## New Student-Athlete

# Pre-Participation Medical Paperwork

## Valparaiso University Athletic Department

Dear Student-Athletes and Parents/Guardians,

On behalf of the athletic training staff, we are excited about the upcoming academic year and athletic season. We look forward to working with you. Our staff is committed to maintaining and improving the health and athletic performance our student-athletes.

As part of the athletic department, and under the direction of the team physician, the athletic training staff provides high quality medical care for all student-athletes. Athletic training is an allied health profession recognized by the American Medical Association. All full time staff and graduate assistant athletic trainers are responsible for the evaluation, management, rehabilitation and treatment of injuries/illnesses that may occur during participation in athletic endeavors. The prevention of these injuries/illnesses, where possible, is of utmost concern. The athletic training staff works in conjunction with team physicians, the Health Center staff, surrounding medical facilities, Valparaiso University Athletic Department staff and the student-athletes to carry out these tasks.

As an integral part of our preventative efforts, we ask that you read and complete the paperwork found in this packet. After completion of the entire packet, please mail the forms to the address below. **This information must be received by the specified due date so that your participation can begin immediately upon your arrival.** Student athletes are not permitted to participate until the completed packet is received. We ask that you also read and review our policies and insurance information found on the Sports Medicine web page (www.valpoathletics.com), and acknowledge that you have read them on the Authorization form.

**Due Dates**

**June 1st -Basketball & Summer School Enrollees**

**July 1st- ALL Sports Fall Enrollees**

**Medical Form Checklist:**

_____ Copy of Health Form (http://www.valpo.edu/health click on Health Form) (original to Health Center)
_____ Sports Medicine Services, Medical Authorization, Assumption of Risk & Health Disclosure (A-D)
_____ Health Center Release Form
_____ Health Insurance & Emergency Contact Form
_____ Insurance/Vision/Dental Card Copy (front & back of card please)
_____ Sickle Cell Form

**Mail all forms to:**
Valparaiso University
Attn: Sports Medicine
1009 Union St.
Valparaiso, IN 46383

If you have questions you may contact us anytime.
Sincerely,

*Valparaiso University Sports Medicine*
219-464-5236

# Pre-Participation Physical Exam Form

## Valparaiso University Athletics Department

The Pre-participation Physical Exam Form must be completed and submitted before a student-athlete is allowed to participate in a Valparaiso University athletic program.

The form is comprised of two sections: the student-athlete's past medical history and the physician exam. The past medical history (first page) contains several questions asking about previous injuries, illnesses, and other medical conditions. It should be completed carefully and completely by the student-athlete and his or her parent(s)/guardians(s). Please be sure all "YES" answers are explained in the space provided.

The second section (second page) is to be completed by a physician after the physician completes a medical exam. The physician will then indicate participation status, sign the form, and include any other recommendations.

Pre-Participation Physical Form: (http://www.valpo.edu/health click on Health Form)

### NCAA Banned Drug and Medical Exceptions Policy

The NCAA bans certain drugs because they may cause harm to student-athletes and/or create and unfair advantage in competition. Medications used in the management of ***Attention Deficit Hyperactivity Disorder (ADHD)*** often are classified as stimulants and are included in this ban. The NCAA does grant medical exceptions to this policy, but requires specific documentation outlining the diagnosis and treatment plan for student-athletes who use prescribed stimulants for the management of ADHD. If you (the student-athlete) or your son/daughter uses medication for ADHD, please contact Nathan Twedt, Associate Athletic Trainer, at 219-464-5236, to ensure proper documentation is obtained. As with all medical information, strict confidentiality will be maintained.

More information about this NCAA policy can be found at:

http://www.ncaa.org/wps/ncaa?ContentID=1458

**Sports Medicine Services, Medical Authorization, Assumption of Risk & Health Disclosure**
**Valparaiso University Athletics Department**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Student-Athlete's Last Name | First Name | Middle Name | Sports(s) |

**Note to Parent/Guardian: Please read, sign and return with other Sports Medicine paperwork.**
***For purposes of this document, I or my shall mean the Student-Athlete and the Parent/Guardian on behalf of the Student-Athlete***

**A. Sports Medicine Services**

I understand that the sport 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. Valparaiso's team physicians do not attend all practices and competitions; however, they are immediately available via cell phone and pagers.

I acknowledge that all athletic injuries and illness are to be reported immediately to the sports medicine staff for evaluation, care, and referral. The Sports Medicine staff assesses the immediate needs and gives authorization to receive medical care from one of the following: Team Physicians, Health Services, and Outside Physicians. No one within the Athletic Department 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 will result in being withheld from participation.

**Student-athlete initials_____**

**B. Assumption of Risk**

In consideration and as a condition of my participation at Valparaiso University in activities with an athletic team, which includes but are not limited to training, trying out, practicing, competing, and traveling, I freely acknowledge that I am aware of and accept the risks associated with such participation and that my participation in such activities is voluntary.

I fully realize the dangers of participating in such activities and fully assume the risk associated with such participation, which may include, but are not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, and which may be caused in whole or in part by numerous factors, including my medical or physical condition, the actions or inactions of other student-athletes, the conditions of premises, and the negligence of entity or individuals released hereby. I waive, release and discharge for myself, my heirs, executors, administrators, legal representatives, assignees and successors in interest any and all rights or claims for injuries or losses of any description that I may have or which may hereafter accrue to me against Valparaiso University, The Lutheran University Association, Inc., either of their directors, employees, or agents, in connection with my participation in activities associated with Valparaiso University athletic teams.

**Student-athlete initials_____**

**C. Medical Authorization**

I grant permission to Valparaiso University 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 Valparaiso University athletic teams which I am a participant.

**Student-athlete initials_____**

**D. Disclosure of Health Conditions**

I authorize the Sports Medicine staff or any such person that they may designate , permission to contact and discuss my health or medical condition with my parents, guardians or immediate family members in the 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.

**Student-athlete initials_____**

In the event of any injury or emergency medical condition, I hereby authorize Valparaiso University Sports Medicine Staff or Team Physician(s) to contact my parent(s)/guardians(s). □ Agree □ Disagree

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

| _____ | _____ |
|---|---|
| Student-Athlete Signature | Date |

| _____ | _____ | _____ |
|---|---|---|
| Parent/ Guardian Signature | Relationship | Date |

(Required regardless of Student-athlete's age)

# Health Center

## Authorization for Release of Medical Information

DATE:_____ ENROLLMENT STATUS: FR SO JR SR

NAME:_____ DOB _____/_____/_____

ADDRESS:_____ PHONE:_____

_____

_____ ____ SS#._____

VARSITY SPORT(S):_____

I hereby authorize **Valparaiso University Health Center** to permit **Valparaiso University Sports Medicine Staff** to review or receive a copy of my medical record and any information contained therein, whether written or audio taped, saved on computer disk, or any other means of storing and/or exchanging medical information.

I understand that I may revoke this authorization to release medical records to Valparaiso University Sports Medicine Staff in writing at any time. This authorization shall remain valid until it is either revoked or the athlete is no longer a member of a Valparaiso University athletic team.

I also understand that unless I indicate otherwise, this authorization to release medical records includes permission to release information pertaining to my physical history **ONLY**. Information pertaining to emotional illness, including treatment for mental illness, drug or alcohol abuse, communicable diseases including HIV/AIDS information may **NOT** be released without my specific written permission.

I understand that my records are protected under federal law and state confidentiality laws and relations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken to release therein and that in any event this consent expires automatically as described below. It is understood that this consent can be revoked at any time except to the extent that action has been taken.

_____ _____

Student Signature Date

I DO NOT authorize the release of a copy of my medical record.

_____ _____

Student Signature Date

This information has been disclosed to you from records protected by federal confidentiality rules (42C.F.R. part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

# Valparaiso University Sports Medicine Health Insurance & Emergency Contact Information

When completed, return this form to:

Attn: Sports Medicine
Athletic/Rec Center
1009 Union Street
Valparaiso IN 46383
Phone: 219-464-5236 x3

Valparaiso University Athletic Department's accident policy only provides insurance coverage for student-athlete injuries that occur while participating in the play or practice of intercollegiate sports. This policy is considered EXCESS or SECONDARY to any other collectible group insurance benefits. This simply means that any claims must FIRST be filed with any other valid and collectible group insurance policy under which the student-athlete is covered. Only after the student-athlete's PRIMARY carrier has exhausted all available benefits will our athletic insurance company consider the payment of remaining balances, **PROVIDED THE CLAIMS ARE SUBMITTED WITHIN THE SPECIFIED TIME PERIOD (52 WEEKS) AND THE FOLLOWING CLAIM PROCEDURES ARE FOLLOWED WITH THE REQUIRED DOCUMENTATION PROVIDED.** The University's athletic policy covers athletic injuries only and is not a substitute for comprehensive medical coverage.

*SEND A COPY OF THE FRONT & BACK OF YOUR HEALTH, PRESCRIPTION, AND/OR DENTAL INSURANCE CARDS WITH THIS FORM.*

**Student name (Please Print) :** _____ Sport: _____
Year in school: ___ Freshman ___ Sophomore ___ Junior ___ Senior ___ 5th Yr ____ Male ____ Female
Social Security No.: _____ or Student ID No.: _____ Date of birth: _____
Current address: _____

**EMERGENCY CONTACT INFORMATION:**
Primary contact name: _____ Relationship: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Secondary contact name: _____ Relationship: _____
Cell phone: _____ Home phone: _____ Work phone: _____

**OTHER INSURANCE INFORMATION:**
**Father/Guardian's name**: _____ Date of Birth: _____
Social Security Number: _____ Employed: Yes ___ No ____
Employer: _____
Address: _____
Phone number: _____ Contact person: _____
Does your father have group Medical Insurance coverage through his employment? Yes ____ No _____
Insurance company: _____
Address: _____ Policy No.: _____
**Mother/Guardian's name**: _____ Date of Birth: _____
Social Security Number: _____ Employed: Yes ___ No ____
Employer: _____
Address: _____
Phone number: _____ Contact person: _____
Does your mother have group Medical Insurance coverage through her employment? Yes _____ No _____
Insurance company: _____
Address: _____ Policy No.: _____

**TYPE OF PLAN:**
☐ Health Maintenance Organization (HMO) ☐ Preferred Provider Organization (PPO) ☐ Standard Medical & Hospitalization Coverage
☐ Other (Describe): _____

- If your mother or father has medical insurance coverage and you are not covered, or are only partially covered, due to policy limitations, please explain: _____
- If you have medical insurance coverage as an eligible dependent from a parents' previous marriage, as mandated in a divorce decree, please give details for filing a claim: _____

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I hereby authorize any physician, hospital, company, employer or organization to release and/or exchange any information regarding the medical history, treatment, or benefits payable incurred from any intercollegiate athletic accidents. I permit the release of any medical information about me to Valparaiso University and Commercial Travelers Mutual Insurance Company or its authorized benefit Plan Administrator. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or had in the past. The company will use this information to find out if any claim is eligible. A photocopy of this authorization shall be as valid as the original. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. I also authorize the Commercial Travelers Mutual Insurance Company or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service and such payment shall release the Insurance Company from liability as to amounts so paid. Any person who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Signature of policy holder: _____ Date: _____

Printed name: _____

** * * Please inform the Sports Medicine Office of any insurance changes during the course of the year. * * **

# Sickle Cell Trait Testing for Incoming Athletes

The NCAA and Valparaiso University are committed to prevention of sudden death and catastrophic incidents in sport. The Division I Legislative Council decided that all incoming Division I student-athletes must be tested for the sickle cell trait, show proof of a prior test or sign a waiver.

Often, sickle cell trait screening is performed on all U.S. babies at birth. However, many student-athletes may not know whether they have the trait. Screening can be accomplished with a simple, relatively inexpensive blood test. Following the recommendations of the National Athletic Trainer's Association (NATA) and College of American Pathologists (CAP) if the trait is not known, the NCAA recommends athletics departments confirm sickle cell trait status in all student-athletes during the medical examination (Bylaw 17.1.5)

You will be unable to participate in practices or games until we have received either proof of the test signed by a physician or a signed waiver. If you are under 18 years of age, these will also need to be signed by a parent or guardian. Three options are available to comply with this requirement:

1. You may perform the screening with a blood test. We recommend that you request the test be done during your pre-participation physical exam with your family doctor. You will be able to perform the test on campus; however, results may take some time which could result in time loss from practices and games.

2. You may provide proof of a prior test. In order for this to be accepted, it must be signed by a physician.

3. You may also sign a waiver. Waiver forms will also be available upon arrival.

**Valparaiso University Sports Medicine**
**Student-Athlete Sickle Cell Trait Form**

The NCAA and Valparaiso University recommend that all student-athletes have knowledge of their sickle cell trait status. It is the goal of the Sports Medicine staff to identify persons presenting for physicals that may be in a high-risk category for sickle-cell disease or trait and initiate appropriate testing.

Sickle cell disease is an inherited blood disorder that affects red blood cells—cells that carry oxygen in our bodies. Persons with sickle cell disease make sickle-shaped blood cells, instead of round-shaped. This deformation decreases the cells' flexibility and results in their restricted movement through the body's blood vessels, depriving downstream tissue of oxygen. This can lead to serious medical problems or even death.

Certain conditions can make the sickling worse. These are infection, overexertion, dehydration, cold weather, stress and high altitude, among others.

Sickle cell trait means that you carry enough genetic material to pass on the trait to your children. If you have children with someone else who has sickle cell trait, the child could get sickle cell disease. People with sickle cell trait usually do not get the disease, but under certain extreme conditions (especially dehydration and high altitude), some sickling may occur.

Student-athletes of African American, Mediterranean, Middle Eastern, Indian, Caribbean and South and Central American ancestry are in the high-risk category for sickle cell disease.

Student-athletes may choose to waive sickle cell testing. By doing so you demonstrate that you understand the risks stated above and voluntarily agree to release, discharge, indemnify and hold harmless Valparaiso University, the Lutheran University Association, Inc., and any of their officers, trustees, directors, employees, agents and insurers from any and all costs, liabilities, expenses, claims, demands, or causes of action for any loss or personal injury that might result from your non-compliance with the recommendation for sickle cell testing by the NCAA and Valparaiso University.

Please check the appropriate statement below:

_____ I understand that I am in the high-risk category and will be/have been tested.
I further agree to provide VU Sports Medicine with documentation of my test results.
_____ Positive _____ Negative _____ Date of Testing

_____ I understand that I am in the low-risk category but will be/have been tested.
I further agree to provide VU Sports Medicine with documentation of my test results.
_____ Positive _____ Negative _____ Date of Testing

_____ I understand that I am in the high-risk category but DO NOT wish to be tested.

_____ I understand that I am in the low-risk category and DO NOT wish to be tested.

_____ _____
*Printed Student-Athlete Name* *Date of Signature*

_____ _____
*Signature of Student-Athlete* *Sport*

_____ _____
*Printed Parent/Guardian (if student-athlete is under 18 years of age)* *Date of Signature*

_____
*Signature of Parent/Guardian (if student-athlete is under 18 years of age)*

_____ _____
*Signature of Supervising Athletic Trainer* *Date of Signature*