William Penn University Sports Medicine Department
Pre-Participation Form Check List

Please fill out all forms entirely. Parents, please remember to sign all forms if your son or daughter is under the age of 18! ALL parents, please be sure to sign the insurance explanation/authorization form and the insurance information form! Please return all completed forms no later than July 15th!

Below is a check list of forms that should be completed.

1. Student-Athlete Contact Information Form
2. Medical History Form
3. Sickle Cell Trait Testing Form **(Take this form along with your physical!)**
4. Physical Form **(must be performed by an MD, PA, or OD for all athletes. No DC will be allowed) (Must include urinalysis)**
5. Insurance Explanation/Authorization Form
6. Insurance Information Form
    - Please check that the following commonly used providers are within your HMO/PPO insurance coverage:
        - Mahaska Health Partnership (Oskaloosa, IA)
        - IowaOrtho (Des Moines, IA)
        - Radiology Partners (Des Moines, IA) (associated with IowaOrtho)
        - Pella Regional Health Center (Pella, IA)
7. Copies of Insurance Cards (Front/Back)
    a. Health/medical
    b. Dental
    c. Prescription
8. Assumption of Risk Form
9. Medical Information Release Form

ATTENTION:

Sickle Cell Trait Testing:

Effective August 1, 2012 the NCAA (The NAIA utilizes the NCAA Sports Medicine Handbook) mandates that all student-athletes either be tested for the sickle cell trait or show proof of a prior test. This legislation applies to all incoming, returning, and tryout student-athletes. The NCAA allows student-athletes to opt out of this testing by signing a waiver. William Penn University recommends that all student-athletes be tested for the sickle cell trait. Testing should be completed at home prior to the school year. Test results should be provided to the WPU Sports Medicine staff.

William Penn University Sports Medicine Department
Medical History

Name:____ Date:______________________
Last First MI

Social Security #:____________________________________ DOB:______________________

Sport(s):______________________________ Sex: M / F Race:______________________

Immediate Family History

Name	Age	Serious Health Problems	If Deceased, Age and Cause
Father:			
Mother:			
Siblings:			

Family History
Has any blood relative had the following?

	Yes	No		Yes	No
Alcohol, drug dependency			Heart disease		
Attempted suicide			High blood pressure		
Blood disease (sickle cell trait, leukemia)			Marfan's Syndrome		
Cancer			Mental disorder		
Diabetes			Stroke		
Eating disorder			Sudden death (before age 50)		
Epilepsy			Other		

Please explain any "yes" answers in the space provided below.

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Personal History Do you have any history of the following:

	Yes	No		Yes	No		Yes	No
ADD/ADHD			Gallbladder trouble			Shortness of breath		
Alcohol/tobacco use			Gum/tooth trouble			Sickle cell trait and/or disease		
Allergies			Heart murmur			Sinusitis		
Anemia			Heart palpitation			Sleeping problems		
Asthma			Heat illness, cramps, stroke			Stomach/intestinal trouble/indigestion		
Back pain			Hernia			Tuberculosis		
Cancer, cyst			High/low blood pressure			Urinary tract problems		
Chemical dependency			Jaundice/hepatitis			Venereal disease		
Chest pain/pressure			Malaria			Vision correction		
Chicken pox			Marfan's Syndrome			--glasses		
Chronic cough			Measles			--contacts		
Chronic diarrhea			Mononucleosis			Weakness, paralysis		
Diabetes			Mumps			Worry, nervousness		
Dizziness/fainting			Pneumonia			*Females only*		
Ear/nose/throat trouble			Polio			Irregular periods		
Eating disorder			Recent weight gain/loss			Severe cramps		
Epilepsy, seizures			Rheumatic fever			Excessive flow		
Eye injury			Rubella			Pregnancy		
Frequent anxiety			Scarlet fever			Other		
Frequent depression								

Please explain any "yes" answers in the space provided below.

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General Medical Questions

	Yes	No
Do you have any **allergies** to food, medication, insects, etc.? **Please list specific allergies below**.		
Do you have a complete and functional set of all paired organs? (Eyes, ears, kidneys, lungs, ovaries, testicles)		
Have you had any illness, injury or surgery that required hospitalization?		
Have you ever been advised to have surgery that you have not had performed?		
Do you have any pins, staples or wires in any part of your body?		
Are you currently taking any medications or nutritional supplements, either prescription or non-prescription, on a routine basis?		
Do you have a learning disability?		
Do you have ADD and/or ADHD?		
Are you taking medication (s) for ADD and/or ADHD? (Requires medical documentation- see checklist above)		
Do you require any special protective or corrective equipment not ordinarily utilized in your sport?		
Please give most recent dates for the following:	Date	
Medical exam		
Dental exam		
Eye exam		

Please explain any "yes" answers in the space provided below.

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Neurological

Do you have any history of the following:

	Yes	No
Head injury or concussion. How many? __________ When? ___________ ImPact testing? ________ When? ___________		
Loss of consciousness		
Memory loss		
Frequent or severe headaches		
Numbness or tingling in the arms, hands, legs or feet		
Burners, stingers, pinched nerves		
Migraines		
Low back pain		
Pain radiating into buttocks or legs		

Cardiac

Have you ever…

	Yes	No
been seen by a cardiologist?		
had an echocardiogram?		
had a cardiac stress test?		
been denied or restricted from participation in sports due to heart problems?		

Please explain any "yes" answers in the space provided below. If seen by cardiologist please provide proof that you have been cleared for athletic activity.

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Orthopedic: Do you have any history of the following:

	Back/Chest			Shoulder			Knees			Arm/Elbow/Wrist/ Hand/Fingers				Hip/Leg/Ankle Foot/ Toes			
	R	L	Date	R	L	Date	R	L	Date	R	L	Body part	Date	R	L	Body part	Date
Fractures/stress fractures																	
Dislocations																	
Separations																	
Sprains/strains																	
Tendonitis/bursi tis																	
Injections																	
Joint locking																	
Torn ligaments																	
Torn cartilage																	
Rotator cuff injury																	
Chondromalacia / grinding																	
Osgood Schlatter's disease																	
Scoliosis, kyphosis, lordosis																	
Surgery																	

Please explain any "yes" answers in the space provided below.

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Medical History Certification

	Yes	No
Do you have or have you ever had any other medical problems or injuries not listed on this form?		
Do you have any medical or health problems that you are currently receiving medical treatment?		
Is there any reason you are not able to participate in athletics?		
Are there any additional health problems that you would like to discuss privately with the athletic trainer or team physician?		

Please explain any "yes" answers in the space provided below.

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1. I hereby state that the above information is true and accurate and understand that failure to record a past injury/condition can affect services rendered by William Penn University as well as possible suspension.

2. I understand that I must refrain from practice or play during medical treatment until discharged by the athletic trainer or team physician.

3. I understand that WPU's secondary policy only covers injuries that occur during a scheduled varsity event, practice or conditioning workout supervised by a coach. This does not include non-supervised workouts or injuries/illnesses that prevent participation in athletics if they were not directly caused by participation in athletics. Voluntary workouts will not be covered whether a coach is present or not.

4. I give permission for all necessary medical entities to release information to William Penn University Sports Medicine and for William Penn University Sports Medicine to release information to all necessary health care providers and facilities included in my care.

______________________________ ______________

Student-Athlete Signature Date

______________________________ ______________

Parent's Signature required if Student-Athlete is under 18 Date

Upon completion of this form, it will be reviewed and signed by a Certified Athletic Trainer.

______________________________ ______________

ATC Signature Date

William Penn University Sports Medicine Department
Pre-Participation Physical Form

Name:___________________________________ High School:___________________________________
DOB:____/_____/____
Sex: M / F
Age:___________

MEDICAL EXAM

Vision: L_________	R_________	Height:_______________
Pupils: L_________	R_________	Weight:_______________
Glasses: Y / N	Contacts: Y / N	Blood Pressure:________/________
Eye Protection: Y / N		Pulse:___________ Resp:_________

	Normal	Abnormal	Comments
HEENT Head			
Ears			
Mouth			
Throat			
Nose			
Dental			
Thyroid			
Lymphnodes			
Lungs			
Heart/Murmur			
Abdomen			
Genitalia			
Hernia			
Skin			

MUSCULOSKELETAL

	ROM	Strength	Reflexes		Flexibility	
Cervical Spine			Biceps C5		Quadriceps	
Shoulders			Triceps C7		Hamstrings	
Elbows			Patellar L4			
Wrists/Hands/Fingers			Achilles S1			
Thoracic Spine/Ribs						
Lumbar Spine						
Hips						
Knees						
Ankles						
Feet/Toes						

Comments:

CLEARANCE FOR ATHLETIC PARTICIPATION **(Fill out the following information below or physical is incomplete.)**

Initial if acceptable:	Med Hx Norm:________	Med Exam Norm:_______	Musculoskeletal Exam Norm:________
Athlete is cleared to participate in:	Collision Sports:_______	Contact Sports:_________	Non-Contact Sports:__________
Reason for not clearing:___________________________		**Modifications or exceptions:**________________________________	

I certify that the athlete has been evaluated in the areas as indicated above to be physically fit to participate in intercollegiate athletics.

___________________________ ___________________________ _______________
Physician Signature Printed Name Date

I do not know of any existing physical condition or additional health reason that would preclude my participation in sports. I hereby authorize the release the information contained in this document to the WPU Sports Medicine staff. Upon written request, I may receive a copy of this document for my personal health care provider.

____ _________________________
Student-Athlete Signature Date

____ _________________________
Parent Signature required if athlete is under 18 Date