WILLIAM PENN
UNIVERSITY

Sports Medicine Department

Pre-Participation Physical Forms - New Student Athletes & Transfer Student Athletes

Sports Medicine Department | 201 Trueblood Avenue, Oskaloosa, IA

William Penn University
Sports Medicine Department

Dear Student-Athlete and Parents/Guardians:

Welcome to William Penn University and Statesmen Athletics! We are excited to have you participating in intercollegiate athletics at William Penn University.

In order to provide quality health care to our athletes, we ask that you please take time to complete the following forms so we have an accurate medical file. These forms are the medical history questionnaire, pre-participation physical, medical insurance explanation/authorization, insurance information, assumption of risk form and medical information release form. **All forms need to be filled out entirely and returned to the WPU Athletic Training Department no later than July 15th. ALL parents, please be sure to sign the medical insurance explanation/authorization form and the insurance information form. Parents, please also remember to sign all forms if your son or daughter is under the age of 18!**

FAXED FORMS WILL NOT BE ACCEPTED!

ATTENTION:

WPU student-athletes are required to maintain primary health insurance coverage for the entire calendar year in order to qualify for the WPU secondary insurance policy. It is your responsibility to provide us with new information if coverage changes. If a student-athlete's primary health insurance coverage lapses, he/she is immediately ineligible for practice and competition. **It is imperative that a change is reported as soon as possible.** Also if primary coverage lapses WPUs secondary policy will no longer be in effect for any open claims. **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. If you wish to seek a second opinion from any other physicians, dentists, optometrists, etc. the Director of Sports Medicine must approve this PRIOR to you scheduling the appointment.** Please thoroughly read the medical insurance explanation/authorization form included in this packet for details.

SPECIAL NOTE: If you have Medicaid as your primary health insurance coverage please be aware that coverage may vary depending on which state the insured receives care in. In certain states athletically-related injuries requiring orthopedic care may not be covered. If this Medicaid is denied as the primary health insurance coverage, you will be required to pay the deductible out-of-pocket in order to receive the benefits of the WPU secondary policy.

By signing below I acknowledge that I have read the above information.

_____	_____	_____	_____
Student-Athlete Signature	Date	**Parent/Guardian Signature Required**	Date

If you do not have primary health insurance coverage you need to find one of your choice provided you are covered for the entire calendar year.

Sincerely,

Sports Medicine Staff
William Penn University
201 Trueblood Avenue
Oskaloosa, IA 52577
(641) 673-1293

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
Contact Information

Student-Athlete Information

Name:_____ Date:_____
Last First MI

Sport(s):_____ DOB:_____ SSN:_____

Home Address: _____
Street City State Zip

Home Phone #_____ Cell #_____

University
Address:_____
Street City State Zip

Parent/Guardian Information

Father/Guardian:_____
SSN:_____
Address:_____
_____
Home Phone #_____
Cell Phone #_____
Employer:_____
Address:_____
_____
Work Phone:_____

Mother/Guardian:_____
SSN:_____
Address:_____
_____
Home Phone #_____
Cell Phone #_____
Employer:_____
Address:_____
_____
Work Phone:_____

Emergency Contact Information

Primary Emergency Contact: _____

Address: _____
Street City State Zip

Home Phone# _____ Work Phone # _____ Cell# _____

Relationship to Athlete_____

Secondary Emergency Contact: _____

Address: _____
Street City State Zip

Home Phone# _____ Work Phone # _____ Cell# _____

Relationship to Athlete_____

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.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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.

_____

_____

_____

_____

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.

_____

_____

_____

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.

_____

_____

_____

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/bursitis	☐	☐		☐	☐		☐	☐		☐	☐			☐	☐		
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.

_____

_____

_____

_____

_____

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.

_____
_____
_____
_____

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
Sickle Cell Trait Testing

About Sickle Cell Trait

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Many individuals, including athletes, who have the sickle cell trait are unaware of their condition.
- The sickle cell trait is usually benign, but complications can arise during periods of severe or prolonged oxygen deprivation, physical exertion, or dehydration.

Effects of the Sickle Cell Trait on Athletes:

- Having the sickle cell trait does not preclude outstanding athletic performance. Athletes at all levels, including high school, collegiate, Olympic and professional, may have the sickle cell trait.
- During intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of the red blood cells into a crescent or "sickle" shape.
- These sickled cells may accumulate in the bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood. In rare cases, death may occur in extreme temperatures and altitudes.
- Common signs and symptoms of a sickle cell emergency include, but are not limited to: increased pain and weakness in the working muscles (especially legs, buttocks, and/or low back); cramping type pain of muscles; soft flaccid muscle tone; and/or immediate symptoms with no early warning signs.

Athletes with the Sickle Cell Trait:

- Athletes with the sickle cell trait will still be able to participate fully in all university athletics.
- Screening for the sickle cell trait allows you and the University to take simple precautions to help prevent injury resulting from the sickle cell trait, allowing you to thrive as a student-athlete.
- Precautions may include gradual preseason condition, setting your own pace during workouts, staying properly hydrated, getting proper recovery between exercises, and monitoring athletes at high altitudes.
- More information regarding the sickle cell trait is available on the NCAA website at www.ncaa.org

In response to these concerns, the NCAA 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 the waiver at the bottom of this page. William Penn University Sports Medicine 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.

Sickle Cell Trait Testing

☐ I have read and fully understand the information provided above, and I **DECLINE** to be tested for the sickle cell trait.

☐ I AGREE to be tested and provide results for the sickle cell trait or to provide proof and results of a prior test.

I acknowledge the risks associated with declining the testing and failing to be aware of my sickle cell trait status, including but not limited to physical distress, collapse and death. I release William Penn University and its employees, volunteers, and agents from any liability arising out of or relating in any way to my sickle cell trait status or my decision to decline testing.

_____ _____

Student-Athlete Signature Date

_____ _____

Student-Athlete Name (Printed) Sport

_____ _____

Parent/Guardian Signature (if under 18 years) Parent/Guardian Name (Printed)

William Penn University Sports Medicine Department
Pre-Participation Physical Form

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

Vision: L_____	R_____	Height:_____
Pupils: L_____	R_____	Weight:_____
Glasses: Y ◯ N ◯	Contacts: Y ◯ N ◯	Blood Pressure:_____/_____
Eye Protection: Y ◯ N ◯		Pulse:_____ Resp:_____

MEDICAL EXAM

	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

William Penn University Sports Medicine Department
Insurance Information Form

Please provide the information requested below, i.e. medical information authorization, a front/back copy of the following (those which apply): health insurance, dental insurance and/or prescription cards. The following information will be updated annually according to the academic, not calendar, year. **WPU student-athletes are required to maintain primary health insurance coverage for the entire calendar year in order to qualify for the WPU secondary insurance policy. If a student-athlete's primary health insurance coverage lapses, he/she is immediately ineligible for practice and competition. It is your responsibility to provide us with new information if coverage changes. <u>It is imperative that a change is reported as soon as possible.</u>**

Student-Athlete Information

Name: _____Sport(s):_____ Sex: M○ F○

SSN: _____ DOB: _____ Student Cell # _____
Campus Address: Permanent Address:
_____ _____
_____ _____

Health Insurance Information
<u>Primary Policy</u>
Policy Holder's Name: _____ Relationship to Athlete: _____
SSN: _____-_____-_____ DOB:_____/_____/_____ Cell Phone:_____
Home Phone: _____ Work Phone: _____ Email:_____
Home Address: Work Address:
_____ _____
_____ _____
Primary Care Physician: _____ Office Phone_____

<u>Primary Policy</u>
Insurance Company**:** _____
Effective Date of Policy: _____ Expiration date of Policy: _____
Policy#:_____ ID#:_____ Group#:_____
Is this an HMO policy? ☐ Yes ☐ No Is this a PPO policy? ☐ Yes ☐ No
Mailing Address for Insurance Company's Claim Office:
_____ Phone_____
_____ Fax_____

<u>Secondary Policy</u> (if applicable)
Insurance Company:_____
Effective Date of Policy:_____ Expiration Date of Policy:_____
Policy#:_____ ID#:_____ Group#:_____
Is this an HMO policy? ☐ Yes ☐ No Is this a PPO policy? ☐ Yes ☐ No
Mailing Address for Insurance Company's Claim Office:
_____ Phone_____
_____ Fax_____

I hereby authorize William Penn University and it's secondary insurance provider to inspect or secure copies of case history record, laboratory reports, diagnosis, imaging results and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original. I authorize WPU Sports Medicine to contact the recorded primary policy holder of the insurance on file when deemed necessary regarding medical information due to an athletically-related injury. We authorize William Penn University or its insurance agent to pay the medical vendors directly for any bills incurred from injuries that are covered under the insurance policy of the University.

_____ _____
Student-Athlete Signature Date

_____ _____
Parent/Guardian Signature Required Date

William Penn University Sports Medicine Department
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, concussions, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal 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 Sports Medicine staff. 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 William Penn University 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 William Penn University, and their officers, agents, and employees from any and all liability, any medical expenses not covered by the William Penn University Department of Intercollegiate Athletics' secondary 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.

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at William Penn University.

_____ _____

Student-Athlete Signature Date

_____ _____

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

William Penn University Sports Medicine Department
Authorization to Release Medical Information

Name:_____
Last First MI

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ DOB:_____

I hereby authorize William Penn University Sports Medicine and it's secondary insurance provider to inspect or secure copies of case history records, laboratory reports, imaging results and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original. I also authorize WPU Sports Medicine to contact the recorded primary policyholder of the insurance on file when deemed necessary regarding medical information due to an athletically related injury. This authorization will automatically expire one year from the date signed. This authorization will be updated according to the academic year, not the calendar year. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Student-Athlete Signature Date

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

_____ _____
Witness Date

SUBMIT