

***WILLIAM PENN
UNIVERSITY***

Sports Medicine Department



Pre-Participation Physical Forms

**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 Sports Medicine Department PRIOR TO ANY ATHLETIC INVOLVEMENT WHATSOEVER.** Parents, please also remember to sign all forms if your son or daughter is under the age of 18!

FAXED, SCANNED, and EMAILED FORMS WILL NOT BE ACCEPTED! WE MUST HAVE THE ORIGINALS MAILED OR HAND DELIVERED!

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 WPU's 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 Sports Medicine Department 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. It is recommended that you enroll in the William Penn SHIP or enroll in Iowa Medicaid. 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

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

Medical History

You MUST put information for any "yes" answers throughout this form

Name: _____
 Last First MI

Date: _____

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.

**William Penn University Sports Medicine Department
COVID-19 Screening**

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? Yes No

During your time away from William Penn University, did you experience, or are you currently experiencing any of the following:

SYMPTOM	YES	NO	LENGTH OF SYMPTOM (DAYS)	EXPLANATION
Fever				
Body Chills				
Extreme Level of Fatigue				
Cough				
Pain / Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste				
Loss of Smell				
Changes to Vision / Eye Discharge				

QUESTION	YES	NO
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?		
Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		
Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?		
During your time away from William Penn University, did you self-quarantine due to suspected symptoms or exposure of COVID-19?		
During your time away from William Penn University, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		

Have you previously been or are you currently diagnosed with COVID-19?

YES NO

DATE OF DIAGNOSIS: ____/____/____

Do you have medical documentation to support your diagnosis and treatment of COVID-19?

YES NO

PHYSICIAN NAME: _____

PHYSICIAN LOCATION: _____

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

Student-Athlete Signature: _____ Date: _____

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			<i>Females only</i>		
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 an incomplete set of any 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		
Do you require any special protective or corrective equipment not ordinarily utilized in your sport?		

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? _____		
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 physician documentation that you have been cleared for athletic activity.

Orthopedic: Do you have any history of the following:

If you have had none of these injuries please initial here: _____

	Back/Chest			Shoulder			Knees			Arm/Elbow/Wrist/H and/Fingers				Hip/Leg/Ankle/Foot / Toes				
	R	L	Date	R	L	Date	R	L	Date	R	L	Bod y part	Date	R	L	Bod y 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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical or health problems that you are currently receiving medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any reason you are not able to participate in athletics?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any additional health problems that you would like to discuss privately with the athletic trainer or team physician?	<input type="checkbox"/>	<input type="checkbox"/>

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.
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 WPU 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 wish to **OPT OUT** of being tested for sickle cell trait and that I have read and fully understand the information provided above.

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
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 Student-Athlete Concussion Statement and Acknowledgement

1. I fully understand and that it is my responsibility to report all injuries and illness and symptoms of concussion to my athletic trainer and/or team physician.
2. I have been provided access to the *William Penn University Sport Concussion Policy and Management Protocol*. I understand and acknowledge that it is my responsibility to completely and thoroughly read and understand its contents.
3. I have thoroughly read and understand the *NAIA/NCAA Concussion Fact Sheet*.

After reading the *NAIA/NCAA Concussion Fact Sheet* and reviewing the *William Penn University Sport Concussion Policy and Management Protocol*, I am aware of the following information:

- A concussion is a brain injury, which I am responsible for reporting to my team physician or certified athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.
- You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or certified athletic trainer.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
- In rare cases, repeat concussions can cause permanent brain damage, and even death.

Signature of Student-Athlete

Date

Printed Name of Student-Athlete