Lindsey Wilson College Student-Athlete Health History
Please use BLUE or BLACK INK only.

Name:_____ Sex:_____ Age: _____ Date of Birth: _____

Address:
Sport:
Personal Physician:

Please check "Yes" or "No" for each item below. Explain "Yes" answers in space provided below.

	Yes	No
Do you have any allergies (examples: pollen, medicine, food, or stinging insects)?	○	○
Have you ever had a rash or hives develop during or after exercise?	○	○
Do you cough, wheeze, or have trouble breathing during or after exercise?	○	○
Do you have asthma?	○	○
Have you had a medical illness or injury since your last checkup or sports physical?	○	○
Have you ever been hospitalized overnight?	○	○
Have you ever had surgery?	○	○
Are you currently taking any prescriptions or nonprescription (over the counter) medications or pills or using an inhaler?	○	○
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	○	○
Have you ever passed out during or after exercise?	○	○
Have you ever been dizzy during or after exercise?	○	○
Have you ever had chest pain during or after exercise?	○	○
Do you get tired more quickly than your friends do during exercise?	○	○
Have you ever had racing of your heart or skipped heartbeats?	○	○
Have you had high blood pressure or high cholesterol?	○	○
Have you ever been told you have a heart murmur?	○	○
Has any family member or relative died of heart problems or of sudden death before the age of 50?	○	○
Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?	○	○
Has a physician ever denied or restricted your participation in sports for any heart problems?	○	○
Is there a history of Marfan's Syndrome in your family?	○	○
Is there a history of premature (prior to age 50) onset of diabetes in your family?	○	○
Have you or any family member been told they have sickle cell/ trait?	○	○
Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, or blisters)?	○	○
Have you ever been knocked out, became unconscious, or lost your memory?	○	○
Have you ever had a seizure?	○	○
Do you have frequent or severe headaches?	○	○
Have you ever had numbness or tingling in your arms, legs or feet?	○	○
Have you ever had a stinger, burner, or pinched nerve?	○	○
Have you ever become ill from exercising in the heat?	○	○

	Yes	No
Have you had any problems with your eyes or vision?	○	○
Do you wear glasses, contacts, or protective eyewear?	○	○
Have you ever had a sprain, strain, swelling after injury?	○	○
Have you broken or fractured any bones or dislocated any bones or joints?	○	○
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	○	○
If yes, circle appropriate item and explain below		
Head Neck Back Chest Shoulder Upper arm Elbow Forearm Wrist Hand Finger Foot Hip Thigh Knee Shin/Calf Ankle		
Do you want to weigh more or less than you do now?	○	○
Do you lose weight regularly to meet weight requirements for your sport?	○	○
Do you feel stressed out?	○	○
Record the dates for your most recent immunizations (shots) for:		
Tetanus _____ Measles _____		
Hepatitis B _____ Chickenpox _____		
Meningitis _____		
I have received information about Hepatitis B and Meningitis and the vaccinations	○	○
Females only		
When was your first menstrual period? _____		
When was your most recent menstrual period? _____		
How much time do you usually have from the start of one period to the start of another? _____		
How many periods have you had in the last year? _____		
What was the longest time between periods in the last year? _____		

Please Explain All Yes Answers: _____

_____

_____

Emergency Contact Information

Name: _____ Work Phone: _____ Home Phone_____

Relation to Student; _____

Cell Phone #: _____ Email Address: _____

Name: _____ Work Phone: _____ Home Phone_____

Relation to Student; _____

Cell Phone #: _____ Email Address: _____

I hereby stated that, in the best of my knowledge, my answers to the above questions are complete and correct

Signature of Student: _____ **Date**: _____

Signature of Parent/Guardian: _____ **Date:** _____

*As of the 2017-2018 school year, the NAIA is conducting testing for performance enhancing drugs at NAIA National Championship and NAIA Invitational competitions. In an effort to protect our student-athletes from unwarranted NAIA drug testing sanctions, we are now requiring that all student athletes report all medications, over the counter and prescription, with appropriate documentation prior to the beginning of the school year.

Medications: Please list all of the Prescription and over the counter medicine and supplements (herbal and nutritional) that you are currently taking

Name of Medicine/Supplement	Reason Taken	How Often Taken	Doctor (if prescribed)

Allergies: Please list any allergies to food, environmental factors (pollen, dust, etc,) stings insects, and medications

Allergy	Reaction

Surgeries: Please list all surgeries you have had.

Surgery	Date or Age at Time of Operation

Circle ALL the conditions that you currently have or have had in the past. Please Explain in the lines provided			
Heart murmur/Irregular Heartbeat	Hepatitis A B C (Circle)	Tuberculosis	Chronic Sickness/Illness
High Blood Pressure/ Hypertension	Kidney Stones	Chronic Bronchitis	Sickle Cell
Stomach Ulcer	Bleed Tendency	Asthma	Dizzyness/Lightheadness during exercise/activity
Anemia (Low Blood Count)	Anxiety	Hypoglycemia	Head Injuries/Concussion
Colon Problems	Depression	Cancer	Other:
Diabetes	Thyroid Disease	Blood Clot/Clotting Disorder	
Arthritis	Emphysema	Heart/Lung Disease	
HIV/AIDS	Osteoporosis	Stroke	
History of Multiple Fractures/Dislocations	Anorexia/Bulimia/Disordered Eating	Kidney/Liver Disease	NONE

Explain ALL Conditions circled above: _____

_____

_____

_____

Circle All the Conditions that any of your FAMILY Members suffer from.			
Stroke	Back Problems	Arthritis	Diabetes
Cancer	Lung Disease	Osteoporosis	High Blood Pressure
Scoliosis	Heart Disease	Kyphosis	
NONE	Don't Know	Other:	

Lindsey Wilson College
Pre-Participation Physical Evaluation

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **% of Body Fat (Optional):** _____ **Pulse:** _____ **BP:** _____

Vision R 20/: _____ **L 20/:** _____ **Corrected: Y/N Pupils: Equal:** _____ **Unequal:** _____

Medical

	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal

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

Clearance: Please Circles one and explain, if necessary

Cleared
Cleared after completing evaluation/rehabilitation for: _____
Not Cleared for: Practice Games Both Other: _____

Reasons/Recommendations: _____
_____

Name of Physician (Print/Type): _____ **Date:** _____
Address: _____ **Phone:** _____

Signature of Physician: _____ **Date:** _____

LINDSEY WILSON COLLEGE
PRIMARY ATHLETIC INSURANCE INFORMATION

TO BE COMPLETED BY A PARENT/GUARDIAN. PLEASE PRINT OR TYPE. COMPLETE ALL BLANKS. FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. IF INFORMATION IS NOT APPLICABLE, PLEASE INDICATE THIS OR THE FOLLOWING (i.e. divorce, deceased, unknown).

Athlete's Name:_____ Sport(s):_____
(First, Middle, Last)

SSN or Passport #:_____ Lindsey Wilson ID #_____

Sex:_____ Date of Birth:_____

Academic Year: FR SO JR SR 5th Athletic Competition: Year: FR SO JR SR 5th

Home Address:_____

City:_____ State:_____

Country:_____ Zip Code:_____

Home Phone #:_____ Student's Cell Phone #:_____

Primary Care Physician Name:_____ Phone #:_____

Please include a photocopy of the front and back of the Primary Insurance Card.

Father/Guardian's coverage for athlete: PRIMARY or SECONDARY?_____
(Or student's own primary insurance information)

Father/Guardian's Name:_____

SSN:_____ Date of Birth: _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

Employer's Name:_____

Employer's Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone #:_____

Medical Insurance Company Name:_____

Mailing Address for Claims:_____

City:_____ State:_____ Zip Code:_____

Policy/ ID #:_____ Group #:_____

Does your primary insurance require: Second opinion for surgery? YES or NO

Pre-authorization for services? YES or NO

Pre-authorization for non-emergency surgery? YES or NO

Is this an HMO, PPO, or Standard Health Plan?_____

Please indicate any special instructions, restrictions, etc. for you insurance plan.

Please include a photocopy of the front and back of the Primary Insurance Card.

Mother/Guardian's coverage for athlete: PRIMARY or SECONDARY?_____

Mother/Guardian's Name:_____

SSN:_____ Date of Birth: _____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

Employer's Name:_____

Employer's Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone #:_____

Medical Insurance Company Name:_____

Mailing Address for Claims:_____

City:_____ State:_____ Zip Code:_____

Policy/ ID #:_____ Group #:_____

Does your primary insurance require: Second opinion for surgery? YES or NO

Pre-authorization for services? YES or NO

Pre-authorization for non-emergency surgery? YES or NO

Is this an HMO, PPO, or Standard Health Plan?_____

Please indicate any special instructions, restrictions, etc. for your insurance plan.

I hereby authorize Lindsey Wilson College and their insurance carrier 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 photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize that Lindsey Wilson College or their insurance carrier may pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by Lindsey Wilson College.

Parent/Guardian Signature:_____ **Date:**_____

Student's Signature:_____ **Date:**_____

Rev. 1/2013

LINDSEY WILSON COLLEGE SPORTS MEDICINE

CONSENT TO TREAT/MEDICAL RELEASE FORM

I,_____, age,_____, while participating in the intercollegiate athletic program at Lindsey Wilson College, hereby consent to be treated by the Lindsey Wilson College Sports Medicine Staff, Team Physician(s), School Nurse, or any other medical doctor recommended by the Team Physician or Lindsey Wilson Sports Medicine Staff.

I expressly authorize the School Nurse and such hospital and /or medical doctor or medical facility, which might render medical treatment to me during this period, to release my medical condition and activity capabilities to Lindsey Wilson Sports Medicine Staff.

I also give Lindsey Wilson College Sports Medicine permission to provide other medical facilities with medical and insurance information that would expedite my care should I need emergency or other patient services.

Date: _____

Athlete Signature: _____

Parent/Guardian Signature (if athlete is under 18 years of age): _____

LINDSEY WILSON COLLEGE
EMERGENCY MEDICAL CONSENT FORM

For athletes under the age of 18

Athlete's Name: _____ **Date of Birth:** _____

Sport(s): _____

Permission is hereby granted the attending physician to proceed with any medical or minor surgical treatment, x-ray evaluation, or immunizations for the above named Lindsey Wilson College student-athlete. In the event of a serious illness, the need for major surgery, or of a significant accidental injury. I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interests of the student-athlete may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is hereby granted the Lindsey Wilson College Sports Medicine Staff to provide the necessary emergency medical treatment to the athlete, prior to the athlete's referral to a physician or hospital.

Signature of Parent(s)/Guardian(s): _____

Date: _____

Name of family physician: _____

Physician Phone #: _____

LINDSEY WILSON COLLEGE SPORTS MEDINICE

Consent to Perform Urinalysis for Drug Testing

I, _____, hereby consent to have a sample of my urine collected and tested fro the presence of drugs in accordance with Lindsey Wilson College Athletic Department Drug Education and Testing Program.

I have read and I understand the Lindsey Wilson College's and National Association for Intercollegiate Athletics'(NAIA) Drug Education and Testing Policy and procedures. I have received a copy of such policies and procedures.

I understand that this testing will occur at such time or times as deemed appropriate by the team physician, the head coach, or the certified athletic trainer. I understand that any urine samples will be sent only to a licensed medical laboratory for actual testing, and that the samples will be coded to insure confidentiality.

I hereby authorize the release of such urine testing results to the team physician, the head coach, certified athletic trainer, and/or other school/NAIA officials, as deemed appropriate. I understand that these results will be made available to me, upon request.

I understand that I am free to withdraw this consent for urinalysis testing. However, I also understand that should I refuse to submit to testing at the time requested, I will not be permitted to participate in any sporting program until such time as the Athletic Director or NAIA Officials deems appropriate.

I hereby release Lindsey Wilson College from any legal responsibility or liability for the release of such information and records as authorized by this form

Name of the Athlete (Print):_____

Sport(s) Participating in: _____

Signature of the Athlete: _____

Date: _____

INTERCOLLEGIATE ATHLETIC ACCIDENT COVERAGE

In regards to the Lindsey Wilson College intercollegiate athletic coverage, I understand that:

The NAIA does not permit Lindsey Wilson College to provide coverage or pay bills incurred for expenses related to illness or conditions which are not sustained as a direct result of an accident in Lindsey's intercollegiate sports program.

Accidental injury as defined by this coverage is "bodily injury resulting directly and independently of all other causes from an accident" sustained by an athletic team member while participating in competition or an OFFICIAL practice session for intercollegiate sports for Lindsey Wilson College during the official season. Therefore, the Lindsey Wilson College athlete accident insurance cannot be responsible for aggravation or re-injury of previous injuries incurred while participating in Lindsey's athletic program, an old high school injury, a non-athletic injury, or for a sickness or a condition.

All medical expenses should be billed directly to the parents or students home address.

Any family or employer group health insurance, or insurance purchased through the college, is the primary source of coverage. Any unpaid balance after processing has been completed by the primary insurance may be submitted to Lindsey Wilson College for processing. Expenses must be incurred within a one year period of date of accident. The student must complete a claim form within 30 days of the date of accident.

If the primary insurance is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization), the parents and athlete are responsible for notifying Lindsey Wilson College of the procedures, restrictions and requirements of the HMO or PPO. The Lindsey Wilson College insurance cannot pay claims denied by an HMO or PPO because procedures, restrictions and requirements are not met.

As the Lindsey Wilson College athlete accident insurance has a usual and customary charge clause, there may be some cost to the student for certain procedures. Arrangements have been made with some facilities and every effort will be made to avoid this. However, should the student require such a procedure where there is a known charge (example, bone scan), above the usual and customary charge, the student will be notified prior to the procedure and be instructed to contact the parent/guardian.

**** As directed above, injury not occurring in official practice or game and illness is not covered. Lindsey Wilson College requires that all full-time students have primary insurance coverage.**

Signatures of:

Father/Guardian: _____ **Date:** _____

Mother/Guardian: _____ **Date:** _____

Student: _____ **Date:** _____

Rev. 3/2010

PROCEDURE FOR SECURING MEDICAL ASSISTANCE AND PAYMENT EXPENSES

1. The student athlete reports the injury to the coach and athletic trainer.

2. The athletic trainer refers the student to a team physician or specialist, or other physician based on the requirements of the primary insurance. Failure to report the injury to the athletic trainer within two weeks of the initial injury or seeing a physician without referral may result in loss of payment by the LWC athletic insurance. It would be very helpful if parents inform their son/daughter of their insurance procedures and provide them with a list of approved providers for Adair County, Kentucky, and surrounding areas, including Campbellsville, Taylor County; Bowling Green, Warren County; Lexington, Fayette County; Louisville, Jefferson County; Glasgow, Barren County; and Greensburg, Green County.

3. In the event of an emergency where the student athlete must be taken to an emergency room, the athletic trainer must be notified as soon as possible. The athletic trainer must schedule any referrals made by the emergency room physician

4. In the event of an injury, the student athlete's primary insurance will be given to the provider first. The provider will process this claim through the primary insurance. Any remaining amount can be submitted to Lindsey Wilson College's excess policy. IT IS THE RESPONSIBILITY OF THE ATHLETE TO PROVIDE THE ATHLETIC TRAINER WITH INFORMATION NEEDED TO SUBMIT THESE CLAIMS TO THE EXCESS POLICY. This information is usually a copy of the primary insurance's Explanation of Benefits (EOB) and a copy of the original bill. *** PLEASE REMEMBER THAT A MEDICAL CLAIM HAS NO DIRECT AFFECT ON YOUR INSURANCE PREMIUMS. *** Failure to provide any primary insurance information is INSURANCE FRAUD, and could result in penalties including, but not limited to: reimbursing the full amount of the claim(s). As with most insurance companies, our policy has a usual and customary charge clause, where there may be some expense to the student athlete. As we have agreements with some providers, every attempt will be made to avoid out of pocket expenses. Any known charges that are not covered by the policy will be discussed with the athlete and/or parents before services are rendered.

5. Occasionally, claims processing is not timely, so the family may need to consider payment for any outstanding bills and submitting to LWC insurance for reimbursement. Any prescription medications must be paid for by the student and submitted for reimbursement.

LINDSEY WILSON COLLEGE WILL NOT BE RESPONSIBLE FOR EXPENSE INCURRED AS A RESULT OF:

1. **A student athlete seeking medical attention without a referral from the athletic trainer, except for an emergency.**
2. **An injury that was not the result of participation in intercollegiate activity. (i.e. intramural participation, pick up games, activity classes)**
3. **A preexisting injury that has been deemed such by Lindsey Wilson College's insurance carrier.**
4. **Any illness.**

I have read and understand the procedures for securing medical assistance and payment expenses:

_____ _____

Student Athlete Date

_____ _____

Parent/Guardian Date

Rev. 3/2011

LINDSEY WILSON COLLEGE SPORTS MEDICINE

Assumption of Risk – Informed Consent

I understand that participation in sports requires an acceptance of risk of injury.

I understand that I may be injured temporarily or permanently while participating in sports and I accept the risk.

I understand that I must follow the rules of my sport(s).

I understand that I must refrain from practice and/or play while injured or ill if restricted by the school nurse, team physician(s), Lindsey Wilson College Sports Medicine staff, or any other medical doctor recommended by the team physician or LWC Sports Medicine Staff.

I understand that should I sustain an injury or illness, which has restricted my participation, that I am not to return to active participation until released by the school nurse, team physician(s), Lindsey Wilson College Sports Medicine Staff, or any other medical doctor recommended by the team physician or LWC Sports Medicine Staff.

In consideration of my being allowed to try out for said sport, I hereby release and forever discharge the Lindsey Wilson College Board of Trustees, its agents and employees, and further covenant not to sue said Board, its above athletic activity, and which results from causes beyond the control, and without the fault or negligence of the Lindsey Wilson College Board of Trustees, its agents, and employees. My true age is stated below. If I am under the age of 18 years, I certify that I have permission of my parents and/or guardians to participate in the stated activities and that they have full knowledge thereof.

The undersigned by signing this release hereby certifies that the undersigned has read and fully understands the conditions herein provided.

Date:_____

Athlete's Signature:_____ Age:_____

Athlete's Printed Name:_____

Signature of Parent/Guardian, if under 18:_____