCAA education services or www.ncaa.org/heath-and-safety/policy/drug-testing , for the current list.** The term "related compounds" comprises substances that are included in the class by their pharmacological action and/or chemical structure. No substance belonging to the prohibited class may be used, regardless or whether it is specifically listed as an example. Many nutritional/dietary supplements contain NCAA banned substances. In addition, the US FDA does not strictly regulate the supplement industry; therefore, purity and safety of nutritional/dietary supplements cannot be guaranteed. Impure supplements may lead to a positive NCAA drug test. (UD may also perform random drug tests.)
***Effective August 2009** stricter application of the NCAA Medical Exception policy, and specifically for the use of banned stimulant medications to treat Attention Deficit Hyperactivity Disorder (ADHD)/ADD etc). The guideline is posted at www.ncaa.org/health-safety . (also ** see this site for sickle cell and other important information)

The term athlete(s) and intercollegiate athletic(s)/sport applies to (aka): student-athlete, cheerleaders, managers (cheer and competitive)

University of Dubuque (UD)

NCAA-DIII Member: http://www.ncaa.org/health-and-safety

Intercollegiate Athletic Assumption of Risk & University's Waiver and Release Consent Form (2018-19)

Please list all intercollegiate sports in which you may participate: ______________________________ **Name**__________________________________
(Last) **(First)**

Student/Parent/Guardian: Please read the following consent forms carefully:
Requires: 1) Initial each section and 2) Sign at bottom of the form that you have read and agree to the information:
If you should choose to refuse to sign any of these, please, write "Refuse to Sign" beside the appropriate document title.

Part I: Waiver and Release

- I, the undersigned, am aware there is a certain risk of injury/illness involved in my participation in Intercollegiate Athletics at University of Dubuque (UD). This document is intended to make me aware of my responsibility in preventing potential injuries/illnesses, complying with the treatment plan of the athletic medical staff, and that there is a risk of injury/illness. I understand that this includes the risk of spinal cord, brain injury, and cardiac problems that may result in paralysis and the possibility of other permanent injury or death associated with the intercollegiate sports in which I compete.
- I have read the "concussion; a fact sheet for student-athletes education sheet. http://www.dbq.edu/CampusLife/FacilitiesandServices/MedicalServices/
- I agree to assume all risk and fully release and discharge members of UD community, its directors, officers, trustees, agents, servants and employees for any injuries/illnesses including death, damages, or loss regardless of severity, which I may sustain as a result of participating in this activity. Some examples of injuries include, but are not limited to, sprains, cuts, fractured bones, jammed fingers, knee/ankle injures, allergic reactions, cardiac problems, spinal cord injury, sickle cell trait complications, brain injury, and concussions.
- I understand that no helmet or protective head gear/collar can prevent head or neck injuries a player might receive while participating in a sport where a helmet/headgear/collar is worn. I understand not to use the helmet to butt, ram, or spear a player. This is a violation of rules of football, specifically, and such use in any sport can result in severe head/neck injuries, paralysis or death to myself and possible injury to another player.
- I have read the above shared responsibility statement. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating in intercollegiate athletics at UD. **(________initial)**

Part II: Medical Responsibilities

- I agree to accept responsibility for reporting my signs and symptoms after sustaining any illness, injury, concussion, or health condition to the UD Health Services, athletic training staff or designated physician.
- I understand that I cannot return to athletic activities until cleared by the Health Services as directed by the team physician.

(________initial)

Part III: Medical Consent and Insurance Consent

- I hereby grant permission to UD team physician(s), or other physicians designated by UD, to provide me with any medical care or surgical care that they deem reasonably necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of, or during UD intercollegiate athletic activities.
- I further authorize UD certified athletic trainers who are under the direction and guidance of UD team physician(s) to provide me with any preventative, first-aid, rehabilitative, or emergency treatment deemed necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of or during UD intercollegiate athletic activities.
- I give permission for medical information to be released and discussed with UD certified athletic training staff and designated team physicians.
- If reasonably necessary to provide the care described in the preceding paragraphs, I grant permission to UD officials to authorize my admission to a hospital or other facility that provides said treatment. **(________initial)**

Part IV: UD Substance Abuse Policy for the Student-Athlete (located: UD Student Handbook)

- I have read and understand UD Substance Abuse Testing Policy. I accept and agree to be bound by that policy. I understand UD may drug test me based on reasonable suspicion of my use of banned or illegal substances or as a result of random testing.
  http://www.dbq.edu/campuslife/facilitiesandservices/medicalservices/substanceabusepolicy/
  NCAA Banned Drugs http://www.ncaa.org/health-and-safety **(________initial)**

Part V: Student-Athlete Authorization/Consent for Disclosure of Protected Health Information to the NCAA/IIAC/Media Outlets

- I understand that my injury/illness information is protected by federal regulations under either the HIPAA or the Family Educational Rights & Privacy Act (FERPA) of 1974 (the Buckley Amendment) and may 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 UD will not release any health care treatment/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 initial (Part III) this authorization/consent in order to be eligible for participation in NCAA/conference athletics. I understand that the ARC and media outlets are not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the ARC/media outlets' use or disclosure of my injury/illness information.
- I, hereby authorize UD and its physicians, certified athletic trainers and health care personnel 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 IIAC/media outlets and its employees or agents. **(________initial)**

I understand that I have the right to revoke all or any part or the above at any time by sending written notification to University of Dubuque Athletic Director. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent. I have read and fully understand UD intercollegiate athletic program requirements and all information supplied is accurate and current to the best of my knowledge.

____ ________________________________

Student's Signature *Date* *(Parent/Guardian signature, if under 18yrs age)*