# *WILLIAM PENN UNIVERSITY*

## *Sports Medicine Department*

# Pre-Participation Physical Forms

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, COVID-19 Screening, 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 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 Sports Medicine Department should 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 Student Health Insurance Plan 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

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:_____ 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.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**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

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

**If Yes please attached as an addendum to this form

Have you been vaccinated against COVID-19?

☐ YES ☐ NO DATE OF FINAL SHOT: _____/_____/_____

**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 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.<br>How many? _____<br>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/ 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 | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | | | ☐ | ☐ | | |
| Tendinitis/ 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.
2. I affirm that I will refrain from practice or play during medical treatment until discharged by the athletic trainer or team physician.
3. I understand that William Penn University'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.

_____ _____

William Penn University 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 decline testing and **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 been provided access to the *William Penn University Sport Concussion Policy and Management Protocol*, I am aware of and agree to 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