Wayne State College
Athletic Training Department

Dear Student-Athlete and Parents/Guardians:

Welcome to Wayne State College and Wayne State Athletics! We are excited to have you participating in intercollegiate athletics at Wayne State College.

In order to provide quality health care to our athlete, 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, insurance information, assumption of risk form and medical information release form. **All forms need to be filled out entirely and returned to the WSC Athletic Training Department no later than July 15.**

All student-athletes are required to carry health/medical insurance while participating in intercollegiate athletics at Wayne State College. Wayne State College carries a ***secondary*** policy to help defray some of the medical costs associated with athletic injuries. Please thoroughly read the insurance information included in this packet for details.

If you have questions regarding completion of the forms, personal insurance coverage requirements or WSC insurance coverage, please contact the Wayne State Athletic Training staff at (402) 375-7310. We look forward to working with you during your intercollegiate athletic career at Wayne State College.

Sincerely,

Athletic Training Staff
Wayne State College
1111 Main Street
Wayne, NE 68787
(402) 375-7310

Wayne State College Athletic Training Department
Pre-Participation Form Check List

Please fill out all forms entirely. Below is a check list of forms that should be completed.

1. Student-Athlete Contact Information Form
2. Medical History Form
3. Physical Form (must be performed by an MD for all athletes)
4. Insurance Information Form
5. Copies of Insurance Cards (Front/Back)
    a. Health/medical
    b. Dental
    c. Prescription
6. Assumption of Risk Form
7. Medical Information Release Form

Please return all completed forms **no later than July 15th** to the following address:

Wayne State College
Athletic Training Department
1111 Main Street
Wayne, NE 68787

Wayne State College Athletic Training Department
Contact Information

Student-Athlete Information

Name:_____ Date:_____
Last First MI

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

Home Address: _____
Street City State Zip

Home Phone #_____ Cell #_____ College #_____

College Address:_____
Street City State Zip

Parent/Guardian Information

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

Wayne State College Athletic Training 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, 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

	Yes	No		Yes	No		Yes	No
Alcohol/tobacco use			Gallbladder trouble			Shortness of breath		
Allergies			Gum/tooth trouble			Sickle cell disease		
Anemia			Heart murmur			Sinusitis		
Asthma			Heart palpitation			Sleeping problems		
Back pain			Heat illness, cramps, stroke			Stomach/intestinal trouble/indigestion		
Cancer, cyst			Hernia			Tuberculosis		
Chemical dependency			High/low blood pressure			Urinary tract problems		
Chest pain/pressure			Jaundice/hepatitis			Venereal disease		
Chicken pox			Malaria			Vision correction		
Chronic cough			Marfan's Syndrome			--glasses		
Chronic diarrhea			Measles			--contacts		
Diabetes			Mononucleosis			Weakness, paralysis		
Dizziness/fainting			Mumps			Worry, nervousness		
Ear/nose/throat trouble			Pneumonia			*Females only*		
Eating disorder			Polio			Irregular periods		
Epilepsy, seizures			Recent weight gain/loss			Severe cramps		
Eye injury			Rheumatic ferver			Excessive flow		
Frequent anxiety			Rubella			Pregnancy		
Frequent depression			Scarlet fever			Other		

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**.		
Have you had any illness, injury or surgery that required hospitalization?		
Do you have any pins, staples or wires in any part of your body?		
Have you ever been advised to have surgery that you have not had performed?		
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 a complete and functional set of all paired organs? (Eyes, ears, kidneys, lungs, ovaries, testicles)		
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?_____		
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.

_____

_____

_____

_____

Orthopedic

	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 Wayne State College 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 Wayne State College cannot be held financially responsible for any injuries or illnesses that are not directly related to a scheduled varsity practice, contest or conditioning session supervised by a coach.
4. I give permission for all necessary medical entities to release information to Wayne State College Athletic Training and for Wayne State College Athletic Training 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 19 Date

Upon completion of this form, it will be reviewed and signed by a Certified Athletic Trainer.

_____ _____

ATC Signature Date

Wayne State College Athletic Training 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			
Body Fat % (opt)			

Urinalysis: Albumin:_____ Sugar:_____ Sp.Gr.:_____ Labs if indicated:_____

Musculoskeletal Exam

	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

Initial the following 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 WSC Athletic Training 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 19 Date

Revised 1/10/07

Wayne State College Athletic Training Department
Medical Insurance Information/Authorization

Primary coverage for any intercollegiate athletic-related injuries is the responsibility of the student-athlete's personal or family insurance policy. The student-athlete must show proof of insurance before participating in any intercollegiate activity. The coverage WSC provides for your student-athlete for injuries sustained while participating or competing in intercollegiate athletics, is EXCESS coverage. This secondary policy has a **$1,000 deductible** per injury which has to be met by either you or your insurance company. Wayne State College does not have the option of waving this provision.

A brief summary of the Wayne State secondary insurance policy is as follows:

1. The student-athlete must see a Wayne State college doctor to be eligible for a claim. If you wish to see any other physicians, dentists, optometrists, etc. the Head Athletic Trainer must approve this prior to you scheduling the appointment.
2. All claims must be filed within 120 days of the injury date or date of service.
3. The student-athlete must report the injury to the WSC athletic training staff in a timely manner so a record can be made in order to file a claim.
4. Covered injuries include: participation 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.
5. All claims must first be submitted to your personal insurance company prior to sending them to the WSC athletic training office.
6. In the event that the WSC insurance denies the claim for whatever reason, the remaining balance is considered your responsibility.
7. The WSC insurance policy has a 104 week statute of limitation from the date of injury.

The procedure for filing a claim with the Wayne State College insurance policy is as follows:

1. All claims will first be submitted to your personal insurance to be processed.
2. After your insurance has paid its portion, you will receive a bill from the provider with the remaining amount owed. Send this bill to the WSC athletic training office and it will be submitted to our insurance.
3. Processing a claim can take up to 4-6 weeks. This necessitates bills being submitted in a timely manner as we do not have the ability to negotiate with collections agencies. *If a claim is approved after you have paid a bill, the insurance company <u>may</u> authorize reimbursement.*
4. We recommend that you make a copy of this form for your records. We also recommend that you make a copy of all the bills you send to the WSC Athletic Training Department.

For more information, please contact the Wayne State athletic training office at (402) 375-7310.

I have read and understand the WSC summary of its supplemental athletic insurance policy and the procedure for filing a claim that may affect me as a parent/guardian and/or student-athlete.

_____
Student-Athlete Printed Name

_____ _____
Student –Athlete Signature Date

_____ _____
Parent/Guardian Signature Required Date

Revised 1/10/07

Wayne State College Athletic Training 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.

Student-Athlete Information

Name:_____ Sport(s):_____

SSN:_____-_____-_____ DOB:_____/_____/_____ Sex: M / F

Campus Address: Permanent Address:

_____ _____

_____ _____

Campus #_____ Student Cell # _____ Student Email:_____

Health Insurance Information

Primary Policy

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_____

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_____

Secondary Policy (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 Wayne State College and A-G Administrators 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. We authorize Wayne State College 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 college.

_____ _____

Student-Athlete Signature Date

_____ _____

Parent/Guardian Signature Required Date

Wayne State College Athletic Training 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, 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 Athletic Training 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 Wayne State College 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 Wayne State College, and their officers, agents, and employees from any and all liability, any medical expenses not covered by the Wayne State College Department of Intercollegiate Athletics' 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 Wayne State College.

_____ _____

Student-Athlete Signature Date

_____ _____

Parent's Signature required if Student-Athlete is under 19 Date

Wayne State College Athletic Training Department
Authorization to Release Medical Information

Name:_____
Last First MI

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ DOB:_____/_____/____

I hereby authorize Wayne State College Athletic Training and A-G Administrators 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. 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 19 Date

_____ _____
Witness Date