
Physicians

Primary

Name _____

Specialty _____

STREET _____

CITY STATE ZIP CODE

PHONE _____

Secondary

Name _____

Specialty _____

STREET _____

CITY STATE ZIP CODE

PHONE _____

Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? YES NO

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? YES NO

Have you ever had the feeling of your heart skipping beats, or racing? YES NO

Have you ever been told that you have a heart murmur? YES NO

Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? YES NO

Does anyone in your family have a history of high blood pressure? YES NO

Have you ever been told that you have / had high blood pressure? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Allergies:

Are you allergic to and/or ever had an unexpected reaction to any medications? YES NO

Are you allergic to and/or ever had an unfavorable reaction to any food items? YES NO

Are you allergic to and/or ever had an unexpected reaction to bee stings, insect bites, etc.? YES NO

Have you ever been diagnosed with seasonal allergies? YES NO

Are you presently taking/have you previously taken any allergy medications? YES NO

Do you carry, or require, an epinephrine pen for any of the above allergies? YES NO

If you answered "Yes" please describe reaction and treatment, including dates where applicable _____

Asthma:

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? YES NO

How Many Acute Asthma Attacks Have You Had In The Past 12 Months? _____

Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? YES NO

Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week? _____

* If you use an inhaler, please bring a second inhaler to the Head Athletic Trainer

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Head Injuries / Concussion:

Have You Ever Suffered A Head Injury / Concussion (no matter how minor)? YES NO

Have You Ever Been Evaluated By A Doctor For A Head Injury / Concussion? YES NO

Were Any Diagnostic Tests Performed? YES NO (check all that apply)
 X-ray MRI CT-Scan Neuropsychological Testing Other _____

Have You Ever Been Hospitalized, Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? YES NO

Do You Suffer From Headaches? YES NO
◆ When? Every Day 1-2 Times/Week 1-2 Times/Month

Do You Have A History of Migraine Headaches? YES NO
◆ How Often _____ Please Describe _____

◆ Medications Taken for Migraines? _____

If you answered "Yes" please describe and include dates where necessary _____

Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? YES NO

◆ Date? _____ Result? _____

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? YES NO

◆ Please Describe _____

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? YES NO

◆ Please Describe _____

Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury? YES NO (check all that apply):

- ◆ Heat Cramps- Date(s)? _____
- ◆ Heat Syncope (Fainting)- Date(s)? _____
- ◆ Heat Exhaustion- Date(s)? _____
- ◆ Heat Stroke- Date(s)? _____

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? YES NO

Have You Ever Been Hospitalized For a Heat-Related Problem? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Diabetic History:

Have You Ever Been Diagnosed With Diabetes? YES NO

Are You Presently Taking or Have You Taken Any Diabetic Medications? YES NO

<u>Medication</u>	<u>Form</u>	<u>Dosage</u>	<u>Frequency</u>

Do You Daily Monitor Your Blood Sugar Level? YES NO

◆ How Many Times Per Day? _____ What Is Your Average Level? _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? YES NO

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

If you answered "Yes" please describe and include dates where necessary _____

Females Only:

At what age did you have your first menstrual period? _____ Are your periods regular? YES NO

Have you ever missed a period? YES NO If yes, when? _____

Do you take any medications during your period? YES NO If yes, what? _____

Do you take birth control pills? YES NO If yes, what? _____

Psychological:

- Have You Ever Been Diagnosed With a Psychological, Mood or Anxiety Disorder? YES NO
- Have You Ever Been Under The Care Of Psychologist, or Psychiatrist? YES NO
- Have You Ever Been On Medication To Control Mood or Anxiety? YES NO
- Has Any Family Member Been Diagnosed With A Psychological, Mood or Anxiety Disorder? YES NO
- Have You Ever Thought About Hurting Yourself, or Others? YES NO
- If you answered "Yes" please describe and include dates where necessary _____
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Eyes:

- Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? YES NO
- Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? YES NO
- Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? YES NO
- Do you routinely wear glasses? YES NO
- Do you routinely wear contact lenses? YES NO Type _____
- If you answered "Yes" please describe and include dates where necessary _____
-
-

Dental:

- Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? YES NO
- Do You Wear Any Type of Dental Hardware? YES NO
- Do You Regularly Wear Protective Dental Wear? YES NO
- If you answered "Yes" please describe and include dates where necessary _____
-
-

Cervical Spine / Neck:

- Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? YES NO
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? YES NO
- Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? YES NO
- If you answered "Yes" please describe and include dates where necessary _____
-
-

Shoulder / Upper Arm:

- Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? YES NO
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Elbow / Forearm / Wrist / Hand:

- Have You Ever Suffered An Injury To Your Elbow / Forearm? YES NO
- Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? YES NO
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? YES NO
- Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm / Wrist / Hand Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Spine / Low Back / Sacroiliac Joint:

- Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? YES NO
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? YES NO
- Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? YES NO
- Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Hip / Groin / Thigh:

- Have You Ever Suffered An Injury To Your Hip / Groin (*including hernias*) / Thigh (including quadriceps or hamstrings)? YES NO
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Had Surgery For A Hip / Groin / Thigh Injury? YES NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip, Groin or Thigh Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? YES NO

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Knee and/or Patella Injury? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? YES NO

Do You Presently Wear A Knee Brace? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? YES NO

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? YES NO

Do You Presently Tape Your Ankle(s) Use Ankle Brace(s)

If you answered "Yes" please describe and include dates where necessary _____

Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? YES NO

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? YES NO

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? YES NO

Have You Ever Suffered An Injury To Your Abdomen? YES NO

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? YES NO

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? YES NO

If you answered "Yes" please describe and include dates where necessary _____

Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>
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****PLEASE NOTE**** - If you are currently under the care of a physician for ADD/ADHD and/or are currently taking prescribed medication for ADD/ADHD, beginning August 1, 2009 the NCAA requires specific documentation as the contents of particular medications may contain substances on the NCAA List of Banned Substances. To assist with this process refer to the Attention Deficit Hyperactivity Disorder (ADHD) Medication Exemption Information Form located on the Whitman College Athletic Training website.

Supplements / Ergogenic Aids:

Please list **ALL** supplements/ergogenic aids that you are **CURRENTLY** taking or **have taken** in the past twelve (12) months and the purpose:

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

Please Answer: *(please add separate page if more room is needed)*

- YES NO Has anyone in your family died before the age of 50 due to a medically related condition?
- YES NO Have you ever had any injury or illness other than those already noted?
- YES NO Do you have any ongoing or chronic illnesses?
- YES NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
- YES NO Are you currently under a physician's care for any medical conditions?

- YES NO Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
- YES NO Have you been diagnoses with an autoimmune disease?
- YES NO Have you ever been diagnosed with anemia?
- YES NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
- YES NO Have you ever had seizures, convulsions, and/or epilepsy?
- YES NO Have you ever had gall bladder disease and/or appendicitis?
- YES NO Do you have ringing in your ears or trouble hearing?
- YES NO Have you ever had the chickenpox or the vaccine? If yes, when? _____
- YES NO Have you had a tetanus booster within the past ten (10) years? If yes, when? _____
- YES NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
- YES NO Are you a vegetarian? If yes, what type? _____

- YES NO 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" drugs?
- YES NO Have you ever been diagnosed with depression and/or bipolar disorder?
- YES NO Have you ever been diagnosed with an anxiety disorder?
- YES NO Have you been diagnosed with a learning disability and/or ADD / ADHD?
- YES NO Do you have a history of anorexia, bulimia, and/or any other eating disorders?
- YES NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
- YES NO Do you regularly lose weight to participate in your sport?
- YES NO Do you want to weigh more or less than you presently do? If yes, what is your ideal weight? _____
- YES NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Whitman College at this time?

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

If you have had surgery or been under the care of a physician for a medical condition in the past 12 months that has restricted your athletic participation in any way, you must provide the Whitman College Athletic Training Department with a written release from the attending physician for participation in activities related to your condition and the specific sport you intend to participate in prior to ANY conditioning, practice or competition.

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through eleven (11) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature

Date

Student-Athlete Print Name

OR

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

Date

Parent/Guardian Print Name

Reviewed By Whitman College Training Staff:

Reviewer's Signature

Date

Reviewer Print Name



Whitman College
H.I.P.P.A. Release Authorization of
Student-Athlete Protected Health Information



I, _____, authorize the Athletic Training Staff of Whitman College, Michael Wilwand D.O., and any other designated team physician(s), Whitman College Student Health Center and Counseling Center staff, paramedic(s) or other health care provider(s) associated with intercollegiate athletic participation at Whitman College, to release any and all information regarding my health or medical condition to any treating or attending health care provider in the normal and regular course of any treatment or procedure I may require as a result of my participation in intercollegiate sports, as well as to the health care providers at any treating hospital or other medical facility.

I authorize the Whitman College Athletic Training Staff to release such medical information to coaches, administrators, and designated medical personnel as it pertains to my safety and continued medical care. I also authorize communication with the following (list parents, relatives, legal guardians, etc.), to whom information about your medical conditions may be communicated to:

1. _____
2. _____
3. _____

This authorization is valid until August 1, 2010, or for the entirety of any injuries/illnesses that occur during the 2009-2010 academic year, for which I receive any medical treatment, and for any follow up consultations which are received for injuries that occur as a result of my participation in intercollegiate athletics. I also understand that I may revoke this authorization at any time by providing written notice to the Whitman College Head Athletic Trainer.

All participants in the 2009-10 Whitman College intercollegiate athletics must complete this form as a condition of participation.

 Student-Athlete Signature

 Date

 Student-Athlete Print Name

 Sport

OR

 Parent/Guardian Signature *(only if under 18 years of age)*

 Date

 Parent/Guardian Print Name



Whitman College Intercollegiate Athletics Authorization and Assumption of Risk Waiver



I, the undersigned, hereby acknowledge, affirm, and represent the following:

A. MEDICAL TREATMENT:

I hereby authorize the Whitman College athletic trainers, team physicians, paramedics and emergency medical technicians (EMTs), and designated medical staff to examine and treat any injuries which may occur, while participating in intercollegiate athletics for Whitman College. I authorize the athletic trainers, team physicians, paramedics, EMTs, and designated medical staff to communicate with athletic department officials and coaching staff regarding their findings and recommendations. I further understand that the team physician and/or his/her designee have the authority to eliminate me from participation as a student-athlete due to an injury/illness, and/or due to undue liability risk of Whitman College.

_____ **Student-athlete initials**

B. STATEMENT OF MEDICAL INSURANCE:

I understand that as a student-athlete at Whitman College I must be covered by individual health insurance before participating in any strength and conditioning session, practice, game, and/or competition. This insurance shall be considered the **PRIMARY** insurance coverage for all athletic related injuries. I understand that the Whitman College Athletic Department provides a **secondary** insurance for injuries reported to the Whitman College Athletic Training Staff, occurring during supervised and official varsity practices, competitions, and/or travel to/from such event. I understand that the National Collegiate Athletic Association (NCAA) provides a catastrophic insurance program for student-athletes seriously injured in practices, games or competitions, and/or related travel that was supervised by approved University coaching staff and approved by the Director of Athletics according to NCAA regulations. **THESE POLICIES, HOWEVER, ARE SECONDARY TO, OR IN EXCESS OF, THE STUDENT-ATHLETE'S INDIVIDUAL HEALTH INSURANCE AND WILL COVER RELATED EXPENSES FOR TWO YEARS AFTER THE INITIAL DATE OF INJURY.** In addition, I further understand and agree that the insurance of Whitman College Department of Intercollegiate Athletics is not effective for an aggravation or re-injury to a preexisting injury, and therefore, Whitman College and their officers, employees, and agents will not be liable for any expenses resulting from such injury, regardless of its disclosure to the team physician(s) and/or members of the Sports Medicine Department.

_____ **Student-athlete initials**

C. ASSUMPTION OF RISK:

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Because of the aforementioned dangers of participating in any athletic activity, I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Athletic Training Department. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

In consideration of Whitman College permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Whitman College and its officers, agents, and employees from any and all liability, any medical expenses not covered by the Whitman College Intercollegiate Athletics' medical insurance coverage, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

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

_____ Student-athlete initials

D. AUTHORIZATION:

I fully understand that the above authorizations shall be effective and valid for one year after the termination of my playing and/or academic career at Whitman College.

I hereby attest that I have read and fully understand the Whitman College Athletic Department's Authorization and Assumption of Risk Waiver. Further, I agree to abide by all the requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

Student-Athlete Signature

Date

Student-Athlete Print Name

Sport

OR

Parent/Guardian Signature (*only if under 18 years of age*)

Date

Parent/Guardian Print Name