# ATHLETICS MEDICAL ELIGIBILITY FORMS AND PRE-PARTICIPATION PHYSICAL EXAM

HOUGHTON COLLEGE

The following are steps to determine medical eligibility that, must be completed prior to participation in intercollegiate athletics at Houghton College.

_____ **Step 1: Pre-participation Evaluation:** All student-athletes are required to have a pre-participation physical exam prior to the first day of athletics related activity. No participation of any kind will be allowed without a physical.

Before going to the doctor for a physical, you should complete the history portion of the form, and review it with the examining physician at the time of the physical exam. The form requires a physician's signature and, once completed, should clearly indicate your medical clearance status for all the sports you expect to participate in during the course of the academic year (indicate these sports at the top of the pre-participation form). Please have your examining medical provider clearly document name, address and phone number. **For fall preseason athletes, completed forms must be returned to the Student Health Center prior to August 15. For students beginning in the spring (January), all forms must be submitted prior to <u>any</u> athletic participation.** Forms may be printed from the websites listed below.

_____ **Step 2: Mandatory Insurance Acknowledgement Form:** Any student participating in intercollegiate athletics will be enrolled in a mandatory accident-only insurance policy. Please read and sign the insurance clarification form and return it to the Athletic Training Room upon arrival on campus.

Also provide photocopies of primary insurance cards, front and back, to both Student Health Services and the Athletic Training Room. Copies of insurance cards given to the Athletic Training Room will be placed in the athlete's personal folder along with the emergency contact information and kept in the assigned medical kit when teams travel off campus.

***Note:** Providing these copies **does not** opt you out of the full-coverage insurance offered by the college to students who do not have a health insurance plan. You must still complete the online waiver located on the Student Health Services website if you wish to opt out.

_____ **Step 3: Release of Medical Information and Permission to Treat Minor forms:** Return these forms with signatures to the certified athletic trainers in the Athletic Training Room upon arrival on campus.

_____ **Step 4: Read and sign each of the following forms:**

- Risk Awareness Form
- ADD/ADHD Medication Form (this form will require a physician's signature)
- Sickle Cell Trait Statement
- Concussion Statement
- Banned Substance Form

Forms and information can be found on the following website:
www.houghton.edu/students/student-health-services/forms

HOUGHTON HIGHLANDERS

EMPIRE 8

NCAA Division III DISCOVER | DEVELOP | DEDICATE

# Preparticipation Physical Evaluation
# HISTORY FORM

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)*

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Class Level (circle one): First-Year Sophomore Junior Senior Sport(s) _____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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# Preparticipation Physical Evaluation
# PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

## PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| **EXAMINATION** | | |
|---|---|---|
| Height Weight | ☐ Male ☐ Female | |
| BP / ( / ) Pulse | Vision R 20/ | L 20/ Corrected ☐ Y ☐ N |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Mandatory Insurance Acknowledgement Form

I understand that as a student-athlete participating in intercollegiate athletics at Houghton College, the college provides a secondary medical insurance policy that I will be enrolled in. To partially off-set this cost all students-athletes will be charged a $50.00 participation fee. I understand that I will be billed this fee upon signing this form and participating in athletics. This insurance policy will not take the place of any primary health insurance I carry; it will be considered a secondary medical insurance coverage. Upon an emergency or medical treatment, my primary health insurance will be billed first for any medical treatment received from a hospital(ER), orthopedic, specialist, physical therapist, etc. Costs incurred from an athletic related injury not covered by primary care insurance, will be submitted to this secondary insurance policy.

Student –Athlete Name:_____
(Please print)

Student-Athlete Signature:_____ Date:_____

Parent's Signature:_____ Date:_____
(If student-athlete is a minor, under 18 yrs. of ages)

**CONSENT AUTHORIZATION AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize the release of my medical information that is pertinent to my participation in intercollegiate sports as may be requested by the certified staff members of Houghton College's Athletic Training Staff and/or the Student Health Services. Information from these records will be used to provide appropriate care and to assist in medical eligibility decisions. All information will be considered confidential. All such records will be maintained in the athlete's permanent medical record files located in the Athletic Training Room and Student Health Services.

As well, I give permission for Student Health Services and Athletic Training Room Staff (Certified Athletic Trainers) to share medical information that is pertinent to my participation in intercollegiate sports. I understand that a copy of any medical records from the team physician's, primary care physician, specialist, physical therapist, etc. will be provided to the Certified Athletic Trainer(s) and will be kept in the athlete's personal folder in the Athletic Training Room and Student Health Services. I understand that any shared information will be kept confidential and that I am not obligated to sign this release.

_____ Yes, I agree to release needed records pertaining to my athlete participation.

_____ No, I wish my records to remain confidential with my physician.

_____ _____

(signature of student-athlete) (date)

_____ _____

(signature of parent/guardian of student-athlete under age 18) (date)

**PERMISSION TO TREAT MINOR:**

**Student-athletes who are not 18 years of age must have their parents' permission to receive medical care.**

I give permission to the Certified Athletic Trainers and Medical Staff of Houghton College as well as Certified Athletic Trainers at the host institution to evaluate and treat my son/daughter. Every effort will be made to contact you and/or the person listed above on the Emergency Notification form prior to any medical services being rendered in an off-campus setting; however, emergency care will be provided as needed.

_____ _____

(Signature of parent only if student-athlete is a minor) (date)

_____

(Relationship to student-athlete)

**Assumption of Risk**

I am aware that participation in intercollegiate athletics involves certain risks that may result in injuries as well as onset of a sudden illness or medical conditions; any of which could result in temporary impairment, permanent disability, or even death. I understand the above risks, and understand that participation in this sport is voluntary.

I understand my responsibility to myself and the athletic program at Houghton College to not withhold information, and will immediately alert the coach, certified athletic trainer, or team physician if an injury or illness arises that affects athletic performance.

_____

Name (Print)

_____ _____

Signature Date

_____ _____

Parents Signature (if student-athlete is under 18 years old) Date

**ADD/ADHD Medication Statement**

The NCAA requires documentation for stimulant medication commonly prescribed for Attention Deficit Disorder (ADD) and/or Attention Deficit Hyperactivity Disorder (ADHD). Many medications used to treat this disorder are among these substances banned by the NCAA. Institutions must present documentation that these medications have been prescribed by a physician and also have been supported by a clinical assessment for education or health reasons. See (www.ncaa.org) Banned Drugs and Medical Exceptions Policy for further explanation. Your medications should be listed below, on the Health History Form and also listed under current medical conditions/medications on cardstock form.

Please provide the following information if you are taking any medication for ADD/ADHD:

Prescribed Medication:

_____

_____

_____

_____

_____

Prescribing Physician:_____

Physician's Address: _____

_____

_____

Phone & Fax number:_____

_____ _____

(Signature of Prescribing Physician) (Date)

**HOUGHTON COLLEGE SICKLE CELL TRAIT TESTING**

About Sickle Cell Trait:

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells and it affects more than 3 million Americans.
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South / Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape). These abnormal cells can occlude bloodstream and "logjam" blood vessels leading to collapse from the rapid breakdown of muscles starved of blood.
- This muscle break down (Rhabdomyolosis) may also cause major damage to the spleen or kidneys and can be fatal.

Sickle Cell Trait Testing:

- The NCAA mandates that NCAA Division III student-athletes beginning their initial season of eligibility and students who are trying out for a team have knowledge of their sickle cell trait status before the student-athlete participates in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc.

## SICKLE CELL TRAIT TESTING WAIVER

I, _____, understand and acknowledge that the NCAA and Houghton College mandate that all Division III student-athletes have knowledge of their sickle cell trait status. Additionally I have read and fully understand the aforementioned facts about sickle cell trait and sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, and prior injures, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and /or knowledge of sickle cell trait status to Houghton College personnel.

**Check one box and sign below:**

- ❑ I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination and I voluntarily agree to release, discharge, indemnify and hold harmless Houghton College, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands or causes of action on account of any loss or personal injury that might result from my non-compliance with the mandate of the NCAA and Houghton College Department of Intercollegiate Athletics.
    - o I hereby understand that with checking that I do not wish to undergo sickle cell testing, I will be required to receive further education regarding sickle cell disease under the direction/instruction of the Houghton College Certified Athletic Trainer(s). _____ (Student-Athlete Initials)
    - o I have attended an additional educational session regarding sickle cell disease.

      _____ _____
      (Student-Athlete Signature) (Date)

      _____ _____
      (Certified Athletic Trainer Signature) (Date)

- ❑ I agree to have sickle cell trait testing and to be tested at my own expense.
- ❑ I have previously been tested for the sickle cell trait and will provide Houghton College with the results.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver. The above information may be shared with the Athletic Department.

_____ _____
Student-Athlete Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Date

_____ _____
Witness Date

Houghton College

Injury, Illness and Concussion Acknowledgement Form

I, _____, recognize that as a Houghton College athlete, I have to be an active participant in my own healthcare. I have the direct responsibility for reporting all of my injuries and illnesses to the Certified Athletic Trainers and/or Team Physician. I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the Certified Athletic Trainers and/or Team Physician.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion that may incur temporary impairment, permanent disability, or even death. I understand the importance of immediately reporting symptoms of a head injury/concussion to the Certified Athletic Trainers and/or Team Physician.

By signing below, I acknowledge that Houghton College has provided me with specific educational materials on what a concussion is and given me an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, _____have read the above and agree that the statements are accurate.

_____ _____

(Student-Athlete Signature) (Date)

_____ _____

(Parent/Guardian signature if under 18 yrs of age) (Date)

Houghton College Department of Intercollegiate Athletics
Banned Substance Form & Medication Exemption Information

Dear Health Care Provider:

_____ is an intercollegiate student athlete at Houghton College. Houghton College is an NCAA Division III institution and is governed by the rules and regulations set forth by the association. Legislation set forth by the NCAA, mandates the collection of medical records for those student athletes who have been prescribed a medication that is on the banned substance for a specific condition where the medication is deemed an appropriate treatment. For a list of banned substance, please refer to the following website: www.ncaa.org/health-safety.

There are specific procedures intercollegiate athletic departments must follow to show compliance with these regulations. In order to insure compliance, student athletes are being asked to provide their health care providers with this information so complete records may be obtained and maintained in their medical file. This information will allow the student athlete to continue to compete in intercollegiate athletics without the risk of a positive drug test and continue to take their appropriate medication as prescribed by their health care provider. Please return this form with all pertinent information to the student athlete.

Students Athlete's Name_____Date of Birth_____

Date of initial evaluation_____ Date of most recent follow up_____

Physician's Diagnosis_____

Assessment utilized for diagnosis_____

Medication prescribed / Follow-up orders_____

Please attach the following:

- Documentation of the comprehensive clinical evaluation used for diagnosis of this student- athlete.
- A copy of the most current prescription to include drug name and dosage.
- Note-worthy alternative non-banned medications that have been tried or considered to treat this student athlete and documentation as to why they are not being utilized.
- For student athletes diagnosed with ADD/ADHD, please attach any rating scale (Connors, ASRS, CAARS) scores and report summaries.

Name of Physician:_____

Address:_____

Specialty: _____ License #_____

Signature: _____ Date:_____