

Willamette University



Athletics

To: New Willamette Athletes
From: Sports Medicine Staff
Re: Athletic Medical Clearance

As you prepare for your first year as a Bearcat, it is our responsibility to determine whether you are physically eligible. Please complete the following medical forms, plus the physical form with your physician during your. **All forms must be completed and returned to us by August 1st.** This date allows for adequate time before your screening if we must request additional information.

Here is a checklist of the documents needed for intercollegiate sports participation:

- ❑ **PHYSICAL EXAMINATION**
 - Willamette Athletics requires you to have a complete physical prior to your first year of participation. Your physician must document your physical condition on the form provided. The exam must occur on or after March 1st of the current year. occur within 6 months of the start of your season.
- ❑ **MEDICAL HISTORY**
 - This form should be completed and taken with you to your physical examination appointment.
 - **Notice that a parent/guardian signature is required to verify accuracy of the information.**
 - If you are currently experiencing a medical problem or have had any major illness or significant injury in the last **two** years, a release for participation from the treating physician is required. This includes any neurological, cardiac, metabolic, orthopedic, or surgical conditions. This release must be **written** and **specific** to the condition in question.
- ❑ **INSURANCE INFORMATION**
 - Fill out as completely as possible.
 - **Be sure the policyholder signature is on the form.**
 - Include a copy (front and back) of your insurance card.
- ❑ **MEDICAL EXAMINATION & AUTHORIZATION WAIVER AND AUTHORIZATION/CONSIST FOR DISCLOSURE FORMS**

The Medical Screen we perform include a review of your medical history with a Nurse Practitioner, an interview and an orthopedic screen with our Athletic Trainers. These are done at no cost to you and provide us a chance to get to know you and your health status so we may provide you with the best medical care possible. This is a screening, not a physical evaluation. As stated above, you must have a complete physical by your physician prior to coming to campus. Your cooperation in providing this information and taking part in the actual screening process determines your eligibility.

Once you've have had your physical, completed the forms and attached any accompanying required documentation the information must be Mail to: (by August 1st)

Willamette University Athletics Attn: Sports Medicine 900 State St. Salem, Oregon 97301

If you have any questions regarding the Medical Screen, please feel free to contact us at (503) 370-6672. Your coach will notify you at a later date when your screening has been scheduled.

Physical Form - - YOUR DOCTOR SHOULD FILL THIS FORM OUT

Sport: _____

Willamette University
Department of Athletics

Last Name: _____ First Name: _____ MI: _____

Medical	Normal	Abnormal Findings
General Appearance		
Face/Skin/Scalp		
Eyes/Ears/Nose/Throat		
Teeth		
Neurological		
Heart		
Lungs		
Thorax and Breasts		
Abdomen		
Lymphatics		
Rectal		
Genitalia		
Pelvic (optional)		
Pap Test (optional)		
Hernia		

Orthopedic	Normal	Abnormal Findings
Neck/Back/Spine		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Height _____
 Weight _____
 BP _____ / _____
 Pulse _____
 Urine _____
 Glucose _____
 Albumen _____
 Micro _____

Vision Right 20/____ Left 20/____
 Corrected Vision Right 20/____ Left 20/____
 Hearing Right _____/15 Left _____/15

Optional Diagnostic Tests:
 Serum Iron _____ Blood Hgb _____
 Serum Ferritin _____ Blood HcT _____

Health Summary (include current treatment, i.e., medication) _____ _____ _____	Clearance to Participate: Unlimited _____
	Limited (explain) _____
	Not Cleared (explain) _____

Name of the Physician (print/type) _____

Address _____ Phone _____

Date of examination _____

Signature of examining practitioner _____

5. Bleeding Problems* Yes No Please Specify: _____

Anemia Yes No

6. Diabetes* Yes No Date of Diagnosis: _____

7. Sensory Deficit

Hearing Yes No Please explain: _____

Sight Yes No Contacts Yes No

8. Heat Illness Disorders

Heat Exhaustion Yes No _____

Heat Stroke Yes No _____

Have you ever had heat cramps? Yes No

Have you ever been dizzy or passed out in the heat? Yes No

9. Dental History

Have you had or do you now have:

Caps Yes No

Crowns Yes No

Plates Yes No

Fractures* Yes No Please explain: _____

10. Have you ever had ANY surgery to any major organs or systems? Yes No

If YES, please explain and include month and year.

11. Other medical Issues

Do you have or have you had problems with:

Anorexia/Bulimia Yes No

Mononucleosis Yes No

Arthritis Yes No

Testicles Yes No

Hepatitis Yes No

Thyroid disease Yes No

Hernias Yes No

Menstrual Irregularities Yes No

Kidneys Yes No

Date of Last Period _____

12. Personal Issues

Height _____

Weight _____

Are you satisfied with your current weight? Yes No

Have you had a recent gain or loss in your weight? Yes No

What do you consider to be your ideal weight? _____

Do you adhere to a strict eating plan? Yes No

13. Have you been seen by a physician in the last year for any illness lasting more than a week and/or have you ever tested positive for any medical conditions?*

Yes No

If YES, please explain _____

List Primary Physician or any attending physician for any ongoing medical condition:

Name

Address

Phone

List Attending Physician(s) for **any surgery** within the past three (3) years:

Name

Address

Phone

14. Medication History

Are you taking any prescription or over-the-counter medications now and/or on a regular basis?

Yes No If YES, please explain _____

Are you taking any dietary supplements/herbal products? Yes No

If YES, please explain _____

15. Allergies

Aspirin Yes No Codeine Yes No Foods Yes No

Ibuprofen Yes No Antibiotics Yes No Bee Stings Yes No

Other Medications Yes No Please List _____

ORTHOPEDIC HISTORY

If you answer YES to any of the questions marked with an asterisk (*) you will need to provide a written release for participation in intercollegiate athletic from the treating physician if the injury occurred within the last two years.

1. Have you ever had any broken bones? * Yes No

If YES, please explain and include month and year _____

2. Have you ever had surgery on any bone, joint or muscle? * Yes No

If YES, please explain and include month and year _____

3. Have you ever sprained, strained, dislocated* or had repeated swelling in:

Head/Face Yes No Shoulder Yes No Forearm Yes No

Shin/Calf Yes No Hand Yes No Foot Yes No

Thigh Yes No Neck Yes No Back Yes No

Wrist Yes No Chest Yes No Elbow Yes No

Knee Yes No Ankle Yes No Hip Yes No

Arm Yes No Groin Yes No Abdomen Yes No

4. Have you ever had any of the following:

Shin Splints Yes No Osgood-Schlatter's Yes No

Chondromalacia Yes No Little League Elbow Yes No

Jumper's Knee Yes No Little League Shoulder Yes No

Tennis Elbow Yes No Patello-Femoral Syndrome Yes No

Stress Fracture* Yes No

5. Have you had any other injuries that caused you to miss a game or practice? * Yes No

If YES, please explain and include month and year _____

6. Do you use any special pads, braces, etc? Yes No

If YES, please list _____

7. Are you currently suffering from any injury (old or new)? Yes No

If YES, please explain and include month and year _____

List Physician(s) who treated any athletic-related injury within the past (2) years:

Name Address Phone

MEDICAL INFORMATION WITHHELD, INCOMPLETE, OR INCORRECT RELIEVES WILLAMETTE UNIVERSITY FROM ALL MEDICO-LEGAL LIABILITY AND MAY DISQUALIFY YOU FROM PARTICIPATION ON ANY WILLAMETTE ATHLETIC TEAM.

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Date _____ Signature of Athlete _____

Date _____ Signature of Parent/Guardian _____

(Both Signatures required – even if athlete is over 18 years old)

Willamette University



Athletics

To: Willamette Athletes and Insurance Policy Holder
From: Sports Medicine Staff
Re: Insurance Information

Insurance Information

It is the Athletic Department's desire that all our athletes have a safe and enjoyable experience while participating in any of our athletic programs. The highest priority for the athletic training staff is to prevent injuries, however, there is always a risk of injury in any sport. In the event that the athlete is injured while participating in a NCAA Intercollegiate event, it is important for us to know about any medical coverage you may have in order to avoid delays in injury management and in claims processing. Therefore, as a requirement for any level of participation, you must complete the "Athletic Insurance Information Form". Please note, it is vital that all requested information be completed in its entirety. Also, any changes to your coverage must be reported and updated immediately to avoid injury or claims management problems. The policy holder, along with the athlete, must sign and date the form at the bottom before participation in any Willamette University athletic activities can be allowed.

Willamette University carries insurance on all varsity athletes, which is "**secondary or excess**" in nature. Your personal insurance is considered to be "primary", and therefore all bills must first be submitted to your insurance provider.

For more information about the Willamette Athletic Insurance Plan please refer to "Insurance Coverage for Athletes" located in the Sports Medicine section of the Athletic Department web pages. If you have any questions regarding our Athletic Accident Insurance and its process, please contact Julie Prieto, the insurance specialist at the University's Wellness Center at 503 370-6972.

Willamette University
Athletic Training Staff

Willamette University
Insurance Information Form

Sport _____
 Athlete Full Name _____ SS# _____ Birthdate _____
 Cell Phone Number _____ Permanent Address _____

Primary Medical Insurance Co _____
 Ins Address _____
 Insurance Phone Number () _____
 Is your insurance company considered a HMO? _____ PPO? _____
 Policy # _____ Group # _____
 Policyholder's Name _____ SS# _____
 Birthday _____ Relationship to Athlete _____
 Address _____
 Home Phone () _____ Work Phone () _____

Secondary Medical Insurance Co _____
 Ins Address _____
 Insurance Phone Number () _____
 Is your insurance company considered a HMO? _____ PPO? _____
 Policy # _____ Group # _____
 Policyholder's Name _____ SS# _____
 Birthday _____ Relationship to Athlete _____
 Address _____
 Home Phone () _____ Work Phone () _____

Willamette Athletic Excess Insurance Policy: Summit America Insurance
 Address 7400 College Blvd., Suite 120 Overland Park, KS 66210
 GR # US030666-08B0421 Student ID # 00

Are there any coverage procedures that we should be aware of in the event your son/doughter sustains an injury which is considered a "non-emergency" (I.e., referrals, coverage limitation)?

Blood Pressure _____ / _____ Pulse _____ bpm

Allergies	
Substance	Type of Reaction

Drugs or Medications		
Type of Drug/Medication	Strength	Frequency

Major Surgeries or Injuries	
Type of Surgery or Injury	Year

Major Medical Illnesses					
Anemia	Y	N	Pneumonia	Y	N
Arthritis	Y	N	Previous head or neck injury	Y	N
Asthma	Y	N	Prior heat related problems	Y	N
Bleeding Disorders	Y	N	Seizure	Y	N
Diabetes	Y	N	Thyroid Disease	Y	N
Heart Murmur	Y	N	Ulcers	Y	N
Hepatitis	Y	N			
Hypertension	Y	N			
Mononucleosis	Y	N			

I/We agree that all information provided in this document is accurate and complete to the best of my/our knowledge and that I/We will update any changes immediately. I/We understand that any incorrect or undisclosed information can result in the improper management of injuries and also duplicate payments. I/We understand the financial responsibility of any injuries improperly managed as a result of incorrect or undisclosed information or failure to follow the procedures for athletic injuries or illness, and medical care will be the obligation of the undersigned.

If a medical emergency arises while participating in an athletic contest away from Willamette University, I consent to an examination and/or treatment by a physician recommended by the host school authorities.

I hereby authorize Willamette University Student Health Services and its Insurance Agent to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize Willamette University and its Insurance Agent to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by Willamette University.

X _____
 Signature of athlete

X _____
 Signature of the policy holder

Name and Telephone Number of person to contact in case of significant injury: Name _____ Phone () _____

WILLAMETTE UNIVERSITY SPORTS MEDICINE DEPARTMENT
Medical Examination & Authorization Waiver

I, _____ hereby acknowledge, affirm, and represent the following:

A. PRESENT PHYSICAL CONDITION:

I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history; that my Health History Questionnaire Form was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with a member of Willamette University's Sports Medicine Team; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition. _____ [initial]

B. MEDICAL CONSENT:

If a serious injury or medical condition should occur in conjunction with participation on intercollegiate athletic teams, the sports medicine and/or coaching staff will attempt to contact a parent/guardian. In the event immediate contact cannot be established, the following statements are provided for your authorization/permission.

I/We hereby grant permission to Willamette University Athletic Department, its athletic team physician and/or athletic trainer, to render aid, treatment, and medical or surgical care deemed reasonably necessary to the health and well-being of the above named Student Athlete.

I/We further authorize the athletic trainers at Willamette University, who are under the direction and guidance of the athletic team physicians, to render any first aid or prevention, rehabilitative or emergency treatment deemed necessary to protect the health and well-being of the above named Student Athlete.

I/We additionally grant permission for hospitalization treatment or surgery at a competent and/or accredited facility when necessary for protecting the health and well-being of the above named Student Athlete. _____ [initial]

C. FUTURE COMPLAINTS:

I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to a member of Willamette University's sports medicine team, no matter how minor or insignificant I may deem them to be. _____ [initial]

D. ACKNOWLEDGMENT & 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, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal 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 Department. 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 Willamette 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 Willamette University, and their offices, agents, and employees from an and all liability, any medical expenses not covered by the University’s Intercollegiate Athletics’ medical insurance coverage, and any and all claims, causes of action or demand of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

I release, waive, discharge and covenant not to sue Willamette University, its officers, agents and employees all of which are hereinafter referred to as “releasees,” from any and all liability tome, my heirs, or next of kin for any and all claims, demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.

I have read and understand the content of the waiver and release and sign voluntarily.

The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family. _____ [initial]

E. AUTHORIZATION:

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 Willamette University.

_____ [initial]

Signature

Date

Parent/Guardian Signature (if under 18 years old)

Date

Willamette University Athletic Training

Student-Athlete Authorization/Consent For Disclosure of Protected Health Information

I hereby authorize the athletic trainers, team physicians, Bishop Wellness Center (including Health, Counseling and Disability Services staff) and other health care personnel representing Willamette University to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medial status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, parents/guardians, hospitals and /or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, Conference commissioner, chaplains and /or clergy members, and the NCAA Injury Surveillance System.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Willamette University. I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Bishop Wellness Center and/or the Athletic Training staff, but if I do, it will not have ay effect on actions Willamette University took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires six (6) years from the date it is signed.

Name of Student-Athlete (print or type)

Signature of Student-Athlete

Date

Social Security Number of Student-Athlete

Date of Birth of Student-Athlete

Signature of Parent/Guardian (if student-athlete is under 18 years of age)

Date