

# Whitman College

## Returning Student-Athlete Updated Health History Questionnaire

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The information contained in this health history form will only be used by the Athletic Training Staff of Whitman College for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain confidential at all times.

(Please print clearly in BLUE or BLACK ink)

Today's Date \_\_\_\_\_

NAME: Last \_\_\_\_\_ First \_\_\_\_\_

Whitman ID # \_\_\_\_\_ Sex:  Male  Female School Year \_\_\_\_\_

Date of Birth \_\_\_\_\_ Varsity Sport(s) \_\_\_\_\_

Year of Eligibility:  Freshman  Sophomore  Junior  Senior  5<sup>th</sup> Year

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**PERMANENT ADDRESS:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**LOCAL ADDRESS / DORM:**

Street / Dorm and Room # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**EMERGENCY CONTACT INFORMATION:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address (if different from permanent address):

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address (if different from permanent address):

Street / Dorm and Room # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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**INSURANCE INFORMATION – Please include a copy of the front AND back of your insurance card**

Do you subscribe to the Whitman College Student Insurance Plan?  Yes  No

Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_

Street / P.O. Box \_\_\_\_\_

Type of Plan:  HMO  PPO  POS  
Plan / Group # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy # \_\_\_\_\_

Phone \_\_\_\_\_



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**ANSWER ALL QUESTIONS** Explain “YES” answers at the end of this section:

1. YES NO Have you had a medical problem, illness, or injury since your last evaluation?
2. YES NO Do you have any allergies (medicine, bees or other stinging / biting insects, environmental)?
3. YES NO Are you presently taking any medication (prescription or over the counter) or use an inhaler?
4. YES NO Has anyone in your immediate family been diagnosed with coronary heart disease before age 55?
5. YES NO Has anyone in your family died suddenly for unexplained reasons?
6. YES NO Have you ever become ill from exercising in the heat? (i.e. heat exhaustion, heat stroke, heat cramps)
7. YES NO Do you have trouble breathing or do you cough or have wheezing during or after activity?
8. YES NO Do you consistently become dizzy or lightheaded during or after exercise?
9. YES NO Do you have any communicable diseases?
10. YES NO Do you need any special equipment, other than what is mandatory, to participate in your sport?
11. YES NO Do you have Anorexia Nervosa, Bulimia or ever engage in the following activities to lose weight: excessive dieting, bingeing, purging, laxative use, diuretic use, restricted food intake, excessive exercise
12. YES NO Do you feel that you have a weight problem (over weight / under weight)?
13. YES NO Do you use alcohol? If yes, how many drinks per week? \_\_\_\_\_
14. YES NO Do you smoke cigarettes? If so, how much? \_\_\_\_\_
15. YES NO Do you ever use street drugs: Cocaine, LSD, Heroin, Speed, others? \_\_\_\_\_
16. YES NO Do you ever use any of the following substances to enhance performance: Anabolic Steroids, Growth Hormone, Androstenedione, Creatine, DHEA, Chromium, Erythropoietin (EPO), others: \_\_\_\_\_
17. YES NO ***Females only:*** Have you gone more than 60 days between periods in the past year? You have your menstrual periods every \_\_\_\_ days that last approximately \_\_\_\_ days.
18. YES NO Have you had any sprains, strains, fractures, dislocations, swelling or other injuries to your bones, joints or muscles **since your last physical examination?** (*indicate below*)
 

Fingers _____	Hand _____	Wrist _____	Forearm _____	Elbow _____	Shoulder _____	Neck _____
Skull _____	Chest _____	Back _____	Pelvis _____	Hip _____	Thigh _____	Knee _____
Shin/Calf _____	Ankle _____	Foot _____	Toes _____	Other: _____		
19. YES NO Do you have a loss of or serious impairment of a paired organ (kidney, eye, lung, testicle)?
20. YES NO Have you had any other medical problems (infectious mononucleosis, diabetes, asthma, anemia, hernia, ulcers, hepatitis, arthritis)?



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For any "YES" response to the above questions, please list the question number followed by a brief explanation:

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If you have had surgery or been under the care of a physician for a medical condition in the past twelve (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 include surgical notes and/or test reports.

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

Signature of athlete:  \_\_\_\_\_ Date: \_\_\_\_\_

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**MEDICATIONS:**

Please list **ALL** prescription and over the counter medications that you are **CURRENTLY** taking or have taken in the past two (2) years and for what purpose:

<u>Medication</u>	<u>Purpose</u>	<u>Dosage</u>	<u>Date(s)</u>

**\*\*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, 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 Documentation Form located on the Whitman College Athletic web site.

**SUPPLEMENTS / ERGOGENIC AIDS:**

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

<u>Supplement</u>	<u>Purpose</u>	<u>Dosage</u>	<u>Date(s)</u>

\* For a list of NCAA banned substances, please visit the Whitman College Athletic Training Website



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Upon reporting to Whitman College, I completed an "Updated Health History Questionnaire" and I truthfully disclosed my medical history to the Whitman College Athletic Training Department and confirm that I am in excellent physical condition. Recognizing that my true physical condition is dependent upon an accurate medical history and full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history; that my Health History Questionnaire Form was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with a member of the Whitman College Sports Medicine Staff; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition understanding that I may be held financially responsible for such exams.



Student-Athlete Signature	/ /
Student-Athlete Printed Name	Sport
OR	
Parent/Guardian Signature (if under 18)	/ /
Parent/Guardian Printed Name (if under 18)	

**Reviewed By Athletic Training Staff:**

Reviewers Signature	/ /
Reviewers Printed Name	



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### 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 condition may be communicated to:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

This authorization is valid for one school year, or for the entirety of any injuries/illnesses that occur during the 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 Whitman College intercollegiate athletics program must complete this form as a condition of participation.



\_\_\_\_\_  
Student-Athlete Signature \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Student-Athlete Printed Name \_\_\_\_\_  
Sport

OR

\_\_\_\_\_  
Parent/Guardian Signature (if under 18) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name (if under 18)



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**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 events. 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 pre-existing 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.



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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 Printed Name

\_\_\_\_\_  
Sport

OR

\_\_\_\_\_  
Parent/Guardian Signature (if under 18)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name (if under 18)

