**SIERRA NEVADA COLLEGE SPORTS MEDICINE**

Dear Student Athlete,

The attached forms are required for your participation in athletics at Sierra Nevada College. Please see a physician and fill out the Pre-Participation Physical Examination form to clear you for activity *prior* to arriving to campus. Send all forms, via mail or electronic mail, to:

Andrea Simich, ATC, LAT
Head Athletic Trainer
999 Tahoe Blvd.
Incline Village, NV 89451
asimich@sierranevada.edu

ALL forms must be completed and turned in by ***July 28, 2017***. Please note that only physicians (MD or DO) can complete the physical examination and clear an athlete for participation. A student athlete will not be allowed to participate in any team activity, including practice, until their paperwork is turned in. Use the checklist below to make sure you have completed everything.

Turn in the following forms:

- ✓ Pre-Participation Questionnaire
- ✓ Copy of Insurance Card (Front & Back)
- ✓ Pre-Participation Health History
- ✓ Pre-Participation Physical Examination (to be completed by physician)
- ✓ Banned Drugs and Dietary Supplements Disclosure
- ✓ Awareness of Risk
- ✓ Medical Consent
- ✓ Shared Responsibility for Sport Safety
- ✓ Concussion Risk Statement
- ✓ Notice of Privacy Practices
- ✓ Referral Policy

**SIERRA NEVADA COLLEGE SPORTS MEDICINE**

PRE-PARTICIPATION QUESTIONNAIRE

The information contained in this medical history form will only be used by the Sierra Nevada College Sports Medicine for purposes of determining if you pose a health threat/risk to yourself on the athletic field. A SNC Athletic Trainer and/or Team Physician will discuss this information with you in detail later in your physical examination. This information will remain CONFIDENTIAL at all times.

Year of Eligibility: FR SO JR SR Redshirt Date: _____

Athlete's Name: _____ Sport(s): _____
(Last)(First) (MI)

Student ID: _____ Date of Birth: ____/_____/_____ Age____ Sex_____

Local Address/Dormitory/etc._____
(street) (city) (state) (zip)

Permanent (Home) address: _____
(street) (city) (state) (zip)

Home Phone: ( )_____ Cell Phone: ( ) _____

**I. Person to notify in case of an emergency:**

Name: _____ Relationship: _____

Address: _____
(street) (city) (State) (zip)

Home Phone: ( ) _____ Business Phone: ( )

Cell Phone: ( ) _____

**II. Father's Name:** _____

Address: _____

_____

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

**III. Mother's Name:** _____

Address: _____

_____

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

**IV. Family Physician:** _____

Address: _____
(street) (City) (State) (Zip)

Phone: ( ) Fax: ( )

NAME:_____

SIERRA NEVADA COLLEGE

**SIERRA NEVADA COLLEGE SPORTS MEDICINE**
HEALTH HISTORY QUESTIONNAIRE

## DENTAL

Have you ever sustained an injury to your teeth, mouth or jaw (TM Joint)? ☐ Yes ☐ No
Please describe: _____

If yes, were any diagnostic tests performed? ☐ Yes ☐ No

Check all that apply: ☐ X-Rays ☐ CT-Scan ☐ MRI ☐ Other: _____

Do you have any of the following: ☐ Braces ☐ Veneers ☐ Dentures ☐ Artificial Implants
☐ Partials ☐ Other (please list): _____

Have you ever been hospitalized, had surgery and/or been seen by a dentist/ oral surgeon for a dental injury? ☐ Yes ☐ No
Please describe incident and date:

## VISION/EYES

Do you have full use of both eyes? ☐ Yes ☐ No

Do you routinely wear any of the following: ☐ Glasses ☐ Contacts ☐ Protective Eyewear for sport (i.e. shield, goggles, etc)
☐ Other :

Have you ever had problems with your vision? ☐ Yes ☐ No

Do you suffer from any of the following? ☐ Blurred Vision ☐ Double Vision
☐ Tunnel Vision ☐ Other Abnormal Eye sight:

Have you ever been hospitalized, had surgery, and/or seen by an ophthalmologist or optometrist for a eye injury? ☐ Yes ☐ No
Please describe incident and date:

## EAR, NOSE, AND THROAT (ENT)

Have you ever sustained an injury or serious illness to your Ear(s), Nose, and/or Throat (ENT)? ☐ Yes ☐ No
Please describe: _____

Do you have a hearing deficit in either/both ear(s)? ☐ Yes ☐ No
Please describe:

Do you routinely wear any of the following ☐ Hearing Aids ☐ Ear Plugs ☐ Other: _____

Do you suffer from any of the following: ☐ Sinus Infections ☐ Frequent Ear Infections ☐ Chronic Congestion

☐ Bloody Noses ☐ Throat Infections ☐ Other:_____

Have you ever been hospitalized, had surgery and/or seen by an Ear, Nose, and Throat Specialist for any injury or illness? ☐ Yes ☐ No
Please Describe Incident and Date: _____

## ALLERGIES

Are you allergic to/ or have you ever had an allergic reaction to any of the following (Check all that apply): ☐ Yes ☐ No

☐ Prescription or Over-the Counter Medications: _____

☐ Seasonal Related Allergies ☐ Food and/or Drink products ☐ Bee Stings, Insect Bites, etc.

☐ Other: (please describe specific allergies): _____

Have you ever been prescribed an Epi-Pen? ☐ Yes ☐ No

Are you presently, or have you ever taken medication for allergies or allergic reactions? ☐ Yes ☐ No

## MEDICATIONS (PRESCRIPTION & OVER THE COUNTER)

Are you currently taking **any** prescription medications or consistent over-the-counter medications? ☐ Yes ☐ No
Please List: (attach additional page if necessary):

Name:_____

**BLOOD ABNORMALITIES & SICKLE CELL ANEMIA**

Have you ever been tested for Sickle Cell Anemia? ☐ Yes ☐ No
Date : _____ Result: _____

Do any members in your family carry Sickle Cell Trait or Sickle Cell Disease? ☐ Yes ☐ No
If so, who: _____

Have you ever been diagnosed with anemia (low hematocrit or low iron)? ☐ Yes ☐ No
Do you or have you ever taken prescription medications/ vitamins/ supplements for anemia? ☐ Yes ☐ No
Do you or have you ever had abnormal bleeding tendencies? ☐ Yes ☐ No
Please describe: _____

Do you have a personal or family history of blood clotting disorders or abnormalities? ☐ Yes ☐ No
If so, who:

**DERMATOLOGY**

Have you ever been diagnosed with MRSA (Methicillin-resistant *Staphylococcus aureus*)? ☐ Yes ☐ No
If so, when:

**CARDIOVASCULAR RISK FACTORS**

Have you ever experienced any of the following during or after exercise / practice? ☐ Yes ☐ No
☐ Chest Pain or Pressure ☐ Felt Dizzy or lightheaded
☐ Irregular Heart Beat (Palpitations), Heart Racing or Skipping ☐ Lost Consciousness or Passed Out
☐ Shortness of Breath

Have you ever been informed that you have (or have had) any of the following: ☐ Yes ☐ No
☐ Heart Disease or infection – when: _____ ☐ High Blood Pressure – when: _____
☐ High Blood Cholesterol – when: _____ ☐ A Heart Murmur – when: _____

Have you ever had an EKG or Echocardiogram? ☐ Yes ☐ No
WHEN: _____

Have you ever been hospitalized, had surgery, or seen a cardiologist for a cardiovascular (heart) related occurrence? ☐ Yes ☐ No
Please describe: _____

Does anyone in your family have any of the following: ☐ Yes ☐ No
☐ Heart Disease: Relationship and Age: _____
☐ High Blood Pressure: Relationship and Age: _____
☐ High Blood Cholesterol: Relationship and Age: _____

Has anyone in your family died of heart problems or sudden death prior to age 50? ☐ Yes ☐ No
Please describe: _____

Has anyone in your family been diagnosed with Marfan's Syndrome? ☐ Yes ☐ No
Please describe:

**ASTHMA & RESPIRATORY HISTORY**

Have you ever been diagnosed with Asthma and/or Exercise Induced Asthma (EIA)? ☐ Yes ☐ No

Do you presently take or have you previously taken any asthma medication? Do you use an inhaler? ☐ Yes ☐ No
How often (per week): _____

In the past twelve (12) months, how many acute asthma attacks have you sustained? _____

Do you use an inhaler at other times when not exercising? ☐ Yes ☐ No

Do you cough frequently during exercise? ☐ Yes ☐ No

Have you ever been diagnosed with Tuberculosis, Pneumonia or any other respiratory issues? ☐ Yes ☐ No

Have you ever been hospitalized for Asthma, Exercise Induced Asthma or any other respiratory issues? ☐ Yes ☐ No
If so, when: _____

Name:_____

**MEDICAL TESTING**

Have you ever been diagnosed with a Communicable Disease (e.g. sexually transmitted infections, hepatitis, etc.) ☐ Yes ☐ No

Have you ever been diagnosed with Infectious mononucleosis (mono)? ☐ Yes ☐ No

**ABDOMINAL, GASTROINTESTINAL (GI), REPRODUCTIVE and INTERNAL ORGANS**

Have you ever been diagnosed with an injury or illness to your stomach, abdomen, reproductive organs, etc.? ☐ Yes ☐ No
Please describe: _____

Have you ever had surgery for an abdominal injury or illness (i.e. appendicitis, hernia, kidney/liver disease, etc.)? ☐ Yes ☐ No
Please describe: _____

Were you born without or are you missing a kidney, an eye, a testicle, an ovary or any other paired organ? ☐ Yes ☐ No
Please describe: _____

Have you sustained an injury or illness to a reproductive organ? ☐ Yes ☐ No
Please describe: _____

Do you routinely suffer from severe recurrent abdominal pain? ☐ Yes ☐ No
Please describe: _____

Do you suffer from chronic or recurrent diarrhea, constipation or been diagnosed with Irritable Bowel Syndrome? ☐ Yes ☐ No
Please describe: _____

Have you been diagnosed by a physician with acid reflux? ☐ Yes ☐ No
If yes, please describe medication(s) that relieves your discomfort: _____

Have you ever been treated, hospitalized or had surgery for abdominal, GI, and/or organ injuries or illness'? ☐ Yes ☐ No
Please describe: _____

**HEAD INJURIES/ILLNESS AND CONCUSSIONS**

Have you ever sustained a head injury or concussion? ☐ Yes ☐ No
How many head injuries or concussions have you sustained? _____
Date(s): _____
Briefly describe incident(s): _____
Amount of Time Missed: _____

Have you ever sustained loss of consciousness related to a concussion? ☐ Yes ☐ No
Please describe: _____

Have you ever sustained memory loss related to a concussion? ☐ Yes ☐ No
Please describe: _____

In the past, have you suffered a seizure? ☐ Yes ☐ No
Briefly describe: _____

Do you suffer from frequent headaches? ☐ Yes ☐ No
How frequently? _____

Do you have a history of Migraines? ☐ Yes ☐ No
How frequently? _____
Medication utilized to suppress migraines? _____

Have you ever been hospitalized due to a head injury, illness or concussion? ☐ Yes ☐ No
Please describe:

**HEAT RELATED INJURIES/ILLNESS**

Have you ever suffered from a heat-related injury or illness? ☐ Yes ☐ No
Check all that appl ☐ Heat Cramps ☐ Heat Syncope (Fainting)
☐ Heat Exhaustion ☐ Heat Stroke ☐ Other:
Please describe: _____

Have you ever been diagnosed with low sodium (hyponatremia)? ☐ Yes ☐ No
Please describe: _____

Have you ever been hospitalized for a heat-related injury or illness? ☐ Yes ☐ No
Please describe: _____

Name:_____

**DIABETIC HISTORY**

Does anyone in your family have Diabetes or do you have a family history of Diabetes? ☐ Yes ☐ No

Please list individuals in family: _____

Have you ever been diagnosed by a physician with Diabetes? ☐ Yes ☐ No

Date: _____

**If no (you have not been diagnosed with diabetes), please proceed to the next section.**

Are you currently taking or have you ever taken diabetic medications? ☐ Yes ☐ No

Please describe: _____

Do you monitor your blood sugar level on a daily basis? ☐ Yes ☐ No

How many times per day? _____ What is your average daily blood sugar level? _____

When did you last have your A1c Level tested? Results?:

**OTHER MEDICAL ISSUES**

Do you ever feel stressed out or under a great deal of pressure? ☐ Yes ☐ No

Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days? ☐ Yes ☐ No

Rate your feeling of depression over the last 6 months (0=low depression, 10= high depression): _____

Do you feel safe? ☐ Yes ☐ No

During the past 30 days, have you used chewing tobacco, snuff or dip? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many cigarettes do you smoke per day (average)? _____ Per Week (average)? _____

How much alcohol do you drink at one time (average)? _____ Per week (average)? _____

Are you happy with your weight and/or your overall physique? ☐ Yes ☐ No

If no, what would you prefer to weigh? _____

Have you ever tried to control your weight by any of the following methods? ☐ Yes ☐ No

☐ Using Laxatives ☐ Vomiting ☐ Excessive Exercise ☐ Diuretics ☐ Diet Pills

☐ Other: _____

Are there certain foods that you do not eat? ☐ Yes ☐ No

Please list: _____

Have you ever had an eating disorder or altered your eating pattern for athletic performance? ☐ Yes ☐ No

Have you been diagnosed by a physician with Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder? ☐ Yes ☐ No

Diagnosis date: _____ Medication(s) Used: _____

When was your most recent follow-up visit with a physician for ADD or ADHD? _____

Have you ever suffered from emotional disturbance (depression, anxiety, etc.)? ☐ Yes ☐ No

Diagnosis date: _____ Medication(s) Used: _____

Have you ever received counseling from a Psychologist, Psychiatrist, or Counselor? ☐ Yes ☐ No

**MALE STUDENT-ATHLETES ONLY**

Have you ever had a testicular exam? ☐ Yes ☐ No

Most recent date: _____

Have you ever sustained a testicular torsion? ☐ Yes ☐ No

When: _____

Did you have an undescended testicle(s) at birth? ☐ Yes ☐ No

Name:_____

Have you ever undergone surgery for a testicular abnormality? ☐ Yes ☐ No
Please describe:

**FEMALE STUDENT-ATHLETES ONLY**

Are your periods regular? ☐ Yes ☐ No
Please describe: _____

Do you ever experience heavy bleeding during your periods? ☐ Yes ☐ No

Do you have a family history of Osteoporosis (thinning of the bones)? ☐ Yes ☐ No

Do you ever experience cramps during your period? ☐ Yes ☐ No
☐ Mild ☐ Moderate ☐ Severe
If so, how do you treat them? _____

Do you use a prescription birth control method? ☐ Yes ☐ No
Please describe: _____

Have you ever had an abnormal pelvic exam or PAP smear? ☐ Yes ☐ No
If so, when? _____

**NECK AND CERVICAL SPINE**

Have you ever had chronic neck pain or suffered an injury to your neck and/or cervical spine? ☐ Yes ☐ No
Briefly describe:

Have you ever been hospitalized or had surgery for a neck and/or cervical spine injury? ☐ Yes ☐ No
Please describe (include date(s):

Have you ever sustained neck pain and/or had numbness, burning or sharp pain in your arm(s) and/or hand(s) (e.g. stinger, burner, pinched nerve, etc.) ☐ Yes ☐ No
Briefly describe: _____

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow Up**

**SHOULDER AND UPPER ARM**

Have you ever had chronic shoulder pain or suffered an injury to your shoulder(s) and/or upper arms? ☐ Yes ☐ No
Briefly describe: _____

Have you ever been hospitalized or had surgery for a shoulder and/or upper arm injury? ☐ Yes ☐ No
Please describe, include date(s): _____

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow Up**

**ELBOWS AND FOREARMS**

Have you ever had chronic elbow(s) or arm pain or suffered an injury to your elbow(s) and/or forearms? ☐ Yes ☐ No
Briefly describe: _____

Have you ever been hospitalized or had surgery for an elbow and/or forearm injury? ☐ Yes ☐ No
Please describe (include date(s): _____

Did you ever miss practice(s) or competition(s) due to an elbow or forearm injury? ☐ Yes ☐ No
Briefly describe:

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow Up**

Name:_____

**WRIST, HANDS AND FINGERS**

Have you ever had chronic wrist, hand or finger pain or suffered an injury to your wrists(s), hand(s) and/or fingers? ☐ Yes ☐ No

Briefly describe: _____

Have you ever been hospitalized or had surgery for a wrist, hand and/or finger injury? ☐ Yes ☐ No

Please describe (include date(s): _____

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up**

**SPINE (THORACIC AND LUMBAR)/RIBS, AND CHEST**

Have you ever had chronic back pain or suffered an injury to your thoracic or lumbar spine, ribs, or chest? ☐ Yes ☐ No

Briefly describe: _____

Have you ever been diagnosed with a stress fracture or sustained a spondylolysis, or spondylolisthesis injury to the vertebra of your spinal column? ☐ Yes ☐ No

If yes, please describe how this was diagnosed: _____

Have you ever been hospitalized or had surgery for a thoracic, lumbar, rib, and/or chest injury? ☐ Yes ☐ No

Please describe, include date(s): _____

Have you ever been told that you were born with a spinal defect? ☐ Yes ☐ No

Briefly describe: _____

Have you ever had pain, numbness, burning or sharp pain into your buttocks, legs or feet? ☐ Yes ☐ No

Briefly describe:

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up**

**HIP, GROIN, THIGH, HAMSTRINGS, AND QUADRICEPS**

Have you ever had chronic pain or suffered an injury to your groin, thigh(s), hamstrings and/or quadriceps? ☐ Yes ☐ No

Briefly describe: _____

Have you ever sustained a stress fracture to your hip(s) and/or thigh (femur)? ☐ Yes ☐ No

Please describe: _____

Have you ever been hospitalized or had surgery for a groin, upper leg, hamstring, and/or quadriceps injury? ☐ Yes ☐ No

Please describe (include date(s): _____

Have you ever sustained a hernia and/or a "sports hernia"? ☐ Yes ☐ No

Briefly describe: _____

Have you ever been diagnosed with Osteitis Pubis (or pubic bone pain)? ☐ Yes ☐ No

Please describe:

**SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up**

Name:_____

**KNEES AND PATELLA (KNEE CAP)**

| | | |
|---|---|---|
| Have you ever had chronic pain or suffered an injury to your knee(s), knee ligament(s), and/or patella(s)?<br>Briefly describe: | ☐ Yes | ☐ No |
| Have you ever been hospitalized or had surgery for a knee and/or patella injury?<br>Please describe, include date(s): | ☐ Yes | ☐ No |
| Does your knee swell, lock, "give way" or feel unstable?<br>Briefly describe: | ☐ Yes | ☐ No |
| Have you suffered chronic knee pain during or after activity?<br>Briefly describe (include pain location): | ☐ Yes | ☐ No |
| **SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up** | | |
| | | |

**LOWER LEGS (TIBIA AND FIBULA) AND ANKLES**

| | | |
|---|---|---|
| Have you ever had chronic pain or suffered an injury to your lower leg(s), tibia(s), fibula(s), and/or ankle(s)?<br>Briefly describe: | ☐ Yes | ☐ No |
| Have you ever sustained a stress fracture to your lower leg (tibia and/or fibula) and/or ankle bone?<br>Please describe: | ☐ Yes | ☐ No |
| Have you ever been hospitalized or had surgery for a tibia, fibula and/or ankle injury?<br>Please describe (include date(s): | ☐ Yes | ☐ No |
| Do you or have you ever suffered from recurrent ankle sprains?<br>Briefly describe: | ☐ Yes | ☐ No |
| Have you ever suffered from chronic shin pain, or shin "splints"?<br>Briefly describe: | ☐ Yes | ☐ No |
| **SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up** | | |
| | | |

**FEET AND TOES**

| | | |
|---|---|---|
| Have you ever had chronic foot/ heel pain or suffered an injury to your foot (feet) and/or toes?<br>Briefly describe: | ☐ Yes | ☐ No |
| Have you ever sustained a stress fracture to your foot (feet) and/or toe(s)?<br>Please describe: | ☐ Yes | ☐ No |
| Have you ever been hospitalized or had surgery for a foot and/or toe injury?<br>Please describe (include date(s): | ☐ Yes | ☐ No |
| Do you currently or have you ever used orthotics or shoe inserts?<br>Check all that apply: ☐ Custom Orthotics ☐ Store-bought Orthotics ☐ Other: | ☐ Yes | ☐ No |
| **SNC Physician and/or Orthopedic Remarks and Recommendations for Follow-up** | | |
| | | |

Name:_____

I affirm that all information contained in this medical history document is true and accurate to the best of my knowledge and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(If student-athlete is under age of 18)

Athletic Trainer Signature: _____ Date: _____

# SIERRA NEVADA COLLEGE SPORTS MEDICINE

## Pre-Participation Physical Examination

**Full Name:** _____ **Sport (s):** _____

**Height:** _____ **Weight:** _____ **Pulse:** _____ **BP:** ____/____ **If elevated:** ____/____ ____/____

**Vision:** **Right Eye: 20/** _____ **Left Eye: 20/** _____ **Both Eyes: 20/** _____ **Correction:** ☐ **Contacts** ☐ **Glasses**

**Pupils:** ☐ **Equal** ☐ **Unequal** **Mouth guard:** ☐ **Yes** ☐ **No**

**Sickle Cell Trait:** ☐ **Unknown & Discussed** ☐ **Yes** ☐ **No**

| General Medical | Normal | Abnormal Findings |
|---|---|---|
| Eyes/ Vision | | |
| Ears/ Hearing | | |
| Nose | | |
| Mouth/ Dental | | |
| Throat | | |
| Thyroid | | |
| Lymph Nodes | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) | | |
| Hernia | | |
| Skin | | |
| **Musculoskeletal** | **Normal** | **Abnormal Findings** |
| Neck/ Cervical | | |
| Thoracic/ Lumbar | | |
| Shoulder/ Upper Arm | | |
| Elbow/ Forearm | | |
| Wrist/ Hand/ Fingers | | |
| Hip/ Thigh | | |
| Knee/ Patella | | |
| Lower Leg/ Ankles | | |
| Foot/ Toes | | |

**Cardiovascular Screening**

☐ Systolic Ejection
☐ Mid-systolic
☐ Holosystolic
☐ Diastolic
☐ Click
☐ Valsalva ↑ ↓
☐ Squat ↑ ↓

Heart Murmur
☐ No
☐ Yes
Grade: I II III IV V VI

Symmetric Femoral Pulses
☐ Yes
☐ No

Stigmata of Marfan's Syndrome – if appropriate:
☐ Arm Span > Height
☐ Chest Deformity (pectus excavatum/carinatum)
☐ Glasses/ Contact Lenses
☐ "Thumb" Sign
☐ "Wrist" Sign
☐ Scoliosis
☐ High Palate

## COMMENTS, RECOMMENDATIONS and PARTICIPATION STATUS

☐ **Cleared** for Athletic Participation ☐ **Not Cleared** for Athletic Participation

☐ Cleared after completing evaluation/ rehabilitation for: _____

Reason for "Not Cleared" Status: _____

Recommendations: _____

Examining Physician Print Name: _____ Examining Physician Signature: _____

Date:

## FOLLOW-UP FINAL CLEARANCE FROM SIERRA NEVADA COLLEGE ATHLETIC DEPARTMENT TEAM PHYSICIAN (if not initially cleared)

Signature: Date:

**SIERRA NEVADA COLLEGE SPORTS MEDICINE**
INFORMATION FOR STUDENT ATHLETES ON DIETARY SUPPLEMENTS AND NAIA BANNED DRUGS

Sierra Nevada College recommends that student athletes meet their nutritional needs through a well-balanced, nutritious diet and recommends against student athletes using unregulated dietary supplements. We understand that there may be student athletes under a physician's care that are taking nutritional supplements or medications due to diagnosed medical conditions or deficiencies. Please inform your athletic trainer if you are taking **any** prescribed medications or supplements.

**NAIA Nutritional/Dietary Supplements Warning:**
*Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff!*

- Dietary supplements, including vitamins and minerals, are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken **at your own risk**.

**Banned Substances:**

- Stimulants
- Anabolic Agents
- Alcohol and Beta Blockers (banned for rifle only)
- Diuretics and Other Masking Agents
- Street Drugs
- Peptide Hormones and Analogues
- Anti-estrogens
- Beta-2 Agonists

**Note: Any substance chemically related to these classes is also banned.**

The institution and the student-athlete shall be held accountable for all drugs within the banned drug class regardless of whether they have been specifically identified.

**Drugs and Procedures Subject to Restrictions:**

a. Blood Doping.
b. Local Anesthetics (under some conditions).
c. Manipulation of Urine Samples.
d. Beta-2 Agonists permitted only by prescription and inhalation.
e. Caffeine if concentrations in urine exceed 15 micrograms/ml.

NOTE: **<u>There is no complete list of banned drug examples!!</u>**

Check with your athletics department staff before you consume any medication or supplement.

**For more information:** Information on dietary supplements and banned drugs is available through the Drug Free Sport Axis: https://dfsaxis.com/users/login

- To access, go to https://dfsaxis.com/users/login, select NAIA, insert password naialive5. On the home page, select **"Ask about Dietary Supplements"** or go to the **"Prescription/Over-the-Counter Drug Search".**

Student athletes are advised to bring **all supplements** to the designated athletics department staff member before using any supplements. The student athlete will be asked to fill out the **Student Athlete Nutritional Supplement and Disclosure Review Form.** The supplements will then be checked through the Drug Free Sport Axis. The DFSAxis is the only authoritative resource related to whether listed ingredients on nutritional supplement labels or in medications contain banned substances. Because of the changing nature of the dietary supplement industry and the manner in which manufacturers use proprietary names and rename products to suit their purposes, there is no way to create a reliable database of reviewed products. Institutional staff should submit each time a student athlete brings forth a dietary supplement as last year's review may no longer apply to this year's newly formulated product by the same name.

Student athletes will receive counseling and education about supplements and every effort will be made to help you make the best choice possible. However, you will be informed that all nutritional/dietary supplements can carry some risk of containing banned substances. "Positive drug-test appeals based on the claim that the student-athletes did not know the substances they were taking were banned have not been successful." (NCAA Sports Medicine Handbook)

**It is the responsibility of the student athlete to check with the appropriate athletics staff member before using any substance.**
**Any product containing a dietary supplement is taken at your own risk.**

# Sierra Nevada College
## Sports Medicine
### Student Athlete Nutritional Supplement Disclosure and Review Form

I, _____, am taking or intend to take the following nutritional supplements or ergogenic aids. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NAIA banned substance that may be found in any substance I take, regardless of the reason or purpose for taking such supplements.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NAIA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NAIA endorses a product or approves its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NAIA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by the Sierra Nevada College Athletic Training Department for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NAIA. Even if the product does not contain any banned substances, I understand that 1) dietary supplements are poorly regulated by the U.S. FDA; therefore, the NAIA and the SNC Athletic Training Staff cannot guarantee the product's purity or safety, 2) Impure supplements can cause a positive drug test, and 3) I am advised that the use of this dietary supplement is at my own risk.

| | **Manufacturer** (Student-Athlete) | **Supplement Name** (Student-Athlete) | **Comments** (AT Staff) | **Banned Substances** (AT Staff) |
|---|---|---|---|---|
| 1. | | | | |
| | | | | |
| 2. | | | | |
| | | | | |
| 3. | | | | |
| | | | | |
| 4. | | | | |
| | | | | |
| 5. | | | | |
| | | | | |

I acknowledge all statements herein to be truthful and accurate and have been advised on the risks of the substances I may be taking.

_____ _____

Student Athlete's Signature Date Head Athletic Trainer Date

Sierra Nevada College
Athletics Department
Awareness of Risk

Name: _____ Sport(s): _____

I am aware that playing or practicing in any sport can be a dangerous activity involving many risks or injury. I understand that the dangers and risks of playing or practicing in the above sport(s) include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of my body, general health and well-being. I furthermore specifically acknowledge that participation in intercollegiate athletics may involve a risk of injury.

In consideration of SNC permitting me to practice, play, try out for or otherwise associate myself with the SNC intercollegiate athletics program, and to engage in all activities related to the program, including practicing, playing and travel, I hereby voluntarily assume all risks associated with participation and agree to discharge and release the state of Nevada, the Regents of Sierra Nevada College, their agents and servants and employees, from any and all liability , claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the intercollegiate athletics program, except where such claims are due to the sole negligence of Sierra Nevada College, its agents or employees. Because of the inherent dangers of participating in a contact or other type of sport, I recognize the importance of following the coach's instructions regarding playing techniques, training, rules of the sport and other team rules, and agree to obey such instructions.

The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

Check one of the following:

☐ I am in good health and I know of no medical reason why I am not able to participate in the Sierra Nevada College Intercollegiate Athletics program.

☐ I have a significant physical condition that may increase my risk in participating in the Sierra Nevada College Intercollegiate Athletics program. My specific physical condition(s) is (are):

_____

(examples include, but are not limited to, those who have heart disease/conditions, those who have only one functioning organ of a paired organ group, those confined to a wheelchair, those who are deaf, blind or missing a limb, those with severe chronic illness, those with a severe reduction in normal physiologic function, and those who may have a physical, behavioral, emotional, or psychological disorder or abnormality that substantially limits a major life activity). I understand that I will be required to obtain the clearance of a physician to participate. I further understand that irrespective of the clearance of the physician, I may be at greater risk of suffering injury, illness or death as a result of my participation. For the specific additional risks associated with my participation, I understand I should consult with my personal physician and specialist, in addition to the team physician. By continuing to participate in intercollegiate athletics despite these additional risks, I agree to assume these additional risks and waive any claims I may have as set forth more fully in each of the above paragraphs.

I certify that I am at least 18 years of age.  If not, parental/guardian signature is required.

Signature: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____

**SIERRA NEVADA COLLEGE SPORTS MEDICINE**
**MEDICAL CONSENT AND PRIVACY NOTIFICATION**

Please read the following consent/authorization forms carefully:
(If you are under 18 years of age, your parents must also sign)

The basic consent of each is:

| | | |
|---|---|---|
| A. | Medical Consent: | Allows the athletic trainers and team physician(s) to treat any injury you receive while at Sierra Nevada College. |
| B. | Shared Responsibility for Sport Safety | Acknowledges that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks. |

If you choose to refuse to sign any of these, please write "**Refuse to Sign**", the date, and your signature.

A photo copy of these authorizations shall be considered as effective and valid as the original for the time I am a participant in the intercollegiate athletic program at Sierra Nevada College.

Forms continue on the following page.

**Medical Consent**

I hereby grant permission to the Sierra Nevada College team physician(s) and/or the consulting physician(s) to render my son, daughter or myself, any treatment or medical or surgical care that they deem reasonable necessary to the health and well-being of the student athlete, including consults/referral to outside medical professionals.

I also hereby authorize the athletic trainer(s) at Sierra Nevada College who are under the direction and guidance of the Sierra Nevada College team physician(s) to render to my son, daughter, or myself any preventative first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to the health and well-being of the student athlete.

In case of serious injury or illness, I understand that reasonable effort will be made to contact the parents/guardians. If contact cannot be made, I hereby give permission to the Sierra Nevada College sports medicine staff, other facilities, or health care providers to administer emergency medical treatment including surgery as deemed advisable.

I authorize the Sierra Nevada College intercollegiate athletic department to provide the health center I am referred to any information requested, and the health center to provide the Sierra Nevada College intercollegiate athletic department any information requested concerning my health and athletic status.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

I understand and agree that Sierra Nevada College may use or disclose protected health information for treatment, payment and operations in accordance with the Notice of Privacy Practices that I have received, and any posted amendments to that Notice. I understand that Sierra Nevada College will not use or disclose protected health information for any purpose other than treatment, payment and healthcare operations, unless such person or entity or authorized to receive such information under law or I have provided a written authorization. (*See full explanation of disclosures and rights in the* ***Notice of Privacy Practices***). If I am being treated while I am a student athlete, I consent and agree that my health information may be used and disclosed in accordance with the Notice of Privacy Practices (and any posted revision of that Notice) and the federal Health Insurance Portability and Accountability Act (HIPAA).

Date: _____ Signature: _____

Signature may be that of athlete 18 years of age and over. If under 18, please have parent or guardian sign.

Date: _____ Signature: _____

**Shared Responsibility for Sport Safety**

Participation in sport requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

Periodic analysis of injury patterns and refinements in the rules and other safety decisions is an ongoing process. However to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule books is insufficient as to rely on warning labels to produce compliance with safety guidelines. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

I understand that by voluntarily participating in athletics at a collegiate level, I am undertaking a non-controllable risk which may result in an injury that may be very severe in nature. Such an injury may result in paralysis and/or death. It is further my understanding that it is entirely my responsibility to report any illness or injury to the athletic training staff or team physician(s). If I do not, Sierra Nevada College will not be responsible for those injuries. A student participating in intercollegiate athletics who reports to a physician without the knowledge of the certified athletic trainer in charge will accept the personal responsibility and expenses of such action. Exceptions are made for away games and during the absence of the athletic trainer at the time of the accident/emergency. I also understand that I must refrain from practice or play while ill or injured. The full-time athletic training staff, through the direction of the team physician(s), will inform the athlete and respective coaching staff of all the athlete's injuries and playing/practice status.

All walk-on student-athletes MUST have primary insurance coverage that is applicable in the state of Nevada. Sierra Nevada College Athletics insurance policy provides insurance for injuries sustained while participating in play or practice and is "EXCESS COVERAGE ONLY". This means that it pays benefits only after taking into consideration the insurance plan held by you or your parent(s). Illness and injuries not directly associated with athletic participation are the responsibility of the student-athlete.

I understand sickness and/or injuries are common in all athletics and that the Sierra Nevada College Intercollegiate Athletic Department will provide the most reasonable medical coverage in order to reduce the severity of such illness and/or injuries. The administration, coaches, and athletic trainers will equally provide to each student the equipment required to produce the safest possible intercollegiate athletic environment regardless of age, sex, race or religion.

I understand that the athletic medical insurance does not cover me until I have been cleared by an athletic medical physical examination. I further understand that the Sierra Nevada College athletic medical insurance is not for coverage of athletic injuries/illnesses not directly related to participation in intercollegiate athletics.

I have read the above shared responsibility statement and understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating at Sierra Nevada College.

_____

Printed Name of Student Athlete Signature Date

If under age 18:

_____

Signature of Parent or Guardian (please identify relationship) Date

# CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

## WHAT IS A CONCUSSION?

**A concussion is a brain injury that:**

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

## HOW CAN I PREVENT A CONCUSSION?

**Basic steps you can take to protect yourself from concussion:**

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

## WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

## WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

**Don't hide it.** Tell your athletic trainer and coach**.** Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

**Report it.** Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

**Get checked out.** Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

**Take time to recover.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

## IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

*Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.*

**SIERRA NEVADA COLLEGE SPORTS MEDICINE**
CONCUSSION RISK STATEMENT FOR ATHLETES

Sierra Nevada College Sports Medicine is committed to prevention, identification, evaluation, and management of concussions; therefore we have developed this information and consent form to educate you about concussions.

Concussion is defined as a complex process caused by trauma to the head or body that affects the brain causing a variety of symptoms as listed below. Current research suggests that 10% of athletes participating in a contact sport and can also occur in non-contact sports. Research in the field of concussion diagnosis and treatment has become a very important topic in recent years. In 2001, the first International Symposium on Concussion in Sport was held in Vienna, Austria. Since then, subsequent meetings have been held and attention to concussion management has increased worldwide.

The National Athletic Trainers' Association (NATA) adopted a policy for institutions requiring programs to develop a written concussion management program as well as providing information on concussions for student athletes and having student athletes sign a concussion risk statement.

Sierra Nevada College Sports Medicine has a concussion management plan on file which states that any student-athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be removed from practice or competition and evaluated by an athletic trainer, team physician or health care professional with experience in the evaluation and management of concussions. Student-athletes diagnosed with a concussion shall not return to activity for the remainder of that day. Medical clearance will be determined by the team physician or athletic trainer.

In addition, all student athletes must sign this form which states that you accept the responsibility of reporting your injuries and illness to the SNC athletic trainer or team physician, including signs and symptoms of concussions.

Signs and symptoms of a concussion:

- Amnesia (loss of memory)
- Confusion
- Headache
- Loss of consciousness
- Balance problems or dizziness

- Double or fuzzy vision
- Sensitivity to light or noise
- Nausea (feeling that you might vomit)
- Feeling sluggish, foggy or groggy
- Feeling unusually irritable
- Concentration or memory problems (forgetting game plays, facts, meeting times)
- Slowed reaction time

If you develop any signs or symptoms of a concussion, don't hide it; tell your athletic trainer and coach right away. Report your symptoms, do not return to the game or practice until your athletic trainer, team physician, or a health care professional clears you. Make sure you get checked out. If you do sustain a concussion, take time to recover. If you have any questions about concussions, please ask them.

**Informed Consent and Acceptance of Responsibility for Reporting Signs of Concussion**

I have read the information on concussion management plans and the signs and symptoms of a concussion. I accept full responsibility for reporting any signs and symptoms of concussion to the SNC Sports Medicine staff.

_____

Name of Student Athlete

_____ _____

Signature of Student Athlete Date

**Notice of Privacy Practices (effective *March 4, 2016*)**

This notice describes how your health information may be used and disclosed by the Sierra Nevada College Sports Medicine Department and your rights pertaining to that information. Please review it carefully.

**UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI)**

Understanding what is in your health record and how your health information is used will help you ensure its accuracy, allow you to better understand who, what, where and why others may access your health information and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, assessment/examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing your protected health information, it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required in order to treat students. The law allows us to use and disclose your health information without your specific authorization for treatment, payment and operations and other specific purposes explained on the next page. This includes the sharing of information, when necessary and appropriate, with other health care components of the College, such as the athletic department, or the on campus counselor, as necessary for your continued care. All other uses and disclosures require your specific authorization.

**YOUR HEALTH INFORMATION RIGHTS**. You have a right to:
Request a restriction on the uses and disclosures of your protected health information as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the designated Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.

- If you received the Notice of Privacy Practices electronically, you may request a paper copy of the Notice.
- Upon written request, you may inspect and obtain a copy of your health record for a fee of $.60 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Send and receive confidential communications of protected health information by alternative means or at alternative location, other than our usual methods. You should address the request in writing to the designated Privacy Officer.
- Revoke an authorization to use or disclose health information at any time except where the action has already been taken.

**RESPONSIBILITIES OF THE SNC ATHLETIC TRAINING DEPARTMENT.** We are required by law to:

- Maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and apply the change to all your protected health information, including information obtained prior to the change.
- If we change our notice of privacy practices, we will post the new changes in the office and a copy will be available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.

- In some circumstances, state or federal law may prohibit or further restrict the disclosure of your health information. If that is the case, we are required to follow the more stringent law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the Head Athletic Trainer Andrea Simich at (775) 881-7578. If you feel your rights have been violated, you may file a complaint in writing. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

We will use your health information for treatment: e.g., we will use information obtained by a physician, nurse practitioner, nurse or other medical professional, staff and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist him/her in your treatment. We will disclose personal health information to coaches pertaining to your current medical condition and any conditions that may restrict your ability to compete.

We will use your health information for payment: e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used as necessary to obtain payment.

We will use your health information for regular health operations: e.g. members of the medical staff, trainees, a Risk or Quality Improvement team, or similar internal operations may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- Business Associates: There are some services provided in our organization through contracts with business associates, such as laboratory services and radiology services. We may disclose your health information to our business associate so that they can perform these services. To protect your health information, we require the business associate to appropriately safeguard your information.
- Notification: We may disclose your health information to a friend or family member involved in your care or assisting you in payment. We may also notify a family member, friend, or other person responsible for your care, about your location and general condition.
- Disclosures required by law or for threats to safety: We may disclose your health information as required by law, or if necessary to avert a serious threat to health or safety, although disclosures are limited in information if obtained through counseling or therapy.
- Public Health: As allowed by law, we may disclose your health information to public health or legal authorities to 1) prevent or control disease, injury or disability 2) to report child abuse or domestic abuse, in which case you may be notified of the disclosure, 3) for purposes related to quality, safety, or effectiveness of FDA-regulated products or activity, 4) to identify exposure to, and prevent the spread of, communicable disease, including notification of individuals that may have been exposed to communicable disease, 5) to an employer to conduct medical surveillance of the workplace or to evaluate whether an employee has a work-related illness or injury, 6) to health oversight agencies as provided by law and 7) to report births and deaths.

- Law Enforcement and Court Proceedings: We may disclose health information to law enforcement in the following circumstances 1) information required by law, 2) limited information for identification and location purposes, 3)information regarding suspected victims of crime, although we will usually attempt to first obtain your agreement to release the information, 4) information about a deceased individual if we have a suspicion that the death resulted from criminal conduct, 5) information that we believe in good faith establishes that a crime has been committed on our premises during our providing of emergency health care. We may also disclose health information to others as required by court or administrative order, or in response to a valid summons or subpoena, for civil subpoenas, we will seek assurances for the requesting party that reasonable efforts have been made to inform you of the subpoena.
- Information Regarding Decedents: We may disclose health information regarding a deceased person to 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may disclose health information to where you have authorized such disclosure. We may also disclose health information where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or the disclosure is approved by an institutional review board (IRB) or properly constituted Privacy Board if the Board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information.

- Military, National Security and Correctional Department Disclosures: We may disclose health information in connection with the responsibilities of the armed services if you are a member, national security and intelligence, protective services for certain government officials, and to correctional officials for health and safety purposes if you are an inmate.
- Marketing and Appointment Reminders: We may contact you to provide appointment reminders or information about treatment alternatives other health-related benefits and services that may be of interest to you.
- Fund Raising: We may contact you as a part of a fund raising effort.

Disclosures requiring authorization: All other disclosures of protected health information will only be made pursuance to your written authorization, which you have the right to revoke at any time, except to the extent that we have already relied upon the authorization.

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with and effective date of

_____
Date

**Student-Athlete Signature**: _____ Date: _____

**If student-athlete is under 18:**
Student-Athlete Parent/Guardian Signature: _____ Date: _____

Dear Parents/Guardians:

It is time to update our insurance files on your son/daughter for the upcoming school year. Enclosed is a questionnaire on what information will be needed. Also, a photo copy of the insurance card (front & back) will be needed to have on file. By having a copy of the insurance card on file we hope all claims are settled in a timelier manner.

If by chance your son/daughter is not covered by your primary insurance, the enclosed form still needs to be completely filled out. At the bottom of the form there is a statement stating that your son/daughter is not covered by your primary insurance, and a signature is required.

Below is information regarding Medical Coverage for Student – Athletes at Sierra Nevada College. Please note that this is a **secondary insurance and all student athletes must have their own primary insurance.**

## REFERRAL POLICY

All referrals for student-athletes that have suffered an athletic related injury to health care providers outside the Athletic Training and Sports Medicine program must be made by a staff Athletic Trainer. If a student-athlete is suffering from a non-athletic related injury or illness/medical condition, a staff Athletic Trainer may still assist in obtaining a referral, but SNC Athletics will not be responsible for any charges incurred.

When a student-athlete is injured, he/she must report to the staff Athletic Trainer as soon as possible. The Athletic Trainer will evaluate the athlete and, if needed, make the proper referral to another medical provider. **If a student-athlete or the student-athlete's parent/guardian makes an appointment or refers himself or herself to another medical provider, the student-athlete becomes responsible for any and all charges incurred (including travel and lodging costs, if applicable). This applies even if the injury occurred at a College sponsored/sanctioned event.** When possible, a staff Athletic Trainer will attend the student-athlete's appointment and communicate with their coach what findings were discussed and what the student-athlete's competitive status may be.

*Please note: if a student-athlete sees an outside physician regarding an applicable injury or medical condition, the student-athlete is asked to bring a copy of the physician's notes or a signed medical release from the physician to the athletic trainer for clearance.

## SECOND OPINIONS

A student-athlete is entitled to a second opinion if desired. However, if the second opinion is at the request of the student-athlete or the student-athlete's parents/guardians, SNC Athletics will not be financially responsible for any costs incurred to get the second opinion, including travel to and from the provider, costs for office visits, tests performed or ordered by the provider and treatments of any kind from the provider.

If the second opinion is at the request of a designated Sierra Nevada College team physician, then SNC Athletics will assist the student-athlete's primary insurance in covering the costs incurred in receiving the second opinion.

## PRE-EXISTING INJURY

Any student-athlete that is identified with a **pre-existing diagnosed injury or diagnosed illness** prior to enrollment at the college must notify or inform his or her staff Athletic Trainer while taking the pre-participation exam. Such injuries may preclude the student-athlete from participation. Clearance of pre-existing injuries must be rendered by the Team Physician. Without such notification subsequent re-injury or exacerbation of the illness will not entitle the student-athlete to benefits or coverage and may not be the responsibility of SNC Athletics.

A student-athlete that does have a pre-existing injury/illness that occurred prior to being enrolled at the college, and is not cleared by their pre-participation physical and is unable to practice/compete will be responsible for all and any treatment/procedures needed for them to compete at the college. SNC Athletics will help out with any in house rehabilitation for that student-athlete to compete.

A student-athlete that had a pre-existing injury prior to being enrolled but has been cleared to participate and has been competing fully, will be evaluated on their pre-participation exam, and will need to be cleared by a Physician. After being cleared they may participate fully at the college. If that student-athlete should acutely injure that body part again after being cleared, it will be considered a new injury, if it occurred during a sanctioned college practice or event.

## MEDICAL CONDITIONS

SNC Athletics secondary insurance policy **does not** cover medical conditions and/or birth defects. If a student- athlete presents to the athletic training room with unknown symptoms, the student-athlete may be referred to a team physician for treatment. If after referral a medical condition/birth defect is diagnosed and it is determined that it is not an athletic related injury, SNC Athletics will no longer be responsible for charges incurred from that point. The Athletic Trainer or Team Physician may still assist with referral of that student-athlete with the understanding that the student-athlete is responsible for all or any charges from that point. (Examples of possible Medical Conditions: Mononucleosis, any internal organ abnormality, reproductive abnormality, abnormal heart condition)

### MEDICAL AND ATHLETIC INSURANCE COVERAGE

During the summer prior to the beginning of fall sports seasons a representative at Sierra Nevada College Athletic Department will send out insurance and parent authorization forms to each athlete's home. The athlete and their parents/guardians must fill out these forms and return them to the school as soon as possible, either before the beginning of the school semester, or the start of practice if the athlete is participating in a fall sport. If the athlete does not have any insurance coverage they must still fill out the insurance information forms and return them to the Sierra Nevada College Athletic Department. If an athlete does not have primary insurance coverage, they are encouraged to purchase the medical insurance provided by the school. **All athletes are required to have proof of insurance before they are allowed to participate in Intercollegiate Athletics in any manner.**

The Sierra Nevada College Athletic Insurance Policy is a **secondary** insurance policy that covers **injuries and conditions directly related to an athlete's sport that occur during practice, games or events.** It also covers rehabilitation of injuries that is required for the athlete to return to their sport. (Supervised is defined by the presence of a SNC Athletics staff) If a student-athlete is injured outside of a supervised

practice/game Sierra Nevada College is not responsible for any charges incurred, but may assist the student-athlete in obtaining a referral. The secondary insurance may also cover rehabilitation of injuries that is required for the student-athlete to return to their sport. Some injuries causing problems in vision, eyesight or dental problems may be considered coverable conditions. The Athletic secondary insurance policy does not cover non - network providers. Athletics reserves the right to approve out-of-network medical providers, and upon this approval Athletics will work to cover the costs. Any differences in the balance are the responsibility of the student-athlete. This will be communicated directly with the student-athlete or student-athlete's parents.

As a secondary policy, the Sierra Nevada College Athletic Insurance Policy will help to cover any co-payments or deductibles applied to the primary insurance. In a case where the athlete has no primary insurance, the Athletic Department insurance plan will become the primary insurance, but only for athletic related injuries and conditions. SNC Athletics will assist the student-athlete with medical treatment and payment for injuries acquired while participating in a school sanctioned intercollegiate athletic practice or event until the student-athlete has been released from care, or once the athlete is no longer eligible and on an active roster. If a student-athlete quits, is asked to leave, or has completed their eligibility, a member of the sports medicine team will work with that student-athlete to resolve any injuries in a timely manner that may have occurred while participating. If no injuries are noted, the student-athlete will be cleared and SNC Athletics is no longer a secondary policy from that date.

In the event that an athlete has to see a medical provider outside of the Athletic Training Room, a bill will be generated for the services that are rendered by the provider. **It is the responsibility of the athlete to submit these bills, along with a copy of the claim, to the insurance company.** There are specific procedures to be followed to ensure payment of the athlete's bills. Failure to follow the procedures may cause the athlete's bills to remain unpaid and the athlete may end up in collections, which will adversely affect their credit. Just because an athlete is on scholarship does not mean that their bills are automatically "taken care of." The procedures to follow are:

1. The athlete's primary insurance information and parent authorization forms must be filled out and a copy on file with the Athletic Training Staff. It is also a good idea for the athlete to have an insurance card or photocopy of their current card with them.
2. When an athlete is injured, he/she must report to the athletic trainer in charge of their sport as soon as possible. The athletic trainer will evaluate the athlete and, if needed, make the proper referral to another medical provider. **If an athlete or the athlete's parent/guardian makes an appointment or refers himself or herself to another medical provider, the athlete becomes responsible for any and all charges incurred (including travel and lodging costs, if applicable). This applies even if the injury occurred at a college sponsored/sanctioned event.**
3. When an appointment is scheduled for the athlete with a provider, the athlete's primary and secondary insurance information will be given to the provider. In the case of a non-athletic related or pre-existing injury or illness, only the athlete's primary information will be given. If the athlete does not have primary insurance and the injury or condition is not athletically related, he or she will have to set up a payment plan with the provider.

**The provider will bill the athlete's primary insurance company first, then the college's secondary policy (if applicable). During the course of the billing process, the athlete may receive documents from the provider indicating pending payments from their insurance company or outstanding balances after payment has been made. The athlete must submit these documents to the secondary**

**insurance company immediately. Failure to do so in a timely manner will cause delays in having the athlete's bills paid and may adversely affect their credit.**

If you have any questions or concerns regarding these policies, please feel free to contact Andrea Simich, Head Athletic Trainer 775-881-7578.

I have read and agree to the terms of the referral policy.

_____
_____
Parent/Guardian Name Student Athlete Name

_____
_____
Parent/Guardian Signature Student Athlete Signature

_____ _____
Date Date