BC Sports Medicine

Policy Information for Student-Athletes & Parents

PLEASE KEEP THIS LETTER FOR FUTURE REFERENCE

Benedictine College is dedicated to providing quality health care for every athlete. Unfortunately, injuries occur in athletic events and athletes may require medical attention. In the event you are injured while performing in an in-season athletic practice or athletic event and receive medical attention, please refer to this letter for payment of medical expenses.

POLICIES AND PROCEDURES CONCERNING MEDICAL EXPENSE COVERAGE

1. Benedictine College (BC) does not provide primary or secondary insurance for athletes.

2. ALL athletes must show proof of insurance before participating in ANY athletic official team practice or contest. Insurance coverage must be maintained for the duration of the time the athlete participates.

3. All medical expenses for injuries sustained while participating in an athletic contest or during an official practice session at **BC MUST BE SUBMITTEND TO THE STUDENT'S PRIMARY INSURANCE PROVIDER**.

4. Visits to a physician for evaluation and minor care are the responsibility of the student athlete and/or student's insurance carrier. After the full benefits of private insurance are utilized the Athletic Department will reimburse up to a MAXIMUM of $500.00 on emergency transport or surgical procedures performed due to an injury sustained during practice or competition. This **DOES NOT** include injuries sustained during intramural activities or accidents on campus.

5. Please be aware that some insurance companies will waive coverage if any injury is sustained during athletic activity. Please be sure your insurance does, in fact, cover athletic injuries. Also, please be sure your insurance coverage is maintained outside of your hometown. Students away from home using insurance may account for higher co-payments or no coverage at all, except in emergency situations. Insurance of student-athletes who are not U.S. citizens should also make sure coverage is guaranteed outside of the athlete's home country.

6. BC's Athletic Trainer(s) and/or Team Physician(s) will arrange for ALL medical treatment and services required for any athletic injury. Medical expenses incurred by an athlete which were obtained **WITHOUT PRIOR AUTHORIZATION** of BC's medical staff will be the sole responsibility of the student-athlete and/or his or her parent(s) or guardian(s).

7. The student-athlete or his or her parent(s) or guardian(s) will be responsible for the payment of medical services regarding:
    - Pre-existing and congenital medical conditions
    - Illness (colds, flu, etc.)
    - Injury, illness, or medical condition not related to BC official athlete practice or game participation
    - Medical expenses for athletic injury referral not authorized by BC medical staff
    - Medications

8. All arrangements for the payment of medical expenses MUST be made before the student-athlete graduates or withdraws from BC. Responsibility for any medical expenses will not be accepted by BC after a period of time of one year following the date of injury.

1020 N. 2nd Street, Atchison, KS 66002 ● Phone: (913) 360-7564 ● Fax: (913) 367-2564

Sports Medicine

Emergency Contact and Insurance Verification

FIRST NAME: _____ LAST NAME: _____ DOB: ____ / ____ / ____

SPORT: _____ CELL PHONE #: _____

THIS FORM WILL BE REQUIRED PRIOR TO ANY ATHLETIC PARTICIPATION.

We would appreciate your assistance in providing the following information for the upcoming athletic season. Should a student-athlete need medical assistance while participating in an official practice or contest; the following information will be needed.

Emergency Contact: _____ Relationship: _____

Contact's Address: _____ City: _____ State: _____

Daytime Phone #: _____ Evening Phone #: _____

Name of Insured: _____ DOB: _____ SSN: _____

Insurance Provider: _____

Group #: _____ Plan #: _____ ID#: _____

Does your insurance cover ATHLETIC INJURIES? ☐ **Yes** ☐ **No**

Is pre-certification required prior to hospital admission? ☐ **Yes** ☐ **No**

Precertification phone #: _____

Do you have a deductible? ☐ **Yes** ☐ **No** Amount: $_____

Do you have a co-payment? ☐ **Yes** ☐ **No** Amount: $_____

Is this medical insurance an HMO, PPO, or other? ☐ **HMO** ☐ **PPO** ☐ **Other**

Does this insurance plan require referrals from your primary care physician? ☐ **Yes** ☐ **No**

Physician Name: _____

Phone #: _____ Insurance Termination Date: _____

To complete this form, it is REQUIRED to return with a front and back photocopy of the insurance card.

If **YES**, please be aware that it is **YOUR** responsibility to obtain any referral **PRIOR** to services rendered unless otherwise dictated by your policy.

It is the sole responsibility of the athlete to purchase, maintain, and inform the Benedictine College Sports Medicine staff of any changes to their insurance policy throughout the academic year. Any medical expenses incurred due to lapse of insurance are the sole responsibility of the injured athlete.

I do hereby state that, to the best of my knowledge and belief, the information that I have provided in the Emergency Contact and Insurance Verification is correct and accurate. I understand that failure to fully complete or any attempts to mislead the College may disqualify my son/daughter from participation of intercollegiate athletics at Benedictine College.

_____ _____

Student-Athlete's Signature Date

_____ _____

Parent/Guardian's Signature ***(if under 18 years of age)*** Date

_____

Parent/Guardian's Print Name

BC Sports Medicine

New Athlete Medical History Questionnaire

FIRST NAME: _____ LAST NAME: _____ MI: ____

SEX (CIRCLE): M F DATE OF BIRTH: ____/____/____ AGE: _____

ACADEMIC YEAR (CIRCLE): 1 2 3 4 5 SPORT: _____

Please answer all of the following questions. Please check either YES or NO for each question and then explain every YES answer in the space provided: THANK YOU.

GENERAL MEDICAL HISTORY

Please answer the following questions:

Current or past medical conditions:

_____
_____
_____

Surgical history:

_____
_____
_____

Significant family history medical conditions (heart attack, high blood pressure, diabetes, etc):

_____
_____
_____

Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?	☐ **Yes** ☐ **No**
Do you use alcohol? If yes, how often?	☐ **Yes** ☐ **No**
Have you ever used/tried marijuana, cocaine, or any other illicit "street" drug?	☐ **Yes** ☐ **No**

If you answered **YES** to any of the above, please explain:

_____
_____
_____
_____
_____

Have you ever had any of the following conditions?

Rubella	☐ **Yes** ☐ **No**	Chickenpox	☐ **Yes** ☐ **No**	Thyroid Disease	☐ **Yes** ☐ **No**
Rebeola	☐ **Yes** ☐ **No**	Mononucleosis	☐ **Yes** ☐ **No**	Meningitis	☐ **Yes** ☐ **No**
Hepatitis	☐ **Yes** ☐ **No**	Mumps	☐ **Yes** ☐ **No**	HIV	☐ **Yes** ☐ **No**

If you answered **YES** to any of the above, please explain:

_____
_____
_____
_____

Allergies:

Have you ever been diagnosed with any allergies (Medicines, Bee Stings, and/or Foods)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever carried an epi-pen for your allergy(s)? ☐ **Yes** ☐ **No**
- Please describe: _____

Are you currently taking/have you previously taken any allergy medications? ☐ **Yes** ☐ **No**
- Please describe: _____

Asthma:

Have you ever been diagnosed with Asthma and/or Exercise Induced Asthma? ☐ **Yes** ☐ **No**
- Please describe: _____

Are you currently taking/have you previously taken any allergy medications or used an inhaler? ☐ **Yes** ☐ **No**
- Please describe: _____

How many acute asthma attacks have you had in the past 24 months? ☐ **Yes** ☐ **No**
- Please describe: _____

Cardiovascular Risk Factors:

Does anyone in your family have a history of high blood pressure? ☐ **Yes** ☐ **No**
- Please describe: _____

Does anyone in your family have a history of high blood cholesterol? ☐ **Yes** ☐ **No**
- Please describe: _____

Has any family member or relative died of heart problems and/or sudden death before age 50? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been told you have/had high blood pressure? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been told you have/had high blood cholesterol? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been told you have a heart murmur? ☐ **Yes** ☐ **No**
- Please describe: _____

Has a physician ever denied or restricted your participation in sports due to any heart problems? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been seen by a heart specialist (Cardiologist)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had an electrocardiogram (EKG) and/or an echocardiogram of your heart? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had chest pain and/or shortness of breath during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice? ☐ **Yes** ☐ **No**
- Please describe:_____

Do you get tired more quickly than your teammates during exercise/practice? ☐ **Yes** ☐ **No**
- Please describe: _____

Diabetic History:

Have you ever been diagnosed with diabetes? ☐ **Yes** ☐ **No**
- Please describe: _____

Are you currently taking any diabetic medication? ☐ **Yes** ☐ **No**

Medication	Form	Dosage	Frequency

Do you monitor your blood sugar level daily? ☐ **Yes** ☐ **No**
- Please describe: _____

Please list any precautions that you take and/or additional information not listed above:

_____

_____

Heat Related Problems:

Have you ever experienced heat cramps, heat exhaustion, and/or heat stroke? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever received intravenous fluids (IV) for a heat related problem? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been hospitalized for a heat related problem(s)? ☐ **Yes** ☐ **No**
- Please describe: _____

Dermatological:

Do you have any skin conditions (i.e. itching, rash, acne, warts, eczema, fungus, etc.)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been under the care of a dermatologist for any condition? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had MRSA or a staph infection? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had herpes glaldatorium (mat herpes)? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ **Yes** ☐ **No**
- Please describe: _____

Vision:

Do you routinely wear glasses? ☐ **Yes** ☐ **No**

Do you routinely wear contacts? ☐ **Yes** ☐ **No**

Do you wear any special devices or protective equipment? ☐ **Yes** ☐ **No**
- Please describe: _____

Is your color vision normal? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever had an eye injury? ☐ **Yes** ☐ **No**
- Please describe: _____

Ear/Nose/Throat:

Do you have frequent ear infections and/or nosebleeds? ☐ **Yes** ☐ **No**

Have you ever had an injury to your ear(s), nose, and/or throat? ☐ **Yes** ☐ **No**
- Please describe: _____
- Days missed? _____

Dental:

Do you have a bridge or any false teeth? ☐ **Yes** ☐ **No**

Have you ever fractured a tooth or had a tooth knocked out? ☐ **Yes** ☐ **No**
- Please describe: _____

Have you ever suffered any other type of injury to your mouth, jaw, and/or teeth? ☐ **Yes** ☐ **No**
- Please describe: _____

Abdomen:

Have you ever been diagnosed with a problem involving your stomach, abdomen, intestines, or rectum? ☐ **Yes** ☐ **No**
- Please describe: _____
- Days missed? _____

Have you ever had abdominal surgery? ☐ **Yes** ☐ **No**
- Please describe: _____
- Days missed? _____

Do you have only one of two paired, functioning organs (kidney, testicles, ovaries, etc.)? ☐ **Yes** ☐ **No**
- Please describe: _____

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

Do you routinely suffer from chronic or recurrent diarrhea? ☐ **Yes** ☐ **No**
- Please describe: _____

Please list ALL prescription and over-the-counter medications, supplements, and/or performance aids that you are CURRENTLY taking or HAVE TAKEN in the past (12) months, and for what purpose:

Medication	Condition	Dosage	Date(s)

Fill out only ONE OF THE FOLLOWING boxes.

MALE Student-Athletes

Have you ever had a testicular injury? ☐**Yes** ☐**No**
- If YES, when? _____

Have you ever been seen by a doctor for testicular pain? ☐**Yes** ☐**No**
- If YES, what for? _____

Do you feel pain or burning with urination? ☐**Yes** ☐**No**

Do you have blood in your urine? ☐**Yes** ☐**No**

Have you had any kidney, bladder, or prostate infections in the last 12 months? ☐**Yes** ☐**No**

Do you have any problems emptying your bladder completely? ☐**Yes** ☐**No**

Have you been diagnosed with:
- Hydrocele ☐**Yes** ☐**No**
- Varicocele ☐**Yes** ☐**No**
- Torsion ☐**Yes** ☐**No**

Have you ever had a hernia? ☐**Yes** ☐**No**
- If YES, please describe:

_____

FEMALE Student-Athletes

Have you had regular/monthly menstrual periods within the past 12 months? ☐**Yes** ☐**No**
- If NO, how many in the past year? _____
- When was your most recent menstrual period? _____

Do you take medications during your menstrual periods? ☐**Yes** ☐**No**
- If YES, what? _____

Have you had a pelvic examination within the last 12 months? ☐**Yes** ☐**No**

Have you ever been diagnosed with a stress reaction or fracture? ☐**Yes** ☐**No**

Do you feel you maintain healthy eating habits? ☐**Yes** ☐**No**
Have you had a weight change (gain or loss) of greater than 10lbs in the past 12 months? ☐**Yes** ☐**No**
Do you regularly lose weight to participate in your sport? ☐**Yes** ☐**No**
Do you want to weight more or less than you presently do? ☐**Yes** ☐**No**
Do you have a history of anorexia, bulimia, and/or other eating disorders? ☐**Yes** ☐**No**
- Please describe: _____

Do you feel stressed out? ☐**Yes** ☐**No**
Do you get the necessary support to deal with your stress? ☐**Yes** ☐**No**
Have you been diagnosed with a mental disorder? ☐**Yes** ☐**No**
- Please describe: _____

CONCUSSION HISTORY

Head Injuries/Concussion:

Have you ever suffered a head injury/concussion (no matter how minor)? ☐**Yes** ☐**No**
- How many? _____
- Dates:_____

Have you ever been evaluated by a physician for a head injury? ☐**Yes** ☐**No**
- Please describe: _____

Have you ever been hospitalized, become unconscious, and/or lost your memory from a head injury? ☐**Yes** ☐**No**
- Please describe: _____

Do you suffer from frequent headaches? ☐**Yes** ☐**No**
- How often? _____
- Please describe: _____

Do you have a history of migraine headaches? ☐**Yes** ☐**No**
- How often? _____
- Please describe: _____

Do you have a history of seizures? ☐**Yes** ☐**No**
- Please describe: _____

ORTHOPEDIC HISTORY

Have you ever injured (sprained, strained, dislocated, fractured, or had repeated swelling) any of the following:

		EXPLANATION
Head/Face	☐ **Yes** ☐ **No**	_____
Neck	☐ **Yes** ☐ **No**	_____
Chest	☐ **Yes** ☐ **No**	_____
Shoulder	☐ **Yes** ☐ **No**	_____
Elbow	☐ **Yes** ☐ **No**	_____
Wrist/Hand	☐ **Yes** ☐ **No**	_____
Thumb/Fingers	☐ **Yes** ☐ **No**	_____
Back	☐ **Yes** ☐ **No**	_____
Hip/Thigh	☐ **Yes** ☐ **No**	_____
Knee	☐ **Yes** ☐ **No**	_____
Lower Leg	☐ **Yes** ☐ **No**	_____
Ankle	☐ **Yes** ☐ **No**	_____
Foot/Toes	☐ **Yes** ☐ **No**	_____

Have you ever been diagnosed with a stress reaction or fracture? ☐ **Yes** ☐ **No**

- Please describe: _____

Name any recent injuries or illnesses within the last 18 months which resulted in surgery, hospitalization, or loss of participation:

_____
_____
_____

REVIEWED BY ORTHOPEDIC PROVIDER _____ _____
Provider's Signature Date

PROVIDER COMMENTS:

_____
_____
_____
_____
_____
_____

THE FOLLOWING CONDITIONS REQUIRE A LETTER FROM YOUR ATTENDING PHYSICIAN CLEARING YOU FROM THE INJURY OR DISORDER BEFORE YOU ARE ALLOWED TO PARTICIPATE:

A) Heart murmurs and heart abnormalities
B) Bone and joint surgeries performed within one year of participation at BC
C) Any medical illness or disease which limits physical participation

I do hereby state that, to the best of my knowledge and belief, the medical history and information that I have provided is complete and accurate. I further understand that any medical information withheld, incomplete, or incorrect discharges Benedictine College from all medical and legal liability and may disqualify me from participating in intercollegiate athletics at Benedictine College.

_____ _____
Student-Athlete's Signature Date

_____ _____
Parent/Guardian's Signature ***(if under 18 years of age)*** Date

_____
Parent/Guardian's Print Name

Sports Medicine

Athlete Physical Examination

FIRST NAME: _____ LAST NAME: _____ MI: ____

SEX (CIRCLE): M F SPORT: _____ DOB: ____/____/____ AGE: _____

I have reviewed the Benedictine College Medical History Questionnaire with the student-athlete, and will address concerns below. _____

Provider's Initials

Vital & Body Composition Information:

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____

Vision: (L) ____/____(-____) (R) ____/____(-____) (B) ____/____(-____) Corrected? □ Yes □ No

GENERAL MEDICAL EXAMINATION

	WNL	Abnormal Findings
HEENT	□	
Cardiac	□	
Lungs	□	
Abdomen	□	
Hernia/Testes	□	□ N/A (F)
Neurological	□	
Dental	□	

Recommendations/Comments:

Examining Provider Signature:_____

ORTHOPEDIC EXAMINATION

	WNL	Abnormal Findings
Neck	□	
Shoulder	□	
Elbow	□	
Wrist	□	
Hand	□	
Back	□	
Hip	□	
Knee	□	
Ankle	□	
Foot	□	

Recommendations/Comments:

Examining Provider Signature:_____

PROVIDER'S STATEMENT

□ Medically disqualified from competition

□ Pending

□ Approved with limitations

□ **Approved for athletic participation**

Comments: _____

_____

_____

_____

_____ _____

Provider's Signature Date

Sports Medicine

Medical Authorizations & Assumption of Risk

FIRST NAME	LAST NAME	MI	SPORT
_____	_____	_____	_____

A. Sports Medicine Services

I understand that the sports medicine staff's primary focus is preventing injury as well as treating and rehabilitation of injuries. I also understand that they will develop a rehabilitation program to fit the student-athlete's needs for a quick recovery and are assigned to attend practices and competitions with priority given to in-season, collision or high-risk sports. BC's team physicians do not attend all practices and competitions; however, are available via contact with the athletic trainer.

I acknowledge that all athletic injuries and illnesses are to be reported immediately to the sports medicine staff for evaluation, care, and referral. The Sports Medicine staff assess the immediate needs and gives authorization to receive medical care from one of the following: Team Physicans, Health Services, and Outside Physicians. No one within the Athletic Department outside of the Sports Medicine team is allowed to authorize any type of care or referral. The student-athlete is responsible to report back to the sports medicine staff with information regarding the doctors' visit and follow-up care. Failure to do so may result in being withheld from participation. Final clearance will be made by the BC medical physicians.

Student-Athlete Initials _____

B. Assumption of Risk

Participation in intercollegiate athletics at Benedictine College requires an acceptance of risk of injury. Participation in your sport could result in serious injury, up to and including death. Serious injuries include (but are not limited to) serious neck and spinal injury which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of your body, general health and well-being. Minor and moderate injuries in athletics include (but are not limited to) sprains, strains, contusions, abrasions, and lacerations.

Protective equipment and preventative taping is available to all athletes as needed in each sport. You must be aware that protective equipment and preventative taping will NOT PREVENT ALL INJURIES FROM OCCURING. To maximize the effectiveness of protective equipment, inspect it daily and exchange all defective equipment. Make sure equipment is properly adjusted and worn during all games and practices.

Waiver of Liability and indemnification – In consideration for being allowed to voluntarily participate in the following sport, _____, on behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I forever WAIVE, RELEASE, DISCHARGE, AND COVENANT NOT TO SUE Benedictine College and its agencies, officers, medical staff, physicians and employees from any and all negligence and liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, as a direct or indirect result of (i) the risks and dangers associated with the above referenced activity or event; (ii) my negligence, intentional act or omission; and/or (iii) the negligence, intentional act or omission of a third party. I further agree to defend, indemnify, and hold harmless Benedictine College, its agencies, medical staff, physicians and employees, from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from my actions during the above referenced activity or event, as well as any activities incidental thereto, wherever, whenever, or however the same may occur. I execute this release for full, adequate and complete consideration, fully intending to be bound by same.

Student-Athlete Initials _____

C. Medical Authorization

I grant permission to Benedictine College athletic trainers, physicians, and/or other medical practitioners to render any preventative, emergency, surgical, or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being, and to arrange for my hospitalization where reasonable and necessary, in circumstances connected with my participation in activities with BC athletic teams which I am a participant.

Student-Athlete Initials _____

D. Disclosure of Health Conditions

I authorize the Sports Medicine staff, or their designee, to discuss my health or medical condition with my parents, guardians, or immediate family members in case of a health emergency on my part. A health emergency shall include (but is not limited to) experiencing serious physical or mental difficulties, requiring hospitalization or treatment for any serious physical or mental ailment, injury, disorder, or other health condition which the Head Athletic Trainer or the Head Coach believes in good faith to be a serious nature.

In the event of any injury or emergency medical condition, I hereby authorize Benedictine College Sports Medicine staff or Team Physician(s) to contact my parent(s)/guardian(s). _____ Agree _____ Disagree

By signing below I have read, understand, and approve of Parts A, B, C, and D above.

_____ _____

Student-Athlete's Signature Date

_____ _____

Parent/Guardian's Signature ***(if under 18 years of age)*** Date

_____

Parent/Guardian's Print Name

Sickle Cell Anemia and Trait Questionnaire/Waiver

Sickle Cell Anemia is an inherited disease in which an abnormal gene affects hemoglobin in the red blood cells. It is inherited from both parents. Sickle cell anemia causes significant anemia and many other serious health problems.

Sickle Cell Trait is a common medical condition that is found in more than three million people in the U.S. Sickle cell trait occurs when the abnormal gene affecting hemoglobin is inherited from only one parent. It cause very few health problems, and does not cause anemia. In rare cases, athletes with SICKLE CELL TRAIT have experienced significant distress, collapse, or even death during rigorous exercise. This is caused by sickling of the red blood cell (red blood cells changing from a normal disc shape to a quarter-moon shape), which can "logjam" blood vessels. This log jam causes a rapid breakdown of muscles tissue that is starved of blood. Heat, dehydration, altitude, and asthma can increase or worsen the complication associated with sickle cell trait, even if exercise is not intense. For more information and resources go to www.ncaa.org/health-safety.

Understanding that the condition is one of inheritance versus race, the sickle gene is common in people whose origin is from areas where malaria is widespread. These populations include ancestry from Africa, South or Central America, the Caribbean, Mediterranean countries, India, and Middle Eastern countries.

Athletes who are positive for the *sickle cell trait* *will not* be prohibited from participating in intercollegiate athletics.

_____	_____	_____
Student-Athlete's (Print) Name	Sport	Date

Please check one of the following statements:

☐ I acknowledge that I have read the above information and **WOULD LIKE TO BE TESTED** for the sickle cell trait. Upon arrival to campus, BC Sports Medicine staff will assist in test scheduling.
(testing will be billed through the student-athlete's primary insurance)

☐ **I HAVE BEEN TESTED PREVIOUSLY.** I acknowledge being tested before and agree to provide proof of my sickle cell trait status. **LOCATION:** _____ **DATE TESTED**:_____

☐ I acknowledge that I have read the above information and **I DO NOT WANT TO BE TESTED FOR SICKLE CELL TRAIT** (must sign waiver below).

Sign below only if you DO NOT want to be tested

I, (please print)_____, understand and acknowledge that Benedictine College recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts and the policy 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, prior injuries, 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 Benedictine College Sports Medicine staff.

I DO NOT WISH to undergo sickle cell trait testing (initial) _____ and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Kansas, the College, its officers, employees, agents and their successors and assigns from any and all costs, claims, damages or expenses, including attorney's fees, arising from any loss or personal injury that might result from my refusal to be tested.

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.

_____	_____
Student-Athlete's Signature	Date
_____	_____
Parent/Guardian's Signature ***(if under 18 years of age)***	Date
_____	
Parent/Guardian's Print Name	

General Student Health Forms Next Page

Mail this form and a copy of your insurance card to: Benedictine Student Health, 1020 N 2nd, Atchison, KS, 66002.

BENEDICTINE COLLEGE STUDENT HEALTH FORM

PART I. STUDENT INFORMATION

Date of entry to Benedictine: Mo____ Yr____ Re-entry? Yes No

Name_____Birth Date_____Sex: M F
First Middle Last

Student's Email_____Student's Cell Phone(_____)_____

Home Address_____Phone(_____)_____
Street City State Country Zip

Father'sName_____Phone(W)(____)_____
First Middle Last (H)(____)_____

Mother's Name_____ Phone(W)(____)_____
First Middle Last Phone(H)(____)_____

Emergency Contact Name_____ Relationship_____

Phone: Work(____)_____ Home(____)_____

PART II. MEDICAL HISTORY

Do you have a present of past history of: (check all that apply)

□Alcohol Abuse	□Drug Abuse	□Joint Disease/Injury	□Sexually Tran Dis (STD)
□Anemia	□Ear Trouble/Hearing Loss	□Measles, Red	□Sickle Cell Trait (Anemia)
□Arthritis	□Eating Disorder	□Menstrual Problems	□Sinus Trouble
□Asthma	□Eye Disease/Problems	□Migraine Headache	□Skin Problems (Chronic)
□Back Problems	□Gallbladder Trouble	□Mononucleosis, Infectious	
□Cancer	□Hay Fever (Recurrent)	□Mumps	□Sleep Problems
□Chicken Pox	□Head Injury	□Pneumonia	□Smoking (how long?)
□Colitis	□Headache (Recurrent)	□Paralysis	
□Convulsions/Seizures	□Heart Disease/Problems	□Polio	□Spleen, Surgical Removal
□Cough (Chronic)	□Hepatitis/Jaundice	□Psychological Counseling	□Thyroid Disease
□Depression	□Hernia/Rupture	□Rheumatic Fever	□Tuberculosis
□Diabetes	□High Blood Pressure	□Rubella (3-day Measles)	
□Disability/Handicap	□Intestinal/Stomach Trouble	□Scarlet Fever	□Urinary Tract Infection

□Other_____

Brief explanation of any marked:

DO YOU HAVE ANY SPECIAL HEATH CONCERNS? Please List:_____

_____

MEDICATIONS (list all currently taking)

_____

_____

DRUG ALLERGIES

_____

_____

HOSPITALIZATIONS/SURGERIES

_____

_____

ALLERGIES (latex, tape, food, others)

_____

_____

PART III. FAMILY HISTORY (place relationship in blank)

□Alcohol/Drug Abuse_____ □Death Before 50_____□Elevated Cholesterol_____ □Hypertension/Stroke_____
□Cancer/Type_____ □Diabetes_____ □Heart Disease_____ □Mental Illness_____
□Other_____

Brief explanation of any marked:

PART IV. CONSENT FOR TREATMENT

By signature, I verify that the information provided on this form is accurate and complete and truthfully recorded. I authorize Benedictine Student Health Center to provide medical services, immunizations, and therapeutic services to the above named student as may be necessary, and if needed, to refer to private care when special service is indicated. (Parent must also sign if student is under 18 years of age).

_____

Student's Signature Signature of Parent/Guardian Date

PART V. REQUIRED IMMUNIZATIONS AND TUBERCULOSIS SCREENING

The Benedictine College policy **REQUIRES** that all newly admitted or readmitted students born after January 1, 1957 show proof of TWO vaccinations for Measles, Mumps, Rubella, show proof of Meningitis vaccine and complete the tuberculosis screening process stated below. Failure to do so will result in being placed on administrative hold and blocked from enrollment in the following semester. History of Measles is NOT acceptable. Please submit one of the following:

- This personal record completed by a healthcare giver
- OR a physician or clinic report
- OR a copy of your school immunization record

A. REQUIRED MMR (measles, mumps, rubella) Date: 1st____/____/____ 2nd ____/____/____
Or: Measles 1st ____/____/____ 2nd ____/____/____ Or date of Immune Titer_____
And Mumps 1st ____/____/____ Or date disease confirmed by physician_____Or date of Immune Titer_____
And Rubella 1st ____/____/____ Or date of Immune Titer_____ (clinical history NOT acceptable for Rubella)

B. REQUIRED TUBERCULOSIS SCREENING (All students must answer the following questions.) **WRITE YES OR NO TO THE FOLLOWING:**

_____You are from or have lived for 2 months or more in Africa, Mexico, Central or South America, the Caribbean, Oceania/Pacific Islands, Asia, Indian Subcontinent, Middle East, or Eastern Europe & N.I.S. (circle those that apply)
_____Have you had any of the following symptoms for more than 2 weeks? Persistent cough, bloody sputum, night sweats, fever, weight loss, or loss of appetite. (circle those that apply)
_____You have been diagnosed with a chronic medical condition that may impair your immune system.
_____Have you had a recent known exposure to Tuberculosis?
_____You are a healthcare worker.
_____You are a volunteer or employee of a nursing home, prison, or other residential institution.

If any of the above applies, the following is required:
***Screening:** Come to Student Health for a free Tuberculosis skin test during hours posted at ext. 7117 after arrival to campus. **OR** provide documentation of PPD mantoux skin tests done in the US within the past 12 months: date given_____date read_____ Result in m.m. of induration_____
(International students: provide date given if BCG given_____/_____/_____)
***Chest X-Ray:** Chest x-rays will be required for anyone with a positive skin test. X-rays will be taken at the Atchison Hospital. Or you may submit an x-ray report taken within the last 12 months, if history of positive PPD. Date of positive PPD___/___/___
***Treatment:** A student with a positive skin test will be referred for follow up for possible treatment. If you have been treated for TB infection or disease, please provide documentation.

C. REQUIRED MENINGITIS VACCINE……._____/_____/_____

D. REQUIRED TETANUS/DIPHTHERIA: Completed primary series of tetanus/diphtheria immunizations (DtaP or DTP)…..
#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____ #5_____/_____/_____

E. REQUIRED TETANUS/DIPHTHERIA BOOSTER within the last 10 years……..____/_____/_____

PART VI. HIGHLY RECOMMENDED IMMUNIZATIONS

HEPATITIS B……..#1_____ #2_____ #3_____
VARICELLA (if not immune to Chicken Pox)……#1_____ #2_____ or date of immune titer_____
INFLUENZA (available in the fall on campus) _____ _____ _____ _____
OTHER……..____/_____/_____

Medical Provider (must be one of the following): □ MD □ Physicians Assistant □ Nurse Practitioner

_____
Signature Print Name Telephone Number

Address: _____

PART VII. STATEMENT OF EXEMPTION TO IMMUNIZATION LAW:

If your personal or religious beliefs or specific medical condition preclude inoculation, you must sign one of the following waivers. Pregnancy is justification for temporary medical exemption. Are you pregnant? _____Yes In the event of an outbreak, exempted persons will be subject to exclusion from school and quarantine. No reimbursement of tuition will be provided.

A. MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or heath, or is medically contraindicated due to other medical conditions.

Medical professional signature_____Business Phone_____Date_____

B. RELIGIOUS/PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself adheres to a religious or personal belief opposed to immunizations. (Parent must sign if the student is under 18 years old)

Student's Signature_____Parent/Guardian Signature_____Date_____
