

Memo

To: Washington College Student Athletes and Their Parents
From: Thad Moore, MA, ATC
Head Athletic Trainer
Subject: Screening

Enclosed you will find a packet of vital forms. These forms **MUST BE COMPLETED IN THEIR ENTIRETY** prior to you receiving your preseason screening by the Athletic Training Staff. This means you must have your parent or guardian signatures where required, all insurance information, **including a copy of your insurance card, front & back**, must be furnished and the medical review must be thoroughly completed. You will not be screened if any of these items are inadequately completed or if you lack any of the necessary signatures or information. We will enforce this very strictly. These forms are due by **August 1, 2009**. Your coach will give a screening time to you. You must check with your coach concerning your specific screening time. These times have been designed to facilitate a prompt start for preseason. We need your cooperation. Please wear shorts and tee shirts to the screenings. Should you or your parents have any questions contact me not your coach. Please note, all of the forms must be completely updated and must be properly and entirely completed. Thank you for your cooperation.

NOTE: Returning athletes are **REQUIRED** to get a physical prior to their return in order to compete on their respective teams. You can download the physical form at www.washingtoncollegesports.com click on the athletic training icon then physical form. Please have your physician complete the physical and return it with the rest of these forms.

Return forms to:

Thad Moore
Head Athletic Trainer
300 Washington Ave.
Chestertown, MD 21620

Checklist:

Enclosed Medical Forms

Copy of Insurance Card (front and back)

Completed Physical Form (Returning Athletes Only)

Insurance for the 2009 -10 Academic Year

Please note, all Washington College student-athletes must provide evidence of insurance that includes coverage for athletically-related injuries. This is a pre-requisite for practice and competition. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the Washington College Department of Athletics.

Insurance coverage must have a limit of at least \$75,000 and cover athletically-related injuries.

Washington College will assume **no responsibility** whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Washington College.

If you have questions regarding the terms of your coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions in your policy regarding athletically-related injuries.

The NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participation in a covered intercollegiate athletic activity (subject to policy terms and conditions). The policy has a \$75,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Washington College. It is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's web-site at www.ncaa.org

If you have any questions regarding this requirement please contact me at (410) 778-7243

Please fill out the form below that applies to you:

A. Student Athlete who is covered under parents insurance.

I, _____, as parent, guardian or legal representative, attest that
(name, please print)

_____ has insurance coverage under a current, in force insurance
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least \$75,000.

If there is a material change in coverage or expiration of coverage, I agree to notify Washington College of this development and update the insurance information I have on file with Washington College.

I understand and agree that Washington College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participation in intercollegiate athletics at Washington College.

(signature)

(date)

B. Student who has their own personal insurance.

I, _____, attest that I have insurance coverage under a current, in force
(student-athlete name, please print)

insurance policy for injuries that occur during my participation in intercollegiate athletics. This coverage has limits of at least \$75,000.

If there is a material change in coverage or expiration of coverage, I agree to notify Washington College of this development and update the insurance information I have on file with Washington College.

I understand and agree that Washington College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participation in intercollegiate athletics at Washington College.

(signature)

(date)

PARENT/INSURANCE INFORMATION FORM

Athlete's Name (Print) _____ Student ID# _____

Date of Birth ____/____/____ Sport(s) _____ Date ____/____/____

Washington College Athletics Department Insurance Policy Statement:

The Athletic Department does **NOT** provide athletic injury insurance for athletes during their competitive season(s). You can purchase school insurance for your son/daughter through Washington College Health Services. To get more information please contact Health Services at: (410) 778-7261.

Please provide the information requested below. This information is critical to prompt treatment and accurate billing procedure. An incomplete form will delay the participation of the athlete.

I hereby authorize Washington College to inspect and secure copies of case history records, laboratory reports, diagnosis, X-rays and other pertinent data records to previous injuries and/ or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

Parent/Guardian Signature: _____

Student Signature: _____

Father/Guardian: _____

Mother/Guardian: _____

Social Security #: _____

Social Security #: _____

Date of Birth: ____/____/____

Date of Birth: ____/____/____

Address: _____

Address: _____

Home Telephone: _____

Home Telephone: _____

Work Telephone: _____

Work Telephone: _____

Cell Phone: _____

Cell Phone: _____

Medical Insurance Information:

Company or Plan: _____

Medical Insurance Information:

Company or Plan: _____

Address: _____

Address: _____

Policy# _____ Group# _____

Policy # _____ Group# _____

Telephone # _____

Telephone # _____

HMO : PPO/PPN:

HMO: PPO/PPN:

Does your insurance require that you use a participating physician or health care facility? Yes No

Is pre-authorization required for surgery? Yes No

Primary Care Physician (Name, Address and Phone Number): _____

I hereby certify that the answers provided are true, complete, and correct to the best of my knowledge.

Signature of Policy Holder: _____

Date: ____/____/____

Washington College Sports Medicine Department Medical History Questionnaire

LAST NAME: _____ FIRST: _____ M.I. _____
 SEX: MALE _____ FEMALE _____ DATE: ____/____/____ Date of Birth: ____/____/____
 SPORT(S) _____ YEAR IN SCHOOL: F ____ SO ____ J ____ S ____

Personal History

Have you had a medical illness or injury since your last sports physical?	<u>Y</u>	<u>N</u>
Have you ever had surgery?		
Explain _____		
Are you currently taking any prescription medications or using an inhaler?		
Are you currently taking any supplements?		
Explain _____		
Do you have any allergies ?		
Are you allergic to bee stings?		
Do you carry and epi-pen?		
Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise?		
Have you ever had racing of your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Do you cough, wheeze, or have trouble breathing during or after activity?		
Do you have asthma?		
Have you had any problems with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
Do you have any hearing deficits?		
Are you susceptible to ear infections?		
Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)?		
Have you ever been treated for MRSA or other staph infection?		
Have you ever had a head injury, concussion or loss of memory?		
How many? _____ Date of most recent _____		
Have you ever had a seizure?		
Do you have frequent or severe headaches?		
Do you have headache brought on by exercise		
Have you ever had a neck injury?		

Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<u>Y</u>	<u>N</u>
Have you ever had a stinger, burner, or pinched nerve?		
Do you use any additional protective or corrective equipment		
Has a physician ever denied or restricted your participation in sports for any reason?		
Family History		
Does anyone in your family have:		
High blood pressure		
Diabetes		
Heart Attack		
Heart Disease		
Died suddenly before the age of 50		
Sickle Cell Trait		
Marfan's Syndrome		

Have you had any of the following: please circle and give date

- | | |
|--------------------------------------|--------------------------------|
| Mononucleosis | Pneumonia |
| Diabetes | Anemia |
| Bronchitis | Sinus problems |
| Epilepsy | Heat Stroke |
| Heat Exhaustion | Stomach problems |
| Menstrual problems | Severe cramps |
| Urinary problems | Hernia |
| Kidney problems | Marfan's Syndrome |
| Sickle Cell Trait | Frequent Anxiety or Depression |
| Dental Problems, Implants or bridges | |

**Have you had any problems with any of following?
Please circle, explain, and give date.**

- | | | | | |
|-----------|-------|------------|-----------|------------|
| Head | Neck | Shoulder | Elbow | Wrist/Hand |
| Back | Hip | Quadriceps | Hamstring | Knee |
| Shin/Calf | Ankle | Foot | | |

Explain:

Washington College Staff Only:

BP: _____ / _____

Pulse: _____

Reviewed by: _____

MEDICAL RELEASE FORM

Student-Athlete's Name

Sport

Cell Phone Number

Campus/School Address

Street/Dorm

City, State, Zip

Permission to Treat Statement:

Permission is hereby granted to Washington College to proceed with any needed medical treatment deemed necessary in the event the parent/guardian cannot be contacted. In the event of serious illness, the need for major surgery or significant accident or injury, I understand that an attempt will be made to contact me in an expeditious manner. In the event I cannot be contacted, permission is granted to render all treatment deemed necessary in the best interest of the above-named athlete.

Parent/Guardian Name (Print)

Student Athlete Name (Print)

Parent/ Guardian Name Signature

Student Athlete Signature

Relationship to Student Athlete

Permission for Medical Records Release:

I hereby give Washington College medical staff permission to obtain medical records pertaining to any injury or condition incurred while participating in intercollegiate athletics at Washington College. I understand an attempt will be made to inform me of the necessity of obtaining medical records.

Parent/Guardian Signature

Student Athlete Signature

Permission to Release Medical Record/Information to Parents/Guardian or WC Medical Staff:

I hereby give Washington College medical staff permission to release my medical record/information to my parent/guardian. I understand an attempt will be made to inform me of any release of medical record/ information.

Student-Athlete Signature

Acceptance of Risk Statement:

I, _____, am aware of and accept the risk of injury associated with
(print name)

participation in intercollegiate athletics and in particular _____ . I will do my part
sport(s)

to reduce the risk of injury by acquiring and maintaining my peak physical condition. I will follow the advice of the medical staff and coaching staff in preparation to participate and in the event of injury or accident incurred due to participating in my sport. If I do not understand or have any questions concerning this Acceptance of Risk Statement, I will get a detailed explanation from the head athletic trainer prior to my participation.

Student-Athlete's Name (print)

Student-Athlete's Signature

____/____/____/
Date of Birth

____/____/____/
Today's Date

Parent/Guardian Name If Under 18 (print)

Parent/ Guardian Signature If Under 18

The undersigned herewith:

- A. Understands that he/she must refrain from participation while ill or injured, whether or not receiving medical treatment, and during medical treatment until he/she is discharged from treatment or given permission by the Team Physician and Athletic Trainer to restart participation despite continuing treatment.
- B. Understand that passing this athletic screening does not mean that e/she is physically able to participate in athletics but only that the evaluator did not find a medical reason to disqualify he/she from participation.
- C. Certifies that the answers to the questions above are correct and true to the best of ones knowledge.
- D. Authorizes the Student Health Services and Sports Medicine Department to exchange and release information to each other that may impact my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/ screening and Washington College Health Service, health evaluation, immunization records, consent for treatment and questionnaire.
- E. Consents to be treated by member of the sports medicine staff, for an injury or illness they deem needing treatment.
 - 1. Parent/Guardian must co-sign if athlete is under the age of 18

Student Signature

____/____/____
Date

Parent/Guardian Signature if Athlete is under 18

____/____/____
Date

MEDICAL PROCEDURES

- A. If ill at home or unable to attend practice or scheduled contest, call coach, athletic trainer, or leave a message.
- B. If taken ill on campus, notify coach, coach's offices, athletic trainer or Student Health Services.
- C. If injured during practice or game, follow the instructions of the doctor or athletic trainer.
- D. If injured and confined in dorm, report to coach and athletic trainer as requested.
- E. All athletes who are injured or ill and cannot compete will be placed on the disabled list by the athletic trainer. Anyone not on this list is expected to report to practice and games.
- F. If the services of a physician are needed, the student-athlete will be referred to them by the athletic trainer or Student Health Services.
- G. The student-athlete will be required to report at designated times for treatment or consultation.
- H. The student-athlete may be returned to the active list on the advice of the team physician or athletic trainer.
- I. Accurate and complete records on each student-athlete will be kept in Student Health Services, the physician's or athletic trainer's office.
- J. Injury or illness unrelated to intercollegiate athletics participation are not the responsibility of the Athletics Department.

Athlete's Signature

____/____/_____
Date

RULES OF THE ATHLETIC TRAINING ROOM

1. **REPORT ALL INJURIES** to the athletic trainer immediately.
2. No cleats, equipment, bookbags, food, drink, etc... allowed in the Athletic Training Room.
3. Athletes must shower after practice prior to receiving treatment.
4. **NO NUDE BODIES** in the Athletic Training Room.
5. All Athletes must sign in and pull their folders prior to receiving treatment.
6. Be on time for all scheduled appointments.
 - The Athletic Training Room is not a viable excuse for being late to practice.
7. No alcohol, drugs, and or tobacco products allowed in the Athletic Training Room.
8. Athletes are not permitted to use the phone.
9. Athletes are not allowed to check email of any kind in the Athletic Training Room.
10. Towels do **NOT** leave the Athletic Training Room.
11. No self treatments in the athletic training room. Do no operate any of the equipment or machines in the athletic training room.
12. No loitering in the athletic training room.
13. Please respect all members of the athletic training staff.
14. No jewelry is allowed on the athletic fields.
15. Please return all equipment issued to you from the trainers. Example: Ace bandages, wraps, pads, etc...
16. Please do not take supplies without asking for them. If you are caught stealing you will be turned in to the proper authorities.

Athlete's Signature

_____/_____/_____
Date