Dear Parents and Student-Athletes,

Welcome to St. Andrews University, we look forward to having you participate in athletics this upcoming school year. This letter is to assist in guiding you through the important paperwork that will need to be completed upon arrival to school.

St. Andrews University requires that all student-athletes have completed all medical participation forms including a current physical exam (completed after June 1, 2018) signed by a physician, and currently be enrolled in an accepted primary insurance plan **before** he/she is able to participate in intercollegiate athletics at St. Andrews University.

Accepted insurance plans can be found on page 9 of this packet.

The following forms must be completed by the student-athlete (**if the student-athlete is under 18, his or her parent or guardian must sign all necessary forms**) and sent by fax, mail or hand delivered upon arrival at SAU to a member of the Athletic Training Department. Copies of the concussion protocol, insurance information, banned substances policy and other protocols can be found on the Athletic Training page on St. Andrews University's athletics website (sauknights.com).

1. Student-Athlete Information Form
2. Authorization and Consent of Treatment
3. Assumption of Risk
4. Drug Testing Acknowledgement
5. Concussion Statement Agreement
6. Sickle Cell Trait Testing Waiver/Results
7. Primary Insurance Acknowledgement (**Must be signed by Primary Insurance Holder**)
8. Medical History Form
9. Pre-Participation Physical Exam
10. Copy of Insurance Cards

If you have any questions, please feel free to contact the Athletic Training Department.

Thank you, and go Knights!

St. Andrews University Athletic Training Staff

Contact Information:

Mailing: Attn: Athletic Training Department
St. Andrews University
1700 Dogwood Mile
Laurinburg, NC 28352
Fax: (910) 277 – 5272
Attn: Athletic Training Department (sport participating in)

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St. Andrews University Emergency Contact and Insurance Information Form

Student-Athlete Information

Full Name: _____ Sport:_____

SAU Email: _____ Date of Birth: _____ SSN: _____

Permanent Address: _____

City: _____ State:_____ Zip: _____

Cell Phone #:_____ Home Phone #: _____ Sex: M F

Emergency Contact Information

Primary Contact: _____ Relationship: _____

Cell #: _____ Email: _____

Secondary Contact: _____ Relationship: _____

Cell #: _____ Email: _____

Primary Insurance Information

Policy Holder's Full Name: _____ Date of Birth: _____

Policy Holder's Home Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Member/Subscriber #: _____ Group #: _____

Employer Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company Phone #: _____

Is your health insurance plan an HMO? YES NO

Please attach a PHOTOCOPY of the FRONT and BACK of ALL YOUR INSURANCE CARDS (Medical, Dental, Vision, Prescription, etc.)

Authorization for Medical Treatment

I, _____, hereby give my consent to the athletic training staff at St. Andrews University to perform athletic training services, including emergency and first aid treatment, to my person relative to injuries and illnesses that may occur during practices for and participation in various athletic contests and events, as well as those occurring during transportation to or from such practice or contest sessions. It is also my understanding that as part of the athletic training staff, the team physician(s) has the authority to withhold me from further participation because of an injury or illness.

Personal Information Consent Form

This authorization is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibits disclosure of PHI unless written authorization is given. Therefore, in order to communicate with your coaches, parents/guardians, or other healthcare providers about your injury and/or condition, the athletic training staff and student health services must obtain your permission.

The release and/or use of certain medical information (otherwise protected) contained in the educational and medical records of student-athletes is often necessary for the conduct of day to day athletic business for the pursuit of the mission and goals of St. Andrews University Athletic Program.

I agree to allow St. Andrews University Athletic Training Staff to disclose and discuss medical records with my parents or legal guardians, coaches, and/or other healthcare providers involved in the student-athletes medical care.

I am accountable for all St. Andrews University, St. Andrews University Athletic Department, Mid-South Conference or Appalachian Athletic Conference policies and NAIA policies as it is stated in each entity's handbook.

The privacy and dignity of the student-athlete is paramount. St. Andrews University's Athletic Department; to the full extent possible under State and Federal Law will protect every student-athlete.

_____ _____
(Student-Athlete Name Printed) (Sport)

_____ _____
(Student-Athlete Signature) (Date)

_____ _____
(Parent Signature: if under 18) (Date)

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Assumption of Risk

I, _____, understand that there are risks of injury or death arising from my participation in intercollegiate athletics and that even though proper coaching techniques are used, rules are adhered to, and protective equipment is used, the possibility of an accident still exists. To decrease the risk of injury, I understand that equipment must be worn properly and that I must adhere to all instructions and all rules applying to the sport. I agree to do so. However, I acknowledge that proper use of equipment, proper training, and adherence to the rules may not prevent all risks of injury and I assume those risks. I also agree to notify the St. Andrews University Athletic Training Staff of any and all injuries or illnesses I may incur during my tenure as a St. Andrews University athlete, including but not limited to the following: concussions, heat illness, orthopedic injuries, and cardiac conditions. I understand that by notifying the Athletic Training Staff in a timely manner of any injury or illness may only help me in getting treatment, and if I withhold this information, I may be exposing myself to potentially more damage and/or a longer recovery. In consideration of my being permitted to participate in St. Andrews University's Intercollegiate Athletic Program, I hereby release St. Andrews University, its trustees, employees, agents, and volunteering in the course of my medical care together with all persons assisting with any phase of the program, from all liability and responsibility for any loss or injury related to my participation in the St. Andrews University athletic program. I recognize that if I elect to have the above named student examined by the group of voluntary physicians, nurses or other allied health workers, that the examination cannot be as comprehensive as that performed in a private physician's office and thus may not detect potentially significant health conditions which might be problematic in sports participation. I further release said volunteers from any liability if injury should occur. I further agree to indemnify and hold harmless said parties from all claims hereafter made by me or on behalf of my parents, guardians, heirs, executors, or assigns.

By signing this consent, you agree that it will remain a valid consent form from the date signed until the day after you are not enrolled at St. Andrews.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18): _____

Drug Testing Acknowledgement and Consent

I acknowledge that I am aware of the St. Andrews University Department of Athletics Drug Testing Policy. I have read and understand this policy and agree to abide by its provisions. I understand that my participation in intercollegiate athletics is contingent on my consent to drug testing policies and procedures, and that there may be consequences if I am found in violation of this policy. In accordance with the terms and conditions of the policy, I consent to have samples of my urine collected and tested for the presence of any of the banned drugs listed in this policy. This Policy may be reviewed on the St. Andrews University Athletics Website under the Athletic Training tab.

I hereby release St. Andrews University, its Trustees, Officers, Employees, Agents and Representatives from legal responsibility or liability for the release of such information and records as authorized by this form.

By signing this consent, you agree that it will remain a valid consent form from the date signed until the day after you are not enrolled at St. Andrews.

Printed Name: _____ Date: _____/_____/_____

Student-Athlete Signature: _____

If under 18, Parent/Guardian Signature: _____

NAIA Nutritional/Dietary Supplements Warning

Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff!

1. Dietary supplements, including vitamins and minerals, are not well regulated and may cause a positive drug test result.

2. Student-athletes have tested positive and lost their eligibility using dietary supplements.

3. Many dietary supplements are contaminated with banned drugs not listed on the label.

4. Any product containing a dietary supplement ingredient is taken at your own risk.

Note to Student-Athletes: There is no complete list of banned substances. Do not rely on this list to rule out any supplement ingredient. Check with your athletics department staff prior to using a supplement or visit www.naia.org/wellness.

To prevent testing positive for any banned substances the Athletic Training Department encourages student athletes to visit dfsaxis.com to review all supplements and substances they are taking. When on the website, use the drop box to select "NAIA" as your organization and password: naialive5. If any questions, contact the Athletic Training Department.

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Concussion Statement Agreement

I, _____ have read and understand the materials that have been provided to me by St. Andrews University. I understand that it is my responsibility to report any signs and symptoms of a concussion I may have honestly and in a timely manner to a Certified Athletic Trainer without fear of repercussions. The policy can be located under the Athletic Training tab on the St. Andrews University Athletics website.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18): _____

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Sickle Cell Trait Testing Waiver

I, _____ hereby agree as follows:

_____ I understand and acknowledge that St. Andrews University Athletic Training mandates that all student-athletes have knowledge of their sickle cell trait status and be provided an opportunity for testing (see next page). Additionally, I have read and fully understand the afore mentioned facts about sickle cell trait and sickle cell trait testing and understand that information is available at http://web1.ncaa.org/web_files/health_safety/SickleCellTraitforSA.pdf.

_____I understand that sickle cell trait does not prohibit me from participating intercollegiate athletics. I recognize that ascertaining 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 including any knowledge of sickle cell trait status to the St. Andrews University Athletic Training and Medical Staff personnel. I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination. To the maximum extent permitted by law, I release, forever discharge, indemnify and hold harmless St. Andrews University, its Athletic Training Department, team physicians, trustees, officers, employees and agents from any and all costs, liabilities, expenses, claims, damages, actions, or causes of action what so ever arising out or related to any loss, personal, injury, damage or property loss related to my waiver of this recommended testing.

_____I am fully aware of the risks and hazards associated with refusing this testing. This is binding on me, my heirs, assignees and personal representatives.

_____I acknowledge that I am 18 years of age or older, or, if I am not, my parent or guardian has also signed this waiver. I have carefully read this document before signing it. My participation in intercollegiate sports at St. Andrews University is voluntary and, prior to choosing to sign this I had an opportunity to consult with my parents, an attorney or counsel of my choice. I further state that I am at least 18 years of age, or if not, my parent/guardian has also signed, and of sound mind. I understand that the St. Andrews University Athletic Training Department recommended that I undergo sickle cell trait testing.

Student-Athlete Signature: _____ Date: _____

Sport(s) Participating in: _____ DOB: _____

(If under 18) Parent/Guardian Signature: _____

Date: _____

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Sickle Cell Results

Name: _____ Date of Birth: _____

Sickle Cell Solubility Test Performed or Attach a Copy of Previous Test Results

Test Results:

Positive for Sickle Cell Negative for Sickle Cell

Physician Signature: _____ Date: _____

Physician Name Printed: _____

Physician Office Phone Number _____

St. Andrews University Athletic Training

Insurance Policy and Procedures

St. Andrews University is concerned with the overall well-being and health of its students-athletes. The institution provides athletic accident coverage for all full-time students who participate in intercollegiate athletics. The athletic insurance plan is an EXCESS coverage policy only. All claims must be filed with the primary insurance first. Benefits are available for covered expenses after all other plans providing medical expense benefits have considered the expenses. The plan covers from the first date to the last date a student–athlete is required to be on campus for participation.

In order to be considered eligible for this insurance policy each student-athlete must complete all medical participation forms. These include forms related to parent/guardian information, primary/secondary insurance information, HIPPA Protected Health Information, substance abuse/code of conduct, assumption of risk, health history, and acceptable physical examination. If any of these forms are not completed to acceptable parameters, the student-athlete is not medically eligible for participation at St. Andrews University and will not be covered under the excess insurance policy. It is required that all student-athletes also have a valid primary insurance carrier, and that a current copy of the active insurance card is on file with the Athletic Training Department.

All costs incurred due to non-athletic related injury and illness will be submitted to the athlete's primary insurance carrier and the remaining balance is the responsibility of the student-athlete and/or parent(s) or guardian(s). Medical abnormalities or pre-existing conditions are the responsibility of the student-athlete and/or their parent(s) or guardian(s). Any costs that are denied by the excess insurance policy are also the responsibility of the student-athlete and/or their parent(s) or guardian(s). It is the responsibility of the student-athlete and/or their parent(s) or guardian(s) to provide the athletic insurance coordinator any outstanding statements and information within an appropriate time frame for consideration of excess insurance claim.

St. Andrews University Excess Policy Description

St. Andrews University has purchased a basic accident insurance policy through K&K Insurance Company to cover students during their participation in NAIA recognized sporting events to help cover any gaps that may arise between a primary insurance policy (required for participation), and the Catastrophic Insurance Policy provided by the NAIA. As this is an excess policy, it only covers medical costs associated with an athletic injury that are not covered by any other valid and collectible insurance. St. Andrews University's policy has a $1,000.00 per injury deductible which must be met through either primary insurance payments or out of pocket costs. Provider discounts do not count towards this deductible. The maximum benefits for St. Andrews's policy are set at $25,000.00 per injury at which time the NAIA's Catastrophic Insurance Policy would begin. This policy does cover most standard care for athletic injuries, but non-traditional, experimental, elective or highly specialized treatments/braces may not be covered. It is important to check with the Athletic Training Department before receiving any treatments. This policy does not provide coverage for general medical conditions/illnesses or pre-existing conditions. This policy becomes null and void if the student-athlete does not adhere to the St. Andrews University Policies for utilizing the secondary athletic insurance policy.

Excess Insurance Procedures

Athletic Injury Claim Form Procedures

1. All injuries must be reported to a SAU Certified Athletic Trainer within 72 hours of the injury occurrence. If you do not report the injury within 72 hours, you may be held responsible for any expenses incurred as a result of treating the injury.
2. All injuries requiring a referral must be documented with an injury claim form. This form must be filled out by a SAU athletic trainer.
3. All injury claim forms must be submitted to the excess insurance carrier by a SAU athletic trainer.
4. A copy of the excess insurance card will be given to the student-athlete to give to each provider that he/she receives services from. For example: if a student-athlete is seen by Dr. Alexander and Dr. Alexander sends the student-athlete to receive x-rays by Scotland Memorial Hospital, the student-athlete must provide each provider (Dr. Alexander and Scotland Memorial Hospital) with the insurance card. If the insurance card is not given to the provider, payment for services may not be provided within the limits of the SAU Policy.
5. The excess insurance carrier will send an Explanation of Benefits (EOB) to the address listed on the patient information form for the student-athlete stating that a claim has been filed with respect to an athletic injury to the student-athlete. All further EOB's from the excess insurance company will be sent to the athletic training insurance coordinator.

Primary and/or Secondary Insurance Procedures

1. A primary insurance carrier is required for each student-athlete. If a commercial carrier (i.e. Anthem, United HealthCare, Cigna, Humana, Blue Cross Blue Shield) is not available, the student-athlete will be required to enroll in the university's primary insurance plan.
    a. All student-athlete's enrolled in NC Medicaid or out-of-state Medicaid are required to purchase the university's primary insurance for participation.

   b. All International students are required to purchase the university's primary insurance for participation.
   c. Information about obtaining student health insurance can be found by visiting https://www.sa.edu/student-life/insurance-forms.
   d. Parents and/or legal guardians are able to carry dependents on their insurance up to the age of 26 years.
   e. If your primary insurance carrier is an HMO plan requiring a Primary Care Physician (PCP), changing the PCP to a local physician in the Laurinburg area will expedite care for athletic and non-athletic injuries or illnesses. In the event the student-athlete's PCP cannot be changed to a local PCP the student may be required to enroll in the school's primary insurance plan.
2. Medical bills will always be sent to the student-athletes primary and/or secondary insurance carrier.
3. Your primary and/or secondary insurance carrier will send you an explanation of benefits (EOB) for the medical services provided. If there is a denial of medical services, your primary and/or secondary insurance carrier will send you a DENIAL explanation of benefits (EOB).
4. ALL EOB's and statements should be brought to the athletic insurance coordinator, so that they may be submitted to the athletic insurance company.
5. Once the excess insurance carrier receives all necessary information the underwriter will determine the status of payment based on the limits within the excess athletic insurance policy.
   a. If the excess insurance carrier determines that the services are within the limits of the athletic insurance policy, payment will be rendered for that service.
   b. If the excess insurance carrier determines that the services charged are not within the limits of the athletic insurance policy, payment will be denied
      i. If payment is denied in full, the student-athlete assumes all costs related to that service.
      ii. If payment is denied in part (typically due to charges over the usual and customary), the student-athlete assumes all costs remaining.
6. All expenses must be incurred within 90 (ninety) days after the covered accident.
7. A student-athlete may only receive benefits for services that have occurred up to 365 days from the date of the covered accident.
8. The student-athlete may submit the incurred expenses for 1 year from the date of the covered accident.

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Primary Insurance Acknowledgement

I have received, fully reviewed, and understand the above St. Andrews University Athletic Insurance information. I attest that I am covered under an excess policy provided by St. Andrews University for injuries incurred at scheduled practices, training, and games. I further understand that all athletes regardless of scholarship status are covered under the same insurance policy and must adhere to the same regulations. I understand that illnesses and other general medical conditions as well as pre-existing injuries are not covered under St. Andrews University's excess insurance policy.

I agree that within this academic school year if for any reason the identified primary policy ceases to be valid I will notify the athletic training staff as soon as I know coverage is no longer in effect. I understand that I must have insurance coverage that covers athletic injuries while I reside at St. Andrews University to participate in athletics and will be disqualified from practice, training, and games if my coverage is terminated, and required to purchase a policy through the university if another plan is not already in place.

I agree that in the event that the excess policy St. Andrews University has purchased is needed that I will be responsible for any co-pays from my primary insurance, and any remaining balance that resulted from uncovered services or that were applied to meet the per injury $1,000.00 deductible. I understand that insurance and out of pocket payments count towards the deductible and write offs do not count towards the deductible.

By signing this you agree that it will remain a valid consent form, from the date signed until the day after you are no longer enrolled at St. Andrews University. **Primary insurance policy holder signature required.**

_____	_____
Printed Name of Student-Athlete	Printed Name of Policy Holder
_____	_____
Signature of Student-Athlete	Signature of Policy Holder
_____	_____
Date	Date

Date: _____ **St. Andrews University Sports Medicine** Sport(s): _____

Medical Health History Form

Name: _____ Date of Birth: _____

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

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 Cholesterol ☐Kawasaki disease ☐ Heart Murmur ☐Heart Infection 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		
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		
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		
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		
31. Have you had infectious mononucleosis (mono) within the last		
32. Do you have any rashes, pressure sores, or other skin		
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		
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		
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		
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 _____ Date_____

If athlete is under the age of 18

Signature of Parent/Guardian _____ Date_____

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Pre-Participation Physical Evaluation

Name: _____ DOB: _____ Sport(s): _____

Examination			
Height	Weight	Sex □Female □Male	
BP /	Pulse	Vision: R 20/ L 20/	Corrected? □Y □N

Medical	**Normal**	**Abnormal Findings**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnadactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Gentiourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis, etc.		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck walk, single leg hop		

Has athlete ever been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder?
□Yes □No If answered yes, please list the date diagnosed, diagnosis, and name of physician.

_____

If you currently are taking any medications for ADHD or ADD please list medications and dosage.

_____

□ Cleared for all sports without restriction

□ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

_____

□ Not Cleared

Reason: _____

Recommendations: _____

_____

Signature of Physician _____, MD or DO Date _____

Address _____ Phone _____