Dear New Badger and Family,

Congratulations and welcome! We are excited to have you as a member of our Badger Family! The following is important information about this medical packet, Spring Hill College's secondary insurance policy, and sickle cell trait.

Please read and fill out the following pages carefully; the next page is a check sheet of what needs to be returned. Late or incomplete packets will result in a delay of medical clearance and participation with your sports team. If you have questions or concerns please contact us by phone **(251) 380-3493** or email **athletictrainer@shc.edu**.

Spring Hill College has a secondary insurance policy for student-athletes, which will cover injuries directly relating to participation in athletics at Spring Hill College. See attached secondary insurance information page for further explanation.

In support of the NCAA recommendation, Spring Hill College recommends all student-athletes know their sickle cell status as it affects more than 3 million Americans and can lead to collapse or death. Sickle cell trait is an inherited condition, and during intense, sustained exercise, the demand for oxygen by the muscles can cause the blood cells to become sickle shaped and block blood vessels. For more information visit www.ncaa.org.

If the student-athlete has not been tested and would like to have the test done, a blood test can be done at your primary care physician's office. If you choose to be tested, the test **MUST** be completed and the results turned in to the Athletic Training Department before medical clearance is given. **ALL** scheduling and costs related to testing are the responsibility of the student-athlete.

Concussion and return to learn policies can be found in the student-athlete handbook at www.shcbadgers.com

If you have questions call or email:

(251) 380-3493
athletictrainer@shc.edu

Thank You,

Dani Ellis ATC/L
Abigail Hunt ATC/L
James Scarborough ATC/L

Spring Hill College Athletic Training Department

Pre-Participation Paperwork Instructions

NCAA Incoming Student-Athlete

The following is a checklist of what needs to be submitted.

Print <u>ONE</u> sided and do <u>NOT</u> staple.

- ☐ Demographic & Emergency Contact (Page 3)
- ☐ Student-Athlete Insurance Information (Page 5) *Requires policy holder signature*
- ☐ Front and Back copies of your insurance card
- ☐ Copy of the **FRONT** of the student-athlete's photo ID (passport is acceptable)
- ☐ Signature Page 1-Includes: Medical Release of Information, Medical Consent, and Drug Testing Consent (Page 6)
- ☐ Signature Page 2-Includes: Shared Responsibility of Sports Safety, Acknowledgement of Personal Responsibility, and Acceptance of Risk Statement (Page 7)
- ☐ Medical History (Pages 8-10)
- ☐ Concussion History (Page 11)
- ☐ Nutritional Supplement Waiver (Page 12)
- ☐ Prescription Drug Medical Exemption (Page 13) *Please contact the Athletic Training Department for further paperwork regarding ADD/ADHD medications*
- ☐ Sickle Cell Trait Waiver (Page 14)
- ☐ Pre-Participation Physical Examination, **must be signed by a M.D. or D.O.** (Page 15)

Mail Completed Packet to:

Athletic Training Department
4000 Dauphin Street
Mobile, AL 36608

Student-Athlete & Parent/Guardian Demographic & Emergency Contact Information

Student-Athlete Information

Name:_____ Date of Birth:_____ Age:_____

Last 4 of SSN #:_____ Academic Class: FR SO JR SR GR Gender: _____

SHC Student ID #:_____ Sport(s): _____

Cell Phone #:_____ Home Phone #:_____

Local Address While Attending SHC:_____

City:_____ State:_____ Zip Code:_____

Res. Hall:_____ Room #:_____ Floor:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Information

In case of an emergency we will call in the order listed.

Contact 1: Relationship:_____

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City:_____ State:_____ Zip Code:_____ Work Phone:_____

Contact 2: Relationship:_____

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City:_____ State:_____ Zip Code:_____ Work Phone:_____

IMPORTANT
Secondary Insurance Information

Spring Hill College Department of Athletics provides a secondary athletic insurance policy, for all eligible student athletes, that helps defer the cost of injuries resulting from participation in SHC sanctioned sports participation. Student athletes are eligible **IF** they meet the following requirements:

- The student athlete is **REQUIRED** to have primary United States medical insurance.
    - The primary insurance **MUST** cover them in the state of ALABAMA **AND** cover collegiate athletic injuries.
- If the primary medical insurance is Tricare, Medicaid, or Kaiser, the student athlete **DOES NOT** qualify for secondary insurance. (Other primary policies may exist that exclude the student athlete from secondary coverage)
- If there is a lapse in or no coverage by the primary insurance at the time of injury, there is **NO** secondary insurance coverage and the student athlete will be responsible for **ANY and ALL** costs associated with the injury.
- ALL athletic medical care **MUST** be coordinated and approved by the Athletic Training Department. *This includes out of state medical care*
- The student athlete will see our approved providers and follow prescribed treatment plan before a second opinion will be approved.
- Appointments or treatments not approved by the Athletic Training Department will **NOT** be covered by the secondary insurance.
- There is a $500 deductible **PER INJURY** before the secondary insurance will make any payments.
- Co-pays are the responsibility of the student athlete.
- Secondary insurance does **NOT** guarantee payment or coverage.
- The Athletic Training Department needs copies of all bills and EOB's (Explanation Of Benefits) in order to process the secondary insurance.

Spring Hill College retains the right to revoke secondary insurance coverage at any time.

Failure to follow proper protocol may result in denial of coverage.

Our approved providers are:

The Orthopaedic Group- Team physician Dr. Jeff Conrad
Compass Urgent Care and Mobile Infirmary Emergency Room (prior approval required)
Encore Rehabilitation- provides physical therapy service ON CAMPUS in the Athletic Training room.

Please feel free to contact us if you have any questions.
Dani Ellis ATC/L
Abigail Hunt ATC/L
James Scarbrough ATC/L

Student-Athlete Insurance Information

Policy Holder's Name:_____ Policy Holder DOB:_____

Address:_____

Relationship to Athlete: _____ Phone:_____

Primary Insurance Company:_____

Primary Insurance Address:_____

Primary Insurance Phone:_____

Member/ID #:_____ Group#:_____

Effective Date of Policy:_____ Expiration. Date:_____

Policy Co-Pay:_____ Policy Deductible:_____

Primary Doctor:_____ Office Number:_____

Does this policy cover athletically related injuries and illnesses? Y ( ) N ( )

Is your son/daughter covered under any other health insurance policy? Y ( ) N ( )

My son/daughter has health insurance that covers them in the State of Alabama. Y ( ) N ( )

☐ I acknowledge there is a $500 deductible per injury claim that must be met before Spring Hill College's secondary insurance policy will pay claims for intercollegiate sport injuries.

☐ I acknowledge the student-athlete and his or her parents/guardians will be responsible for bills that do not meet the $500 deductible per injury claim.

_____ _____

Student-Athlete's Signature Date Policy Holder's Signature Date

_____ _____

Student-Athlete's Printed Name Date Policy Holder's Printed Name Date

Signature Page 1

Medical Release of Information

I,_____(print name), hereby authorize the physicians, athletic trainers, and other healthcare personnel representing Spring Hill College's athletic training department to release information regarding my medical condition(s) (including but not limited to: type and severity of injury, prognosis, diagnosis, athletic participation status and related personally identifiable information) to other healthcare providers, hospitals and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or college administrators, and my parents/guardians for the purpose of coordinating continuing medical care as necessary.

I,_____ (print name), am voluntarily choosing to participate in intercollegiate athletics at Spring Hill College and understand that giving authorization/consent for the disclosure of this health information is a condition of my participation in intercollegiate athletics at Spring Hill College.

I,_____(print name), agree that once information is disclosed by Spring Hill College to a third party, Spring Hill College is no longer liable for any further disclosure of the health information by the third party.

I,_____(print name), understand that I may revoke this authorization/consent at any time by notifying the athletic training department in writing. I understand it will not have any effect on the actions Spring Hill College officials/representatives took in reliance on this authorization/consent prior to receiving the revocation in writing. This authorization/consent expires one year from the date it is signed.

Student-Athlete's Signature	Date	Parent/Guardian Signature (if athlete is under 19)	Date
Student-Athlete's Printed Name	Date	Parent/Guardian Printed Name (if athlete is under 19)	Date

Medical Consent

I, _____ (print name), hereby authorize the athletic trainers at Spring Hill College who are under the direction and guidance of the Spring Hill College Team Physicians, to render any preventative, first aid, rehabilitative, or emergency treatment that they deem necessary for my health and well-being.

I, _____ (print name), hereby grant permission to the physicians and/or their consulting physicians utilized by the Spring Hill College Athletic Department to render any treatment, medical, or surgical care that they deem necessary for my health and well-being.

Student-Athlete's Signature	Date	Parent/Guardian Signature (if athlete is under 19)	Date
Student-Athlete's Printed Name	Date	Parent/Guardian Printed Name (if athlete is under 19)	Date

Drug Testing Consent

I understand as a condition of my participation in intercollegiate athletics as Spring Hill College,

I, _____(print name), agree to allow the Spring Hill College athletic department to conduct random or reasonable suspicion drug screenings as outlined by this drug testing policy, a copy of which I acknowledge I have received, reviewed, and understand (see student-athlete handbook for drug testing policy).

I understand that a collection of a urine sample may occur at any time and will be screened for substances identified in the Spring Hill College athletic department drug testing policy. If the drug screen is positive, I understand and agree that I will be subjected to the positive test sanctions as outlined in the policy; including, but not limited to notification of positive test results to my parent(s) or legal guardian(s).

I further understand that the Spring Hill College athletic department drug testing policy and any of its attachments may be amended at any time with or without notice, at Spring Hill College athletic department's sole discretion.

Student-Athlete's Signature	Date	Parent/Guardian Signature (if athlete is under 19)	Date
Student-Athlete's Printed Name	Date	Parent/Guardian Printed Name (if athlete is under 19)	Date

Signature Page 2

Assumption of Risk Statement

I, _____(print name), understand the chance of sustaining a catastrophic sports injury is extremely remote, yet understand that serious injuries can and do occur to anyone. Participation in my sport(s) could result in death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to 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.

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Shared Responsibility in Sports Safety

Participation in athletics requires an acceptance of the possibility of risk of injury. Student-athletes rightfully assume that those who are responsible for such activities have taken reasonable precaution to minimize such risk and that their participating peers will not intentionally inflict injury upon them.

Periodic analysis of injury patterns or refinements in the rules and other safety decisions will be made by the NCAA, individual sport's governing bodies and Spring Hill College's athletic department. Spring Hill College will remain compliant with all safety precautions set by the sport's governing body, or the conference to insure the safety of all participants.

I, _____(print name), have read the above shared responsibility statement and I understand that there is an inherent risk that is involved with my participation in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating in athletics at Spring Hill College.

1. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.
2. Understands that his/her having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics; but only that the examiner did not find a medical reason to disqualify him/her.
3. Fully realizes that Spring Hill College cannot be held responsible for any previous medical condition(s) that he/she might have. And Spring Hill College is not responsible for any incurred costs associated with the pre-existing medical condition as it was not related to participation at Spring Hill College.
4. Understands that for your health and safety you must report athletic injuries to the sports medicine staff as soon as they occur. This information is also needed to ensure proper insurance coverage for athletic injuries, which must be reported within 90 days of the injury occurring. Spring Hill College will not be responsible for any medical expenses related to athletic injuries that not have not been reported.
5. Understands that the athletic medical insurance at Spring Hill College is secondary coverage, which will cover the remaining balance on an athletic related injury only.

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Acknowledgment of Personal Responsibility to Provide Notification of Injury/Illness

I, _____(print name), understand that it is my responsibility to notify the Spring Hill College Athletic Training Staff of any and all injuries/illnesses, athletic or otherwise, suspected injuries/illnesses, and any and all pre-existing conditions that may result in further injury/illnesses to myself, teammates, opponents, or athletic staff members. This also mean that I will keep the athletic training staff aware of any changes in the status of medical insurance.

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Medical History

Circle any of the following that you have, have had, or are now undergoing treatment for:

1. Anemia	14. Heart Palpitation	27. Mumps
2. Anxiety/Depression	15. Heat Illness	28. Narcolepsy
3. Appendicitis	16. Hepatitis	29. Pneumonia
4. Asthma	17. Hernia	30. Sexually Transmitted Disease
5. Bladder Illness/Injury	18. High/Low Blood Pressure	31. Spastic Colon
6. Bleeding Tendencies	19. Irritable Bowel Syndrome	32. Spleen Illness/Injury
7. Chicken Pox/Shingles	20. Kidney Disease/Injury	33. Stomach Trouble
8. Diabetes	21. Learning Disability	34. Stress Fracture
9. Eating Disorders	22. Liver Disease	35. Thyroid Disorder
10. Fainting/Passing Out	23. Measles	36. Tuberculosis
11. Frequent/Severe Headaches	24. Menstrual Disorder	37. Tumors/Growths/Cysts/Cancer
12. Hearing Defect	25. Mental Illness	38. Ulcers
13. Heart Disease	26. Mononucleosis	

DISLOCATIONS

1. Have you ever dislocated a joint? Y ( ) N ( )
   If yes, explain what joint and when:_____
   _____
2. Did you see a physician? Y ( ) N ( )
   If yes, give Date(s):_____Doctor's Name:_____
   City, State:_____

FRACTURES

3. Have you ever broken a bone? Y ( ) N ( )
   If yes, explain what bone and when:_____
   _____
4. Did you see a physician? Y ( ) N ( )
   If yes, give Date(s):_____Doctor's Name:_____
   City, State:_____

OTHER MAJOR INJURIES/SURGURIES

5. Have you ever had an injury that took you out of a game or practice? Y ( ) N ( )
   If yes, explain what injury, when and for how long:_____
   _____
6. Did you see a physician? Y ( ) N ( )
   If yes, give Date(s):_____Doctor's Name:_____
   City, State:_____
7. Have you ever had an injury that resulted in surgery? Y ( ) N ( )
   If yes, explain: _____
   _____

Date(s):_____Doctor's Name:_____ City, State:_____

8. Have you ever been told to have a test or surgery that you did not elect to do? Y ( ) N ( )
If yes, explain:_____
_____

9. Did you see a physician? Y ( ) N ( )
If yes, give Date(s):_____Doctor's Name:_____
City, State:_____

10. Have you ever been told you cannot take part in any sport? Y ( ) N ( )
Explain:_____
_____

GENERAL

11. Have you ever passed out while exercising? Y ( ) N ( )
12. Have you ever passed out for any reason? Y ( ) N ( )
13. Do you frequently cough after exercise? Y ( ) N ( )
14. Have you ever had chest pain while exercising? Y ( ) N ( )
15. Have you ever seen a cardiologist, pulmonologist, or neurologist? Y ( ) N ( )
If yes, why?_____
Doctor's Name:_____ City, State:_____
16. Have you ever been told you have a heart murmur? Y ( ) N ( )
17. Did you have an EKG or Echo? Y ( ) N ( )
If yes, give Date(s):_____
Doctor's Name:_____ City, State:_____
18. Has anyone in your family died before the age of 50 or suddenly? Y ( ) N ( )
If so, who and how did it happen:_____
19. Does any disease or health condition run in your family, i.e. Diabetes, Heart Disease, etc.? Y ( ) N ( )
If yes, explain: _____
20. Have you ever been told you have an eating disorder? Y ( ) N ( )
If yes, what did you have?_____ Did you get treatment? Y ( ) N ( )
Were you admitted to the hospital? Y ( ) N ( ) Date(s):_____
Doctor's Name:_____ City, State:_____
21. Are you allergic to any medications? Y ( ) N ( )
If yes, what medication(s)?_____
22. Do you have any other allergies (i.e. insects, stings, pollen, foods, etc.)? Y ( ) N ( )
If yes, what?_____
23. Are you currently taking any medications (i.e. Anti-Depressants, Ritalin, etc.)? Y ( ) N ( )
If yes, which medication(s)?_____
24. Do you have a bridge or false teeth? Y ( ) N ( )
25. Have you ever fractured a tooth? Y ( ) N ( )
26. Have you ever had a tooth knocked out? Y ( ) N ( )
27. Do you wear a mouth guard? Y ( ) N ( )
28. Do you wear orthodontic appliances/braces? Y ( ) N ( )
29. Have you ever been to an eye doctor? Y ( ) N ( )
If yes, date of last visit:_____
30. Do you wear glasses or contact during sports participation? Y ( ) N ( )
31. Have you ever suffered an eye injury? Y ( ) N ( )
If yes, explain:_____
32. Is your color vision normal? Y ( ) N ( )
If no, what color(s) can you not see?_____
33. Do you have frequent headaches? Y ( ) N ( )
34. Have you ever been told you have migraines? Y ( ) N ( )
Doctor's Name:_____ City, State:_____
35. Have you ever had a seizure? Y ( ) N ( )
If yes, explain:_____
Doctor's Name:_____ City, State:_____

36. Were you ever told that you have a congenital spinal defect? Y ( ) N ( )
37. Were you ever told that you have spondylolisthesis/spondylolysis? Y ( ) N ( )
38. Were you ever told that you have a bulging or herniated disc? Y ( ) N ( )
39. Have you ever had problems with your knee(s)? Y ( ) N ( )
    If yes, explain:_____
    _____
40. Did you see a physician? Y ( ) N ( )
    If yes, give Date(s):_____Doctor's Name:_____
    City, State:_____
41. Have you ever had problems with your feet/toes? Y ( ) N ( )
    If yes, explain:_____
42. Did you see a physician? Y ( ) N ( )
    If yes, give Date(s):_____Doctor's Name:_____
    City, State:_____
43. Have you ever used orthotics? Y ( ) N ( )
    R____ L____ Date(s)_____
44. Have you ever lost a paired organ (i.e. kidney, eye, testicle, or ovary)? Y ( ) N ( )
45. Have you ever had a PRP injection (platelet rich plasma)? Y ( ) N ( )
    If yes, explain:_____
    _____
    Date(s):_____Doctor's Name:_____
    City, State:_____
46. Do you have any other medical problems? Y ( ) N ( )
    If yes, explain:_____
    _____
    _____
47. Have you ever played at or attended another college or university? Y ( ) N ( )
    If yes, what school(s)?_____

I hereby state that, to the best of my knowledge, all of the information in this questionnaire is correct and accurate. I understand that my failure to report medical history accurately could result in a delay or denial of my clearance for athletic participation or could result in harm to my body.

_____		_____	
Student-Athlete's Signature	Date	Parent/Guardian Signature (if athlete is under 19)	Date
_____		_____	
Student-Athlete's Printed Name	Date	Parent/Guardian Printed Name (if athlete is under 19)	Date

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Athletic Trainer Only

I, _____, have read and re-viewed this medical history. I have also informed the appropriate coach of any medical history that he/she must know about. Our team physician has also been notified of any conditions that he/she must know about.

_____ _____

Signature of Athletic Trainer Date

Concussion History

A concussion is a disturbance in brain function caused by a direct or indirect force to the head. It results in a variety of non-specific symptoms and often does not involve loss of consciousness.

Playing with a concussion can result in significant long and short term adverse side effects. It is of extreme importance to know your individual concussion/head injury history. See student-athlete handbook for concussion and return to learn policies.

Have you ever been told that you had a concussion? Y ( ) N ( )

If so, how many? _____ Dates: _____

Who diagnosed you? (Circle ALL that apply)

Coach Parent MD ATC Teammate Other:_____

If you answered yes to the above question, you must answer the questions below:

Did you ever lose consciousness from a concussion? Y ( ) N ( )

Did you have any amnesia from a concussion? Y ( ) N ( )

How long were you held from practice or competition with a concussion? _____

Was the concussion athletics related? Y ( ) N ( )

Practice or game? _____

Did you have a CT/MRI? Y ( ) N ( )

Did you see a neurologist? Y ( ) N ( )

Did you have long term academic side effects? Y ( ) N ( )

Did you have recurrent headaches after any concussions? Y ( ) N ( )

Have your ever been removed from practice or competition to be evaluated for a concussion? Y ( ) N ( )

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Nutritional Supplement Waiver

I, _____, acknowledge that below is an accurate list of the ergogenic aids, creatine powder, amino acids, protein supplements, or other similar substances, referred to as 'supplements' that I am currently taking or have taken in the last 6 months.

NAME/ MANUFACTURER	DOSAGE	MAIN INGREDIENTS	REASON FOR TAKING	DATES TAKEN

☐ **I am not currently taking any supplements**.

I understand and agree:

1. Spring Hill College Department of Athletics neither approves of nor condones the use of supplements.
2. I have been informed of the College and NCAA policies in regards to the use of supplements, and have had any questions about these policies answered. NCAA banned substance list can be found at: **http://www.ncaa.org/**
3. The use of supplements may result in serious harm to me, possible permanent injury to my health, and even death.
4. I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance.
5. I must list all supplements on the Chain of Custody Forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at any time in the future any form of supplements.

I further understand and agree Spring Hill College, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, and/or future use of supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release Spring Hill College, and their officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of supplements.

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Prescription Drug Medical Exception

The NCAA allows for the use of certain medications that have been banned under their drug testing policy. To use these medications, there are some stipulations and forms that must be completed and turned in prior to participation and clearance by the NCAA and the Spring Hill College Athletic Department.

Below is the list of the types of medications the NCAA allows with proper documentation. Indicate if you are taking a medication that falls into one or more of the following categories:

- ☐ ADD/ADHD – If checked, contact the Athletic Training Department for additional paperwork
- ☐ Male Pattern Baldness
- ☐ Hypogonadism
- ☐ Fertility Treatments (NOT birth control)
- ☐ I am not currently taking any medications that require further documentation.

If you have **ADD/ADHD you must contact the Athletic Training Staff and obtain the proper documents to become cleared** by the NCAA and the Spring Hill College Athletic Department for any practice and competition. Any of the other categories, you must submit a letter from the prescribing doctor highlighting the reason for the medication along with a copy of the prescription prior to practice and competition.

List the name & dosage of medication(s) you have been prescribed:

1. _____ 3._____

2._____ 4. _____

I acknowledge that the above is an accurate representation of the medications I have been prescribed that are in one or more of the categories listed above and any inaccuracy will affect my eligibility if I were to be drug tested by the NCAA.

_____ _____

Student-Athlete's Signature Date Parent/Guardian Signature (if athlete is under 19) Date

_____ _____

Student-Athlete's Printed Name Date Parent/Guardian Printed Name (if athlete is under 19) Date

Sickle Cell Trait Waiver

I,_____ (print name), understand the implications of playing sports with Sickle Cell Trait. I also understand it is in my best interest to be tested for sickle cell trait. If I have sickle cell trait, I will abide by the precautions set forth in this policy. I will work with the Spring Hill College Athletic Training Staff and my coach to develop the best plan for my continued safe participation in athletics at Spring Hill College.

Student-Athlete Signature: _____ Date: _____

For more information about sickle cell trait go to http://www.ncaa.org/sport-science-institute/sickle-cell-trait

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MUST SIGN **ONE** OF THE FOLLOWING

I **decline** testing and release Spring Hill College Athletics and athletic training from any litigious or financial repercussions should a sickle cell situation present itself.

Student-Athlete Signature: _____ Date: _____

I **have been tested** and have attached my results or I have previously submitted results to the Spring Hill College Athletic Training Department.

Student-Athlete Signature: _____ Date: _____

I am **planning to be tested**. I understand this test is done at my expense and the results must be submitted with my medical paperwork prior to being medically cleared for participation.

Student-Athlete Signature: _____ Date: _____

Parent Signature (If student-athlete is under 19): _____ Date: _____

Spring Hill College Sports Medicine

Pre-Participation Physical Examination

Must Be Completed by a Licensed Physician (MD or DO)

Name_____ Date of Birth_____Sport(s) _____

Height_____ Weight_____ Pulse_____ BP _____/_____ Vision R 20/_____L 20/_____ Contacts Yes or No

	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/Ankle		
Foot		

☐ Cleared For Athletic Participation

☐ Cleared After Completing Evaluation/Rehabilitation For: _____

_____

_____

☐ Limited Participation: _____Reasons: _____

_____

☐ Not Cleared Recommendations:_____

_____

All physician contact information must be completed in full and legible otherwise physical is invalid

Name of Physician (print/type/stamp): _____ Date_____

Address: _____ Phone _____

Signature of Physician _____ (M.D. or D.O.)