ATS Athlete Forms Library

Acceptance of Risk/Medical Authorization

	Section	Sub-Section	Q#
ACCEPTANCE of RISK/MEDICAL AUTHORIZATION			
Please read, sign, and return to us the following consent form. If you are younger than 18 years of age, parental consent is also required.	1	1.01	1

I am aware that trying-out, practicing or playing in any intercollegiate sport may be a dangerous activity involving many risks or injury. I understand that the dangers and risks include, but are not limited to, death, serious head, neck and spinal injuries, paralysis, injuries or impairment to the musculoskeletal system or other aspects of the body, general health and well-being.

Because of the dangers of participating in sports, I recognize the importance of following the instructions and guidance of the athletic department personnel regarding playing techniques, training, rules of the team and sport, equipment, and obey such rules. I also acknowledge that some sports are classified as violent contact sports involving even greater risk of injury than other sports.

I hereby grant permission to the XXX Team Physicians and/or their consulting physicians to render to myself (son/daughter) any treatment, medical or surgical care that they deem reasonably necessary to my (his/her) health and well-being. All approval of final medical clearance is determined by the Heidelberg Team Physicians.

I also hereby authorize the XXXX Athletic Training Staff, who are under the guidance and direction of the XXXX University Team Physicians, to render to myself (son/daughter) any preventative measures for injuries, first aid, treatment, management, and rehabilitation of athletic injuries and emergency treatment that they deem reasonable and necessary to my (his/her) health and well-being, including practices, games, and travel. An athlete's noncompliance can and will result in termination of care by the medical staff.

I grant permission for hospitalization if deemed necessary at an accredited hospital.

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ADHD Information Form

	Section	Sub-Section	Q#
ADHD Medical Exceptions Questions & Answers			
Background The NCAA bans classes of drugs that can be harmful to student-athletes and that can create unfair advantages during competition (NCAA Bylaw 31.2.3). Some medications that student-athletes are prescribed for legitimate medical reasons contain NCAA banned substances. The NCAA, through the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) has a procedure to review and approve the use of medications that contain NCAA banned substances through a Medical Exceptions Procedure. Effective August 1, 2009, there will be a stricter application of the NCAA Medical Exception policy, and specifically for the use of banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD)	1	1.01	0
What should student-athletes who have been diagnosed with ADHD and/or have been prescribed stimulant medications do? Student-athletes who have been diagnosed with ADHD and/or have been prescribed stimulant medications should immediately notify a member of the Department of Sports Medicine to begin the process of obtaining the necessary documentation.	1	1.02	0
What if a student-athlete has been treated since childhood with ADHD stimulant medications? Student-athletes who have been treated since childhood with ADHD stimulant medications but do not have the pertinent records with regards to the diagnosis, management, and continuing evaluation must undergo a comprehensive evaluation to obtain the necessary documentation.	1	1.03	0
What documentation must the student-athlete obtain from his/her prescribing physician? At a minimum, student-athletes must provide the following documentation from the prescribing physician to the University of XXX Department of Sports Medicine Description of the evaluation process which identifies the assessment tools and procedures; 1. Statement of the diagnosis, including when it was confirmed; 2. A copy of all testing that was performed to reach the diagnosis 3. History of ADHD treatment (previous / ongoing); 4. Statement that a non-banned ADHD alternative has been considered if a stimulant is currently prescribed; 5. Statement regarding follow-up and monitoring visits 6. Copy of the most recent prescription (as documented by the prescribing physician).	1	1.04	0
The aforementioned documentation must be on file with the University of xxxx Department of Sports Medicine in order for the student-athlete to participate in intercollegiate athletics at the University of xxx All INformation may be sent to: xxx xxx xxx XXX-XXX-XXXX	1	1.05	0
Who can student-athletes, parents, coaches, etc. contact with questions regarding issues surrounding **ADHD medications and the NCAA Medical Exceptions Policy?**	1	1.06	0

ATS Athlete Forms Library

ADHD Information Form

	Section	Sub-Section	Q#
Student-athletes and/or parents with questions regarding the diagnosis of ADHD and/or the medication(s) prescribed should start by directing questions to the physician who initially conducted the evaluation and diagnosis. Individuals with specific questions regarding the NCAA Bylaws related to banned substances, drug testing, and/or medical exceptions can view the NCAA website (www.ncaa.org/health-safety) and/or contact xxx			
I affirm that I have been informed by University of xxx personnel about NCAA Banned substances List and NCAA Medical Exceptions Policy at it specifically pertains to the use of banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD) or like conditions.	2 2	2.01 2.01	0 0
I AM NOT presently taking and/or have taken within the last 12 months any banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions.	2 2	2.02 2.02	0 0
I AM presently taking and/or have taken within the last 12 months banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. If Yes, please list the medication currently being taken.	2	2.02	0
I, the undersigned, do hereby affirm that I understand that I am to immediately notify a member of the University of XXX Department of Sports Medicine should I ever be prescribed the aforementioned stimulant medications and that I must obtain and submit appropriate documentation from the prescribing physician.	3	3.01	0
I further attest that I have had any and all questions regarding the NCAA ADHD Medical Exceptions Policy answered to my satisfaction.	3	3.02	0
By typing your full name here, you attest that you have read and answered all questions in this document truthfully	3 3	3.03 3.03	0 0

ATS Athlete Forms Library

Assumption of Risk for Participating in Intercollegiate Athletics

	Section	Sub-Section	Q#
	1	1.01	1
I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF 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 XXXX University OF XXX permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby assume all risks associated with participation and agree to hold XXX University of XXX, its employees, agents, representatives, coaches and volunteers, harmless from any and all liability, actions , causes of action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to XXX University			
	1	1.02	2
The XXX University of XXXs team that I participate with is:	1	1.02	2
Note: If you are under 18 years of age you will NEED a parent or guardian to sign this form.	1	1.03	3
	1	1.04	4
Please Enter Todays Date:	1	1.04	4

ATS Athlete Forms Library

Athlete Emergency Release Form

	Section	Sub-Section	Q#
Medical/Insurance Information			
	1	1.01	1
Has anyone in the athlete's family (mother, father, siblings, grandparents, etc) died suddenly before the age of 50 years.	1	1.01	1
Has anyone in the athlete's family (mother, father, siblings, grandparents, etc) died suddenly before the age of 50 years.	1	1.01	1
	1	1.02	2
Has the athlete ever passed out during exercise or stopped exercising because of dizziness?	1	1.02	2
Has the athlete ever passed out during exercise or stopped exercising because of dizziness?	1	1.02	2
	1	1.03	3
Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?	1	1.03	3
Does the athlete have asthma (wheezing), hay fever or coughing spells after exercise?	1	1.03	3
	1	1.04	4
Has the athlete ever broken a bone, had to wear a cast or had an injury to any joint?	1	1.04	4
Has the athlete ever broken a bone, had to wear a cast or had an injury to any joint?	1	1.04	4
	1	1.05	5
Does the athlete have a history of a concussion (getting knocked out?)	1	1.05	5
Does the athlete have a history of a concussion (getting knocked out?)	1	1.05	5
	1	1.06	6
Has the athlete ever suffered a heat related illness (heat stroke?)	1	1.06	6
Has the athlete ever suffered a heat related illness (heat stroke?)	1	1.06	6
	1	1.07	7
Does the athlete have anything he or she wants to discuss with the physician?	1	1.07	7
Does the athlete have anything he or she wants to discuss with the physician?	1	1.07	7
	1	1.08	8
Does the athlete have a chronic illness or see a physician regularly for any particular problem?	1	1.08	8
Does the athlete have a chronic illness or see a physician regularly for any particular problem?	1	1.08	8
	1	1.09	9
Does the athlete take any medication?	1	1.09	9
Does the athlete take any medication?	1	1.09	9
	1	1.10	10
Is the athlete allergic to any medications or to bee strings?	1	1.10	10
Is the athlete allergic to any medications or to bee strings?	1	1.10	10

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Athlete Emergency Release Form

	Section	Sub-Section	Q#
	1	1.11	11
Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc?)	1	1.11	11
Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc?)	1	1.11	11
	1	1.12	12
Does the athlete have any problems with vision (eyes)?	1	1.12	12
Does the athlete have any problems with vision (eyes)?	1	1.12	12
	1	1.13	13
Does the athlete habitually use drugs, alcohol, or cigarettes?	1	1.13	13
Does the athlete habitually use drugs, alcohol, or cigarettes?	1	1.13	13

Parent's Statement

	14	14.01	15
The above named student has my permission to participate in interscholastic sports and to travel with the team to events using transportation that qualifies under the school's regulations. In case of injury, I give my consent for my child to have initial treatment by a hospital physician, team physician, or other medical personnel which is deemed necessary. This permission includes admission to the hospital and emergency surgery.			
The above named student has my permission to participate in interscholastic sports and to travel with the team to events using transportation that qualifies under the school's regulations. In case of injury, I give my consent for my child to have initial treatment by a hospital physician, team physician, or other medical personnel which is deemed necessary. This permission includes admission to the hospital and emergency surgery.			

ATS Athlete Forms Library

Athletic Consent Form

Section	Sub-Section	Q#
1	1.01	1

PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY:
(If you are under 18 years of age, your parents/guardian MUST also sign)
The basic content of each consent is:
A. Medical Consent: Allows xxxx University athletic trainers and team physicians to treat any illness or injury you sustain while at xxxxx University.
B. Release of Information: Allows xxxx University athletic trainers and team physicians to release information concerning your illnesses or injuries to parents and/or coaches.
C. Shared Responsibility: Discusses the shared responsibility for health and safety between athlete and staff. Informs you that there are certain inherent risks involved in participating in intercollegiate athletics and states that you are willing to assume responsibility for such risks.
If you choose to refuse to sign any of these consents, please write “Refused to Sign” with the date and your initials.
Medical Consent - Part A
I hereby grant permission to XXXX University team physicians and/or their consulting physicians to render to me (or to my son or daughter if under 18 years of age) any treatment or medical or surgical care that they deem reasonably necessary to preserve and/or improve my health and well-being (or the health and/or well being of my son or daughter).
I also hereby authorize the athletic trainers at xxxx University, who are under the direction and guidance of the xxxxx University team physicians, to render to me (or to my son or daughter if under 18 years of age) any preventive, first aid, rehabilitative or emergency treatment that they deem reasonably necessary to preserve and/or improve my health and well-being (or the health and/or well being of my son or daughter).
When necessary for executing such care, I grant permission for my hospitalization at XXXX University Hospital or another accredited hospital (or for hospitalization of my son or daughter).

ATS Athlete Forms Library

Athletic Department Compliance Forms

	Section	Sub-Section	Q#
Student Athlete Compliance			
As Rostered Student-Athlete at Archbishop Spalding High School	1	1.01	1
By Clicking YES, I Promise to	1	1.01	1
--- Represent my school, my coaches, my teammates and myself in a manner which is appropriate and just.			
--- Maintain a healthy and competitive approach to athletics.			
--- Accept responsibility for my actions both on the playing field and in the classroom.			
--- Lead by example in the areas of self-respect and respect for others.			
--- Compete to the best of my abilities.			
--- Refrain from the use of prohibited substances such as steroids, drugs, alcohol, and tobacco products.			
--- Refrain from the use of vulgar or profane language at all school sanctioned events / activities.			
--- Demonstrate good sportsmanship and fair play at all times.			
--- Understand that academics take priority over athletics.			
--- Take responsibility for all personal belongings by securing these items in assigned school and athletic lockers or by taking items that do not fit into lockers with me to practice sites.			
--- Thank Jesus Christ for granting me good health and athleticism.			
Athletic Compliance Agreement			
Athletic Department Handbook Compliance Form	2	2.01	1
As a rostered student athlete, and as the parent/guardian of a student athlete, I affirm by clicking YES that I have read and understand the contents of the “Athletic Handbook for Athletes, Parents, and Coaches”	2	2.01	1
I understand and will abide by the “Athletic Chain of Command”			
I will strive to make the “Athletic Experience” a positive one			
I will attend the mandatory pre-season Meet the Coaches meeting			
Athletic Compliance Form			
Athletics/Extra-Curricular Random Drug Testing Agreement	3	3.01	1
By clicking YES, I pledge to remain free of alcohol, tobacco, and illegal substances and to exhibit good behavior and citiizenship. I understand that the school may elect to conduct random drug testing. I further understand that violation of this pledge or refusal to comply with random drug testing may result in suspension or exclusion from extracurricular activities in addition to disciplinary consequences as a student at XXXX xxxx High School.	3	3.01	1
I acknowledge that I have read and understand the school policy on alcohol, tobacco, and illegal substancees as outlined in the Student Handbook (page 17-18).			
Athletic Department Parents Pledge			

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Athletic Department Compliance Forms

	Section	Sub-Section	Q#
As a Parent at Archbishp Spalding High School	4	4.01	1
By Clicking YES I Promise To:	4	4.01	1

--- Represent XXX XXXX High School in a manner which is appropriate and just.
--- Demonstrate and support good sportsmanship at all athletic events.
--- Demonstrate positive support for my child and for all members of the team.
--- Support the coaching staff in their efforts to develop and refine athletic ability.
--- Be supportive of the policies, procedures, rules and regulations of the school.
--- Maintain academic achievement as the main priority of the Spalding experience.
--- Refrain from the use of prohibited substances such as steroids, drugs, alcohol, and tobacco products on school property.
--- Refrain from the use of vulgar or profane language at all school sanctioned events / activities.
--- Lead by example in the areas of self-respect and respect for others.
--- Be thankful for the opportunity afforded to me as a member of the XXXX community.

Athletic Department Participation & Travel Waiver

Please read, carefully, the statement below and select your response to the left. By Clicking Yes I agree to the following:	5	5.00	1

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Athletic Department Compliance Forms

	Section	Sub-Section	Q#
I am aware playing or practicing to play/participate in any sport can be a dangerous activity involving many risks of injury. I do understand that the dangers and risks of playing or practicing any sport include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to play/participate in any sport may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life. Because of the dangers of participating in the above intramural or interscholastic athletic activity, I recognize the importance of following teachers' and coaches' instructions regarding playing techniques, training and other team rules, and agree to obey such instructions. In consideration of XXXX (hereinafter "The School") permitting me to engage in all activities related to the sport, including, but not limited to, trying out, practicing or playing/participating in that sport, I hereby voluntarily assume the risk of accident, injury or damage to person or property. Furthermore, I voluntarily release and dischargeThe School, its employees, agents, representatives, coaches and volunteers from, without limitation, any and all actions, causes of action, claims, demands, damages, costs, expenses, compensation, and/or suits at law or in equity, on account of or relating to any act or omission byThe School, its employees, agents, representatives, coaches or volunteers. I also agree to defend, indemnify and save The School harmless from and against any and all liability, actions, causes of action, debts, claims, demands, or suits at law or in equity of any kind and nature whatsoever which may arise, directly or indirectly, by or in connection with my participation in any activity. The terms hereof shall serve as a release for my heirs, estate, executor, administrator, and assignees. I further acknowledge that if I am participating in football, rugby, cheerleading, wrestling, baseball, ice hockey, lacrosse or soccer, I am aware that they are or potentially are violent contact sports involving even greater risk of injury than other sports. In addition, I acknowledge all the regulations and the potential of denial and dismissal from sport participation for violations of School policy and/or the expectations and standards of the coach(es).	5	5.00	1
By Clicking Yes:	5	5.01	1
I hereby give consent for the above-mentioned student to represent his/her school in athletic activities, including team/individual travel for local and out-of-town trips. I authorize the school to obtain, through a physician of its choice, any emergency care that might be reasonably necessary for the student in the course of such athletic travel. I also agree that we/I will not hold XXXX or anyone acting in its behalf responsible for any injury occurring to the above-mentioned student in the course of such athletic travel.	5	5.01	1

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Athletic Department Compliance Forms

	Section	Sub-Section	Q#
By Clicking Yes I agree:	5	5.02	1
My son/daughter has permission to drive to practices.	5	5.02	1
By Clicking Yes I agree:	5	5.03	3
My son/daughter has permission to drive to practices and to transport one additional student passenger to these activities.	5	5.03	3
By Clicking Yes, I agree	5	5.04	4
My son/daughter has permission to be a passenger in a coach or parent-driven car to practices.	5	5.04	4

Concussion Awareness Statements

What can happen if my child keeps on playing with a concussion or returns to soon?	6	6.01	1
Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.			
By clicking Yes, I affirm that I have read the statement below and agree to the statement as written.	6	6.02	1
If you think your child has suffered a concussion	6	6.02	1

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. XXX requires the consistent and uniform implementation of a well established return to play concussion guidelines that have been recommended for several years:

"a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"
and
"…may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/Concussion

Release for Helmet Sports

ATS Athlete Forms Library

Athletic Department Compliance Forms

	Section	Sub-Section	Q#
By clicking yes, to the statement below that applies to the helmet sport that my student athlete plays, I affirm I have read the warnings and have been made aware of the inherent risks.	7	7.01	1
THIS IS TO CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE WARNING LABEL AS IT APPEARS ON THE OUTSIDE MY HELMET. THE LABEL READS FOOTBALL WARNING: DO NOT STRIKE AN OPPONENT WITH ANY PART OF THIS HELMET OR FACEMASK. THIS IS A VIOLATION OF FOOTBALL RULES AND MAY CAUSE YOU OR YOUR OPPONENT TO SUFFER SEVERE BRAIN OR NECK INJURY. SEVER BRAIN OR NECK INJURY MAY ALSO OCCUR ACCIDENTALLY WHILE PLAYING FOOTBALL OR LACROSSE. NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.	7	7.01	1
By clicking yes, to the statement below that applies to the helmet sport that my student athlete plays, I affirm I have read the warnings and have been made aware of the inherent risks.	7	7.02	2
BASEBALL/SOFTBALL HELMET WARNING: WARNING DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN BASEBALL OR SOFTBALL	7	7.02	2
By clicking yes, to the statement below that applies to the helmet sport that my student athlete plays, I affirm I have read the warnings and have been made aware of the inherent risks.	7	7.03	3
HOCKEY WARNING WARNING NO HELMET CAN PREVENT ALL HEAD OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN HOCKEY. DO NOT USE THIS HELMET TO BUTT AN OPPOSING PLAYER. THIS IS IN VIOLATION OF THE HOCKEY RULES AND SUCH USE CAN RESULT IN SEVERE HEAD OR NECK INJURIES, PARALYSIS OR DEATH TO YOU AND POSSIBLE INJURY TO YOUR OPPONENT	7	7.03	3
By clicking yes, to the statement below that applies to the helmet sport that my student athlete plays, I affirm I have read the warnings and have been made aware of the inherent risks.	7	7.04	4

	Section	Sub-Section	Q#
LACROSSE WARNING DO NOT USE THIS HELMET IF THE SHELL IS CRACKED OR DEFORMED; OR IF THE INTERIOR PADDING IS DETERIORATED. SEVERE HEAD OR NECK INJURY, INCLUDING PARALYSIS OR DEATH MAY OCCUR TO YOU DESPITE USING THIS HELMET. NO HELMET CAN PREVENT ALL HEAD INJURIES OR ANY NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN LACROSSE.	7	7.04	4
By clicking yes, to the statement below that applies to the helmet sport that my student athlete plays, I affirm I have read the warnings and have been made aware of the inherent risks.	7	7.05	5
I ALSO UNDERSTAND THAT FOOTBALL AND LACROSSE ARE POTENTIALLY INJURIOUS SPORTS AND AGREE TO ACCEPT THE RISK OF INJURY ASSOCIATED WITH COMPETITION IN THESE SPORTS. NO HELMET CAN PREVENT ALL SUCH INJURIES.	7	7.05	5

Medical Exam Authorization

Please read the following statement	8	8.01	1

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Athletic Department Compliance Forms

	Section	Sub-Section	Q#
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 either to the personal family physician, School's Team Physician, the head or assistant athletic trainer, head or assistant athletic director, or head coach his/her designee, or my parents no matter how minor or insignificant I may deem them to be. I understand that my responsibility to report injuries and illnesses includes, but is not limited to, reporting signs and symptoms of concussions. I acknowledge that I have accessed and read the educational materials about concussions in the ATS system under Electronic Documents or on the Athletic Training webpage under Athletic Training Resources, and that I understand the signs and symptoms of concussions.	8	8.01	1
I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. Permission is also granted for the school athletic trainer, the approved health care provider to proceed with any use of modalities for the care, treatment, and rehabilitation of the above named student who is participating in ASHS athletic events. Treatments such as first aid, diagnostic procedures, rehabilitative exercises and therapeutic modalities that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract the school, or the opposing team's school. Modalities will only be utilized under the standing orders of the team physician and/or orthopedic surgeon, and will only be administered by the certified athletic trainer. Additionally, I authorize the use of neurocognitive testing programs for the management of concussions. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.			

Consent for Emergency Medical Transport

Please read the following statement and select yes or no	9	9.01	1
In the event emergent care is necessary, I give permission for my child to be transported to the nearest emergency room based on local EMS protocols to receive necessary treatment.	9	9.01	1

Consent to Receive OTC Medication

Please read the question and select yes or no. If you select no, please type NO MEDS in the box below or list the medications you do not wish to be administered.	10	10.10	1
Permission is given to the xxxx Atheltic Training Staff to administer over the counter medication through the standing orders provided by the team physician. Please list in the box to the right any medication your child should not recieve.	10	10.10	1

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Athletic Department Compliance Forms

	Section	Sub-Section	Q#
Permission to Release Medical Records			
Please read the following question and select yes or no:	11	11.01	1
I understand that xxxx xxx High School athletic trainer, the approved health care provider for ASHS, may request information regarding the athlete's health status from a physicians' office, and I hereby give my permission for the receipt and release of this information as it pertains to my child's ability to safely participate in athletics. In addition should treatment be necessary, I give permission for a physician's office to release medical information to allow for the timely treatment of my child by the approved health care provider for ASHS. This request is to facilitate open communication between the athletic trainer and the treating physician in order to optimize patient care. This information cannot and will not be released to other parties without first being approved by the guardian or parent of the athlete. I understand I will be notified of the necessity of obtaining medical records.	11	11.01	1

ATS Athlete Forms Library

Athletic Participation Statements (All Athletes)

	Section	Sub-Section	Q#
Assumption of Risk and Release			
	1	1.01	1
I verify that I have been informed that I may be injured while participating in intercollegiate athletic practice or competition which include but are not limited to training, try-outs, practicing, playing, and traveling. I fully realize the dangers in participating in such activities and fully assume the risks associated with such participation, which may include but are not limited to the possibility of serious physical injury and/or mental trauma, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment. These injuries may be caused in whole or in part by numerous factors including my medical or physical condition, the actions or inaction of athletes, the conditions of premises, and the negligence of the entity or individuals released hereby. I freely acknowledge that I am aware of and accept the risks associated with such participation.	1	1.01	1
I waive, release and discharge of myself, heirs, executors, administrators, legal representatives, and assignees any and all rights or claims for injuries or losses of any description that I may have or which may hereafter result to me against xxx, its trustees, employees or agents, in connection with my participation in activities associated with a xxx intercollegiate athletic team.	1	1.01	2
	1	1.01	3
Medical Consent to Treatment			
	2	2.01	3
I grant permission to physicians, athletic trainers, and/or other medical professionals or practitioners associated, assisting, or employed in connection with xxx athletic programs or student athletes, to render any preventative, emergency, surgical, or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being in circumstances connected with my participation in activities associated with a xxx athletic team. I understand that all athletic-related injuries, including signs and symptoms of concussions, must be reported to the Athletic Training staff immediately, except in the case of an emergency or in the absence of an athletic trainer in which case the athlete must report the injury within two school days and/or prior to any further athletic participation. Failure to do so may result in loss of benefits through the secondary athletic insurance policy. In the event of an injury, the athletic trainer will make all necessary referrals to the appropriate medical provider (emergency room, physician, etc.). The host athletic trainer should be consulted at away contests in the absence of a xxx Athletic Training staff.	2	2.01	3
This Consent is not intended to, and does not, create a duty on the part of physicians, athletic trainers, and/or other medical professionals or practitioners associated, assisting, or employed in connection with xxxx athletic programs or student athletes, to render or arrange for such treatment or care.	2	2.01	4
	2	2.01	5
Authorization For Release Of Medical Information			

ATS Athlete Forms Library

Athletic Participation Statements (All Athletes)

	Section	Sub-Section	Q#
	3	3.01	5
I herby authorize xxx and its physicians, athletic trainers, and health care personnel to disclose my protected health information and any related information regarding any injury or illness (physical or psychological) incurred while participating as an NCAA student-athlete to the xxx Athletic Training Staff and its employees or agents. I understand that my protected health information will be used by thexxxAthletic Training staff for the purpose of managing athletic illness or injury.	3	3.01	5
I understand that my signing of this authorization is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health care plan or receipt of any benefits if applicable on whether I provide the authorization requested for this disclosure. I also understand that I am not required to sign this authorization in order to be eligible for participation in NCAA or conference athletics. This authorization expires three hundred and eighty days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the Athletic Training Staff.	3	3.01	6
	3	3.01	7

ATS Athlete Forms Library

Concussion Self-Eval

	Section	Sub-Section	Q#
Please answer using the range 1=Poor, 6=Normal			
	1	1.03	3
How is your level of confusion?	1	1.03	3
	1	1.04	4
How is your level of concentration?	1	1.04	4
	1	1.05	5
How is your level of remembering?	1	1.05	5
	1	1.06	6
How is your level of dizziness?	1	1.06	6
	1	1.07	7
How is your level of drowsiness?	1	1.07	7
	1	1.08	8
How is your level of fatigue?	1	1.08	8
	1	1.09	9
How is your level of headache or pain?	1	1.09	9
	1	1.10	10
How is your level of nervousness?	1	1.10	10
	1	1.11	11
How is your level of sensativeity to light?	1	1.11	11
	1	1.12	12
How is your level of sensativity to noise?	1	1.12	12
	1	1.13	13
How is your level of trouble sleeping?	1	1.13	13

ATS Athlete Forms Library

Concussion Symptom Diary

Symptoms

	Section	Sub-Section	Q#
Please choose a Severity Rating below: (0 being the least severe and 6 being the most severe)	2	2.02	2
Headache	2	2.02	2
	2	2.03	3
Nausea	2	2.03	3
	2	2.04	4
Vomiting	2	2.04	4
	2	2.05	5
Balance problems	2	2.05	5
	2	2.06	6
Dizziness (spinng or movement sensation)	2	2.06	6
	2	2.07	7
Lightheadedness	2	2.07	7
	2	2.08	8
Fatigue	2	2.08	8
	2	2.09	9
Trouble falling asleep	2	2.09	9
	2	2.10	10
Sleeping more than usual	2	2.10	10
	2	2.11	11
Sleeping less than usual	2	2.11	11
	2	2.12	12
Drowsiness	2	2.12	12
	2	2.13	13
Sensitivity to light	2	2.13	13
	2	2.14	14
Sensitivity to noise	2	2.14	14
	2	2.15	15
Irritability	2	2.15	15
	2	2.16	16
Sadness	2	2.16	16
	2	2.17	17
Nervous/Anxious	2	2.17	17
	2	2.18	18
Feeling more emotional	2	2.18	18
	2	2.19	19
Numbness or tingling	2	2.19	19
	2	2.20	20
Feeling slowed down	2	2.20	20

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Concussion Symptom Diary

	Section	Sub-Section	Q#
	2	2.21	21
Feeling like "in a fog"	2	2.21	21
	2	2.22	22
Difficulty concentrating	2	2.22	22
	2	2.23	23
Difficulty remembering	2	2.23	23
	2	2.24	24
Visual problems	2	2.24	24
	2	2.25	25
Other	2	2.25	25
	2	2.25	25

ATS Athlete Forms Library

Consent for Random Drug Testing (NJ)

	Section	Sub-Section	Q#
READ, SIGN AND DATE			
	1	1.01	1

In Executive Order 72, issued December 20,2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, High School website or NJSIAA website without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances. In addition we understand the attached list may not be the most current. It is our responsibility to regularly check the High School website under Athletic Physical Exam Forms or the NJSIAA website (njsiaa.org/medicalissues.aspx <http://njsiaa.org/medicalissues.aspx>) for the most current list.

Agreements and Signatures

Athlete	2	2.01	2
	2	2.01	2
Athlete	2	2.02	3
	2	2.02	3
Parent/Guardian	2	2.03	4
	2	2.03	4
Parent/Guardian	2	2.04	5
	2	2.04	5

ATS Athlete Forms Library

Health Appraisal

	Section	Sub-Section	Q#
	1	1.03	3
Since the conclusion of LAST season have you had any medical problems?	1	1.03	3
Since the conclusion of LAST season have you had a physician visit?	1	1.03	3
	1	1.04	4
Since the conclusion of LAST season have you had any hospitalizations?	1	1.04	4
	1	1.05	5
Since the conclusion of LAST season have you had any operations/surgeries?	1	1.05	5
	1	1.06	6
Since the conlusion of LAST season have you had any fractures/cast?	1	1.06	6
	1	1.07	7
Since the conlusion of LAST season have you had any recent illnesses?	1	1.07	7
	1	1.08	8
Allergies:	1	1.08	8
	1	1.09	9
Current Medications:	1	1.09	9

ATS Athlete Forms Library

Health Habits Questionnaire

	Section	Sub-Section	Q#
Background Information			
Current school status	1	2.01	5
Full-time undergraduate	1	2.01	5
Graduate student	1	2.01	7
Other. Please describe...	1	2.01	8
Your current year in college	1	3.01	9
1	1	3.01	9
2	1	3.01	10
3	1	3.01	11
4	1	3.01	12
5	1	3.01	13
6	1	3.01	14
Graduate student	1	3.01	15
Other. Please describe	1	3.01	16
Greek membership	1	4.01	17
Fraternity	1	4.01	17
Sorority	1	4.01	18
Neither	1	4.01	19
Ethnic/racial group	1	6.01	26
American Indian	1	6.01	26
Asian American	1	6.01	27
Caucasian	1	6.01	28
Hispanic	1	6.01	29
Other. Please describe	1	6.01	30
Health Habits			
Have you in the past or do you currently use cigarettes?	2	7.01	31
Currently use (started within last 6 months)	2	7.01	31
Have used in the past (6 months ago or more)	2	7.01	32
Currently use and have used in the past	2	7.01	33
Never used	2	7.01	34
Do you have any comments or concerns about cigarettes? Please type in.	2	7.01	35
Have you in the past or do you currently use chewing tobacco?	2	8.01	36
Currently use (started within last 6 months)	2	8.01	36
Have used in the past (6 months ago or more)	2	8.01	37
Currently use and have used in the past	2	8.01	38
Never used	2	8.01	39
Do you have any comments or concerns about chewing tobacco? Please type in.	2	8.01	40
Have you in the past or do you currently use marijuana/THC?	2	9.01	41
Currently use (started within last 6 months)	2	9.01	41
Have used in the past (6 months ago or more)	2	9.01	42

ATS Athlete Forms Library

Health Habits Questionnaire

	Section	Sub-Section	Q#
Currently use and have used in the past	2	9.01	43
Never used	2	9.01	44
Do you have any comments or concerns about marijuana/THC? Please type in.	2	9.01	45
Have you in the past or do you currently use ecstasy?	2	10.01	46
Currently use (started within last 6 months)	2	10.01	46
Have used in the past (6 months ago or more)	2	10.01	47
Currently use and have used in the past	2	10.01	48
Never used	2	10.01	49
Do you have any comments or concerns about ecstasy? Please type in.	2	10.01	50
Have you in the past or do you currently use amphetamines/stimulants?	2	11.01	51
Currently use (started within last 6 months)	2	11.01	51
Have used in the past (6 months ago or more)	2	11.01	52
Currently use and have used in the past	2	11.01	53
Never used	2	11.01	54
Do you have any comments or concerns about amphetamines/stimulants? Please type in.	2	11.01	55
Have you in the past or do you currently use cocaine?	2	12.01	56
Currently use (started within last 6 months)	2	12.01	56
Have used in the past (6 months ago or more)	2	12.01	57
Currently use and have used in the past	2	12.01	58
Never used	2	12.01	59
Do you have any comments or concerns about cocaine? Please type in.	2	12.01	60
Have you in the past or do you currently use heroine?	2	13.01	61
Currently use (started within last 6 months)	2	13.01	61
Have used in the past (6 months ago or more)	2	13.01	62
Currently use and have used in the past	2	13.01	63
Never used	2	13.01	64
Do you have any comments or concerns about heroine? Please type in.	2	13.01	65
Have you in the past or do you currently use other recreational drugs not listed above?	2	14.01	66
Currently use (started within last 6 months)	2	14.01	66
Have used in the past (6 months ago or more)	2	14.01	67
Currently use and have used in the past	2	14.01	68
Never used	2	14.01	69
	2	14.01	70
Do you have any comments or concerns about using recreational drugs? Please type in	2	20.01	71
	2	20.01	71
Do you have comments or concerns about family members with drug use/abuse problems? Please type in	2	21.02	73
	2	21.02	73

ATS Athlete Forms Library

Health Habits Questionnaire

	Section	Sub-Section	Q#
Do you have any comments or concerns about a friend, roommate, teammate or family members having drug use/abuse problems? Please type in	2	22.01	75
	2	22.01	75
Drug Testing	2	22.02	76
Do you think the drug testing program at our school is fair?	2	22.02	76
Do you think the testing program deters use of banned drugs?	2	22.02	77
Do you think the drug testing program is easy to beat if someone uses drugs?	2	22.02	78
What percentage of athletes at our school do you think use alcohol?	2	29.01	79
enter a percentage from 0-100	2	29.01	79
What percentage of athletes at our school do you think use Marijuana/THC?	2	124.01	85
enter a percentage from 0-100			
Have you in the past or do you currently use steroids?	2	132.01	130
Have used in the past (6 months ago or more)	2	132.01	130
Currently use and have used in the past	2	132.01	131
Never used	2	132.01	132
Do you have any comments or concerns about steroids? Please type in.	2	132.01	133
Have you in the past or do you currently use vitamins/supplements?	2	133.01	134
Currently use (started within last 6 months)	2	133.01	134
Have used in the past (6 months ago or more)	2	133.01	135
Currently use and have used in the past	2	133.01	136
Never used	2	133.01	137
List any supplements or vitamins that you use.....	2	133.01	138
Have you in the past or do you currently use weight loss medications?	2	134.01	139
Currently use (started within last 6 months)	2	134.01	139
Have used in the past (6 months ago or more)	2	134.01	140
Currently use and have used in the past	2	134.01	141
Never used	2	134.01	142
Do you have any comments or concerns about weight loss medications? Please type in.	2	134.01	143
Do you feel out of control when you are stressed?	2	135.01	144
	2	135.01	144
Do you have any comments or concerns about feeling out of control when stressed? Please type in	2	135.01	145
Do you have a history of depression, or feel depressed?	2	136.01	146
	2	136.01	146
Do you have any comments or concerns about a history of depression, or feeling depressed? Please type in	2	136.01	147
Are you currently or have you ever been involved in psychotherapy?	2	137.01	148
Currently (last 6 months)	2	137.01	148
In the past (6 months ago or more)	2	137.01	149
Currently and in the past	2	137.01	150

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Health Habits Questionnaire

	Section	Sub-Section	Q#
Never	2	137.01	151
If you currently are or have been involved in psychotherapy, please describe why	2	137.01	152
Seat Belts and Helmet Use	2	138.01	153
Do you wear a seat belt at least 90% of the time?	2	138.01	153
Do you have any comments or concerns about wearing a seat belt? Please type in	2	138.01	154
	2	138.04	155
If you rise (or were to ride) a bicycle do (would) you almost always wear a bicycle helmet?	2	138.04	155
If you ride (or were to ride) a motorcycle do (would) you almost always wear a motorcycle helmet?	2	138.04	156
Do you have any comments or concerns about wearing bicycle/motorcycle helmets? Please type in	2	138.04	157
Sexual Health Habits	2	138.07	158
Do you understand and regularly perform a self-breast exam or self-testicular exam?	2	138.07	158
Do you have any comments or concerns about performing a self-breast exam or self-testicular exam? Please type in	2	138.07	159
	2	139.01	160
Are you sexually active?	2	139.01	160
Do you have any comments or concerns about being sexually active? Please type in	2	139.01	161
Current sexual partner(s)	2	140.01	162
Opposite sex	2	140.01	162
Same sex	2	140.01	163
Both	2	140.01	164
None	2	140.01	165
Past sexual partner(s)	2	140.04	166
Opposite sex	2	140.04	166
Same sex	2	140.04	167
Both	2	140.04	168
None	2	140.04	169
Do you practice safe xex? (abstinence, condoms)	2	141.01	170
	2	141.01	170
How do you practice safe sex?	2	141.02	171
Abstinence (not having sex)	2	141.02	171
condoms and/or dental dams	2	141.02	172
None of the above	2	141.02	173
Other. Please type in	2	141.02	174
Do you have any concerns or questions about save sex practices? Please type in	2	141.02	175

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Health Habits Questionnaire

	Section	Sub-Section	Q#
	2	142.01	176
Do you have a history of more than two (2) sexual partners in the last 6 months?	2	142.01	176
Do you have any concerns regarding your number of sexual partners in the last 6 months?	2	142.01	177
	2	143.01	178
Do you have a history of any sexually transmitted disease?	2	143.01	178
Do you have any comments or concerns about having a history of any sexually transmitted diseases? Please type in	2	143.01	179
Do you have any concerns or questions about HIV?	2	144.01	180
	2	144.01	180
What are your concerns or questions about HIV? Please type in	2	144.01	181
Do you have any additional concerns or questions about your health habits? Please type in	2	145.01	182
	2	145.01	182
Do you have any family members with drug use/abuse problems?	2	2,102.00	72
Please explain....	2	2,102.00	72

Nutrition

Current Nutritional State	3	183.01	183
What is your present height (in inches)? (60 inches = 5 feet; 72 inches = 6 feet) Please type using this format: 66. Please type in the number ONLY - do NOT add the word "inches" or the symbol "	3	183.01	183
What is your present weight (in pounds)? Type using this format: 125. (Please type in the number ONLY - do NOT add the word "pounds" or the symbol "LBS")	3	183.01	184
	3	183.02	185
Are you happy with your present weight?	3	183.02	185
Do you have any comments or concerns about being happy with your weight? Please type in	3	183.02	186
	3	187.01	187
If you are not happy with your present weight, what is your desired weight (in pounds?) (Please type in the number ONLY - do NOT add the word "pounds" or the symbol "LBS")	3	187.01	187
(Please type in the number ONLY - do NOT add the word "pounds" or the symbol "LBS")	3	188.00	188
What has been your highest weight (in pounds)	3	188.00	188
What has been your lowest weight since age 16 (in pounds)	3	188.00	189
Do you have trouble maintaining your optimal weight?	3	188.00	190
Do you have any comments or concerns about having trouble maintaining your optimal weight? Please type in	3	188.00	191
In an average 2 days, how many servings of grains (cereal, bread, rice, pasta) have you eaten?	3	192.01	192
None	3	192.01	192

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Health Habits Questionnaire

	Section	Sub-Section	Q#
1	3	192.01	193
2	3	192.01	194
3	3	192.01	195
4	3	192.01	196
More than 4	3	192.01	197
In an average 2 days, how many servings of dairy products (milk, yogurt, cheese) have you eaten?	3	198.01	198
None	3	198.01	198
1	3	198.01	199
2	3	198.01	200
3	3	198.01	201
4	3	198.01	202
More than 4	3	198.01	203
In an average 2 days, how many servings of beans, nuts, or tofu have you eaten?	3	204.01	204
None	3	204.01	204
1	3	204.01	205
2	3	204.01	206
3	3	204.01	207
4	3	204.01	208
More than 4	3	204.01	209
In an average 2 days, how many servings of chicken or fish have you eaten?	3	210.01	210
None	3	210.01	210
1	3	210.01	211
2	3	210.01	212
3	3	210.01	213
4	3	210.01	214
More than 4	3	210.01	215
In an average 2 days, how many servings or fruits have you eaten?	3	216.01	216
None	3	216.01	216
1	3	216.01	217
2	3	216.01	218
3	3	216.01	219
4	3	216.01	220
More than 4	3	216.01	221
In an average 2 days, how many servings of red meat have you eaten?	3	222.01	222
None	3	222.01	222
1	3	222.01	223
2	3	222.01	224
3	3	222.01	225
4	3	222.01	226
More than 4	3	222.01	227

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Health Habits Questionnaire

	Section	Sub-Section	Q#
In an average 2 days, how many servings of vegetables have you eaten?	3	228.01	228
None	3	228.01	228
1	3	228.01	229
2	3	228.01	230
3	3	228.01	231
4	3	228.01	232
More than 4	3	228.01	233
In an average 2 days, how many servings of eggs have you eaten?	3	234.01	234
None	3	234.01	234
1	3	234.01	235
2	3	234.01	236
3	3	234.01	237
4	3	234.01	238
More than 4	3	234.01	239
How many meals do you eat each day?	3	240.01	240
1	3	240.01	240
2	3	240.01	241
3	3	240.01	242
4	3	240.01	243
5	3	240.01	244
6	3	240.01	245
7	3	240.01	246
8	3	240.01	247
Other. Please type in	3	240.01	248
	3	249.00	249
Do you diet regularly	3	249.00	249
Do you have comments or concerns about dieting regularly? Please type in	3	249.00	250
	3	251.00	251
Are there certain food groups you do not like?	3	251.00	251
Do you have comments or concerns about not likeing certain food groups? Please type in	3	251.00	252
	3	253.00	253
Do you feel out of control of your eating patterns?	3	253.00	253
Do you have comments or concerns about feeling our of control of your eating patterns? Please type in	3	253.00	254
Have you ever tried to control your weight by excessive exercise?	3	255.01	255
Currently (last 6 months)	3	255.01	255
In the past (6 months ago or more)	3	255.01	256
Currently and the past	3	255.01	257
Never	3	255.01	258
Do you have any comments or concerns about controlling your weight by excessive exercise? Please type in	3	255.01	259

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Health Habits Questionnaire

	Section	Sub-Section	Q#
Have you ever tried to control your weight by vomiting?	3	260.01	260
Currently (last 6 months)	3	260.01	260
In the past (6 months ago or more)	3	260.01	261
Currently and in the past	3	260.01	262
Never	3	260.01	263
do you have any comments or concerns about controlling your weight by vomiting? Please type in	3	260.01	264
Have you ever tried to control your weight by using diet pills?	3	265.01	265
Currently (last 6 months)	3	265.01	265
In the past (6 months ago or more)	3	265.01	266
Currently and in the past	3	265.01	267
Never	3	265.01	268
Do you have any comments or concerns about controlling your weight by using diet pills? Please type in	3	265.01	269
Have you ever tried to control your weight by using laxatives?	3	270.01	270
Currently (started last 6 months)	3	270.01	270
In the past (6 months ago or more)	3	270.01	271
Currently and in the past	3	270.01	272
Never	3	270.01	273
Do you have any comments or concerns about controlling your weight by using laxatives? Please type in	3	270.01	274
Have you ever tried to control your weight by using diuretics?	3	275.01	275
Currently (last 6 months)	3	275.01	275
In the past (6 months ago or more)	3	275.01	276
Currently and in the past	3	275.01	277
Never	3	275.01	278
Do you have any comments or concerns about controlling your weight by using diuretics? Please type in	3	275.01	279
Have you ever tried to control your weight by dieting/fasting?	3	280.01	280
Currently (last 6 months)	3	280.01	280
In the past (6 months ago or more)	3	280.01	281
Currently and in the past	3	280.01	282
Never	3	280.01	283
Do you have any comments or concerns about controlling your weight by dieting/fasting? Please type in	3	280.01	284
Have you ever had an eating disorder?	3	285.01	285
Currently (last 6 months)	3	285.01	285
In the past (6 months ago or more)	3	285.01	286
Currently and in the past	3	285.01	287
Never	3	285.01	288
Please elaborate.....	3	285.01	289
Sports Nutritionist	3	290.01	290

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Health Habits Questionnaire

	Section	Sub-Section	Q#
Would you like to see the sports nutritionist?	3	290.01	290
Do you have questions or concerns for the sports nutritionist? Please type in	3	290.01	291

Alcohol Consumption

Have you in the past or do you currently use alcohol?	4	292.01	292
Currently use (started within last 6 months)	4	292.01	292
Have used in the past (6 months ago or more)	4	292.01	293
Currently use and have used in the past	4	292.01	294
Never	4	292.01	295
Have you in the past or are you currently being treated for an alcohol problem?	4	296.01	296
Currently use (started within last 6 months)	4	296.01	296
Have used in the past (6 months ago or more)	4	296.01	297
Currently use and have used in the past	4	296.01	298
Never	4	296.01	299
Other treatment history	4	300.01	300
I have received treatment for anxiety disorder.	4	300.01	300
I have received treatment for drug abuse.	4	300.01	301
I have received treatment for depression.	4	300.01	302
I have received treatment for manic depression.	4	300.01	303
I have received treatment for liver disease	4	300.01	304
I have received treatment for ulcers	4	300.01	305
I have received treatment for schizophrenia	4	300.01	306
How often do you have a drink containing alcohol in season?	4	307.01	307
Never	4	307.01	307
Monthly or less	4	307.01	308
2 to 4 times a month	4	307.01	309
2 to 3 times a week	4	307.01	310
4 or more times per week	4	307.01	311
How often do you have a drink containing alcohol out-of-season (during the school year)?	4	312.01	312
Never	4	312.01	312
Monthly or less	4	312.01	313
2 to 4 times a month	4	312.01	314
2 to 3 times a week	4	312.01	315
4 or more times per week	4	312.01	316
How often do you have a drink containing alcohol in the summer?	4	317.01	317
Never	4	317.01	317
Monthly or less	4	317.01	318
2 to 4 times a month	4	317.01	319
2 to 3 times a week	4	317.01	320
4 or more times per week	4	317.01	321

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Health Habits Questionnaire

	Section	Sub-Section	Q#
How many drinks containing alcohol do you have on a typical day when you are drinking in season?	4	322.01	322
0, 1, or 2	4	322.01	322
3 or 4	4	322.01	323
5 or 6	4	322.01	324
7 or 8	4	322.01	325
10 or more	4	322.01	326
How many drinks containing alcohol do you have on a typical day when you are drinking out-of-season (during the school year)?	4	327.01	327
0, 1, or 2	4	327.01	327
3 or 4	4	327.01	328
5 or 6	4	327.01	329
7 or 8	4	327.01	330
10 or more	4	327.01	331
How many drinks containing alcohol do you have on a typical day when you are drinking in the summer?	4	332.01	332
0, 1, or 2	4	332.01	332
3 or 4	4	332.01	333
5 or 6	4	332.01	334
7 or 8	4	332.01	335
10 or more	4	332.01	336
How often do you have four or more drinks on one occasion in season?	4	337.01	337
Never	4	337.01	337
Less than monthly	4	337.01	338
Monthly	4	337.01	339
Weekly	4	337.01	340
Daily or almost daily	4	337.01	341
How often do you have four or more drinks on one occasion out-of-season (during the school year)?	4	342.01	342
Never	4	342.01	342
Less than monthly	4	342.01	343
Monthly	4	342.01	344
Weekly	4	342.01	345
Daily or almost daily	4	342.01	346
How often do you have four or more drinks on one occasion in the summer?	4	347.01	347
Never	4	347.01	347
Less than monthly	4	347.01	348
Monthly	4	347.01	349
Weekly	4	347.01	350
Daily or almost daily	4	347.01	351
How often during the last year have you found that you were not able to stop drinking once you started?	4	352.01	352

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Health Habits Questionnaire

	Section	Sub-Section	Q#
Never	4	352.01	352
Less than monthly	4	352.01	353
Monthly	4	352.01	354
Weekly	4	352.01	355
Daily or almost daily	4	352.01	356
How often during the last year have you failed to do what was normally expected of you because of drinking?	4	357.01	357
Never	4	357.01	357
Less than monthly	4	357.01	358
Monthly	4	357.01	359
Weekly	4	357.01	360
Daily or almost daily	4	357.01	361
How often during the last year have you needed a first drink of alcohol in the morning to get yourself going after a heavy drinking session?	4	362.01	362
Never	4	362.01	362
Less than monthly	4	362.01	363
Monthly	4	362.01	364
Weekly	4	362.01	365
Daily or almost daily	4	362.01	366
How often during the last year have you had a feeling of guilt or remorse after drinking?	4	367.01	367
Never	4	367.01	367
Less than monthly	4	367.01	368
Monthly	4	367.01	369
Weekly	4	367.01	370
Daily or almost daily	4	367.01	371
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	4	372.01	372
Never	4	372.01	372
Less than monthly	4	372.01	373
Monthly	4	372.01	374
Weekly	4	372.01	375
Daily or almost daily	4	372.01	376
Have you or someone else been injured as a result of your drinking?	4	377.01	377
No	4	377.01	377
Yes, but not in the last year	4	377.01	378
Yes, in the last year	4	377.01	379
Has a relative or a friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	4	378.00	380
No	4	378.00	380
Yes, but not in the last year	4	378.00	381
Yes, in the last year	4	378.00	382

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Health Habits Questionnaire

	Section	Sub-Section	Q#
	4	383.01	382
Do you have a current injury that requires medical treatment?	4	383.01	382
If you do have a current injury that requires medical treatment, did you drink immediately prior to the injury?	4	383.01	383
Do you have comments or concerns about drinking immediately to the injury? Please type in	4	383.01	384
	4	388.01	388
Do you have any family members with alcohol use/abuse problems?	4	388.01	388
	4	388.02	389
Do you have comments or concerns about family members with alcohol use/abuse problems? Please type in	4	388.02	389
Do you have any concerns about a friend, roommate, teammate or family members having alcohol use/abuse problems?	4	390.01	390
	4	390.01	390
Please explain...	4	390.01	391
Have you recently thought of or attempted suicide?	4	392.01	392
	4	392.01	392
Do you have comments or concerns about recent thoughts of or attempted suicide? Please type in	4	392.02	393
Have you attempted suicide?	4	392.02	393
Discuss.....	4	392.02	393
Do you have any alcohol-related concerns that you would like to discuss with a medical professional?	4	394.01	394
	4	394.01	394
What are your questions or concerns that you would like to discuss with a medical professional? Pleast type in	4	394.01	395
I declare that all of the above information is true to the best of my knowledge	5	396.00	396
Print your name in the text box to digitally sign.	5	396.00	396

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Health History Questionnaire

	Section	Sub-Section	Q#
Personal History			
	1	1.01	0
What is your race or ethnic background?	1	1.01	0
What is your height?	1	1.01	0
What is your weight?	1	1.01	0
Are you right or left handed?	1	1.01	0
Information about your father	1	1.02	0
What is your father's name?	1	1.02	0
What is your father's age?	1	1.02	0
If your father is deceased, what was the cause of death?	1	1.02	0
If you father is deceased, what was his age at the time of death?	1	1.02	0
Information about your mother	1	1.03	0
What is your mother's name?	1	1.03	0
What is your mother's age?	1	1.03	0
If your mother is deceased, what was the cause of death?	1	1.03	0
If you mother is deceased, what was her age at the time of death?	1	1.03	0
Cardiovascular Risk Factors			
Have you ever had chest pain and/or shortness of breath during or after exercise / practice?	2	2.01	0
If Yes, Please Explain	2	2.01	0
Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice?	2	2.02	0
If Yes, Please Explain	2	2.02	0
Do you get tired more quickly than your teammates / friends do during exercise / practice?	2	2.03	0
If Yes, Please Explain	2	2.03	0
Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice?	2	2.04	0
If Yes, Please Explain	2	2.04	0
Have you ever been told that you have a heart murmur?	2	2.05	0
If Yes, Please Explain	2	2.05	0
Has any family member or relative died or heart problems and/or of sudden death before age 50?	2	2.06	0
If Yes, Please Explain	2	2.06	0
Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems?	2	2.07	0
If Yes, Please Explain	2	2.07	0
Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?	2	2.08	0
If Yes, Please Explain	2	2.08	0
Does anyone in your family have a history of high blood pressure?	2	2.09	0

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Health History Questionnaire

	Section	Sub-Section	Q#
If Yes, Please Explain	2	2.09	0
Have you ever been told that you have / had high blood pressure?	2	2.10	0
If Yes, Please Explain	2	2.10	0
Does anyone in your family have a history of high blood cholesterol?	2	2.11	0
If Yes, Please Explain	2	2.11	0
Have you even been told that you have / had high blood cholesterol?	2	2.12	0
If Yes, Please Explain	2	2.12	0

Allergies

Have You Ever Been Diagnosed With Seasonal Allergies?	3	3.01	0
If Yes, Please Explain	3	3.01	0
Are You Presently Taking/Have You Previously Taken Any Allergy Medications?	3	3.02	0
If Yes, Please Explain	3	3.02	0
Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications?	3	3.03	0
If Yes, Please Explain	3	3.03	0
Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items?	3	3.04	0
If Yes, Please Explain	3	3.04	0
Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.?	3	3.05	0
If Yes, Pleaes Explain	3	3.05	0

Asthma

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma?	4	4.01	0
If Yes, please describe the condition and list the dates of diagnosis.	4	4.01	0
Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler?	4	4.02	0
If Yes, Please List the Medication, Dosage & Frequency.	4	4.02	0
	4	4.03	0
How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week?	4	4.03	0
	4	4.04	0
How Many Acute Asthma Attacks Have You Had In The Past 12 Months?	4	4.04	0
Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma?	4	4.05	0
If yes, please list dates and circumstances.	4	4.05	0
	4	4.06	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition?	4	4.06	0

Head Injuries / Concussion

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Health History Questionnaire

	Section	Sub-Section	Q#
Have You Ever Suffered A Head Injury / Concussion (no matter how minor)?	5	5.01	0
If yes, please list dates and time missed due to the injuries.	5	5.01	0
Have You Ever Been Evaluated By A Doctor For A Head Injury / Concussion?	5	5.02	0
If yes, please provide details.	5	5.02	0
Were Any Diagnostic Tests Performed?	5	5.03	0
X-ray	5	5.03	0
CT-Scan	5	5.03	0
MRI	5	5.03	0
Neuro-Psychological Testing	5	5.03	0
Other	5	5.03	0
	5	5.04	0
Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion?	5	5.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion?	5	5.04	0
	5	5.05	0
Do You Suffer From Headaches?	5	5.05	0
If You Do Suffer From Headaches, How Often Do They Occur?	5	5.06	0
Every Day	5	5.06	0
1-2 Times Per Week	5	5.06	0
1-2 Times Per Month	5	5.06	0
If You Do Suffer From Headaches, Where do they occur?	5	5.07	0
Left Side of the Head	5	5.07	0
Right Side of the Head	5	5.07	0
Front of the Head	5	5.07	0
Back of the Head	5	5.07	0
All Over the Head	5	5.07	0
	5	5.08	0
Do You Have A History of Migraine Headaches?	5	5.08	0
If You Suffer From Migraine Headaches, How Often Do They Occur?	5	5.08	0
If You Suffer From Migraine Headaches, Please Describe Them.	5	5.08	0
If You Suffer From Migraine Headaches, Please List Any Medications You Take For Them.	5	5.08	0
Have You Had Headaches For More Than Three (3) Months?	5	5.08	0

Eye

When Was Your Last Eye Exam?	6	6.01	0
Date	6	6.01	0
Findings?	6	6.01	0
Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease?	6	6.03	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	6	6.03	0

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Health History Questionnaire

	Section	Sub-Section	Q#
If Yes, Were Any Diagnostic Tests Performed?	6	6.04	0
X-ray	6	6.04	0
CT-Scan	6	6.04	0
MRI	6	6.04	0
Other	6	6.04	0
Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury?	6	6.05	0
If Yes, Please Describe	6	6.05	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury?	6	6.06	0
If Yes, Please Describe	6	6.06	0
Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight?	6	6.07	0
If Yes, Please Describe	6	6.07	0
	6	6.08	0
Do you routinely wear glasses?	6	6.08	0
Do you routinely wear contact lenses?	6	6.09	0
If Yes, What Type?	6	6.09	0
Do you require any special devices / equipment?	6	6.10	0
If Yes, Please Describe	6	6.10	0

Ear / Nose / Throat

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat?	7	7.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	7	7.01	0
If You Have Suffered An Ear, Nose or Throat Injury, Were Any Diagnostic Tests Performed?	7	7.02	0
X-ray	7	7.02	0
CT-Scan	7	7.02	0
MRI	7	7.02	0
Other	7	7.02	0
Have You Ever Been Hospitalized For An Ear, Nose, and/or Throat Injury?	7	7.03	0
If Yes, Please Describe	7	7.03	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ear, Nose, and/or Throat Injury?	7	7.04	0
If Yes, Please Describe	7	7.04	0

Dental

When Was Your Last Dental Exam?	8	8.01	0
Please List Findings of That Exam.	8	8.01	0
Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth?	8	8.02	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	8	8.02	0
If Yes, Were Any Diagnostic Tests Performed?	8	8.03	0
X-ray	8	8.03	0

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Health History Questionnaire

	Section	Sub-Section	Q#
CT-Scan	8	8.03	0
MRI	8	8.03	0
Other	8	8.03	0
Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury?	8	8.04	0
If Yes, Please Describe	8	8.04	0

Cervical Spine / Neck

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck?	9	9.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	9	9.01	0
If Yes, Were Any Diagnostic Tests Performed?	9	9.02	0
X-ray	9	9.02	0
CT-Scan	9	9.02	0
MRI	9	9.02	0
Other	9	9.02	0
Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury?	9	9.03	0
If Yes, When, Where & Why?	9	9.03	0
Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries?	9	9.04	0
If Yes, Please List How Many & Any Time Missed.	9	9.04	0
Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers?	9	9.05	0
If Yes, Please List Dates & Describe.	9	9.05	0
Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck?	9	9.06	0
If Yes, Pelase List The Date, The Surgeon & Describe	9	9.06	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury?	9	9.07	0
If Yes, Please Describe	9	9.07	0
	9	9.08	0
Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate?	9	9.08	0
Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?	9	9.08	0

Shoulder / Upper Arm

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm?	10	10.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	10	10.01	0
If You Have Suffered A Shoulder or Upper Arm Injury, Were Any Diagnostic Tests performed?	10	10.02	0
X-ray	10	10.02	0
CT-Scan	10	10.02	0
MRI	10	10.02	0
Other	10	10.02	0
Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury?	10	10.03	0
If Yes, When, Where & Why?	10	10.03	0

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Health History Questionnaire

	Section	Sub-Section	Q#
Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm?	10	10.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	10	10.04	0
You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury?	10	10.05	0
If Yes, Please Describe	10	10.05	0

Elbow / Forearm

Have You Ever Suffered An Injury To Your Elbow / Forearm?	11	11.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	11	11.01	0
If You Have Suffered A Elbow or Forearm Injury, Were Any Diagnostic Tests performed?	11	11.02	0
X-ray	11	11.02	0
CT-Scan	11	11.02	0
MRI	11	11.02	0
Other	11	11.02	0
Have You Ever Been Hospitalized For An Elbow / Forearm Injury?	11	11.03	0
If Yes, When, Where & Why?	11	11.03	0
Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm?	11	11.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	11	11.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Elbow / Forearm Injury?	11	11.05	0
If Yes, Please Describe	11	11.05	0

Wrist, Hand, & Fingers

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)?	12	12.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	12	12.01	0
If You Have Suffered An Injury to Your Wrist, Hand or Fingers, Were Any Diagnostic Tests Performed?	12	12.02	0
X-ray	12	12.02	0
CT-Scan	12	12.02	0
MRI	12	12.02	0
Other	12	12.02	0
Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury?	12	12.03	0
If Yes, When, Where & Why?	12	12.03	0
Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)?	12	12.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	12	12.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury?	12	12.05	0
If Yes, Please Describe	12	12.05	0

Spine / Low Back / Sacroiliac Joint

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint?	13	13.01	0

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Health History Questionnaire

	Section	Sub-Section	Q#
If Yes, List Dates, Time Missed & A Description Of The Disorder	13	13.01	0
If You Have Suffered An Injury to Your Spine, Low Back or Sacroilliac Joint, Were Any Diagnostic Tests Performed?	13	13.02	0
X-ray	13	13.02	0
CT-Scan	13	13.02	0
MRI	13	13.02	0
Other	13	13.02	0
Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury?	13	13.03	0
If Yes, When, Where & Why?	13	13.03	0
Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint?	13	13.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	13	13.04	0
Have You Ever Had Numbness/Tingling Down One (1) or Both Legs?	13	13.05	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	13	13.05	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury?	13	13.06	0
If Yes, Please Describe	13	13.06	0

Hip / Groin

Have You Ever Suffered An Injury To Your Hip / Groin (including hernias and/or sports hernias)?	14	14.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	14	14.01	0
If You Have Suffered An Injury to Your Hip or Groin, Were Any Diagnostic Tests Performed?	14	14.02	0
X-ray	14	14.02	0
CT-Scan	14	14.02	0
MRI	14	14.02	0
Other	14	14.02	0
Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury?	14	14.03	0
If Yes, When, Where & Why?	14	14.03	0
Have You Ever Had Surgery For A Hip / Groin Injury?	14	14.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	14	14.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury?	14	14.05	0
If Yes, Please Describe	14	14.05	0

Thigh / Hamstring / Quadriceps

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps?	15	15.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	15	15.01	0
If You Have Suffered An Injury to Your Thigh, Hamstring Or Quadriceps, Were Any Diagnostic Tests Performed?	15	15.02	0
X-Ray	15	15.02	0
CT-Scan	15	15.02	0

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Health History Questionnaire

	Section	Sub-Section	Q#
MRI	15	15.02	0
Other	15	15.02	0
Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury?	15	15.03	0
If Yes, When, Where & Why?	15	15.03	0
Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury?	15	15.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	15	15.04	0
You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury?	15	15.05	0
If Yes, Please Describe	15	15.05	0

Knee / Patella

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)?	16	16.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	16	16.01	0
If You Have Suffered An Injury to Your Knee Or Patella, Were Any Diagnostic Tests Performed?	16	16.02	0
X-Ray	16	16.02	0
CT-Scan	16	16.02	0
MRI	16	16.02	0
Other	16	16.02	0
Have You Ever Been Hospitalized For A Knee and/or Patella Injury?	16	16.03	0
If Yes, When, Where & Why?	16	16.03	0
Have You Ever Had Surgery For A Knee and/or Patella Injury?	16	16.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	16	16.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury?	16	16.05	0
If Yes, Please Describe	16	16.05	0
Have You Ever/Do You Presently Wear A Knee Brace?	16	16.06	0
If Yes, Which Knee, Which Brand & Model & What Is The Reason For Wearing?	16	16.06	0

Ankle / Lower Leg

Have You Ever Suffered An Injury To Your Ankle / Lower Leg?	17	17.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	17	17.01	0
If You Have Suffered An Injury to Your Ankle Or Lower Leg, Were Any Diagnostic Tests Performed?	17	17.02	0
X-Ray	17	17.02	0
CT-Scan	17	17.02	0
MRI	17	17.02	0
Other	17	17.02	0
Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury?	17	17.03	0
If Yes, When, Where & Why?	17	17.03	0
Have You Ever Had Surgery For An Ankle / Lower Leg Injury?	17	17.04	0

	Section	Sub-Section	Q#
If Yes, Pelase List The Date, The Surgeon & Describe	17	17.04	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury?	17	17.05	0
If Yes, Please Describe	17	17.05	0
Do you Presently	17	17.06	0
Wear Ankle Brace(s)	17	17.06	0
Tape Your Ankle(s)	17	17.06	0
Other	17	17.06	0

Foot / Toes

Have You Ever Suffered An Injury To Your Foot / Toe(s)?	18	18.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	18	18.01	0
If You Have Suffered An Injury to Your Foor Or Toe(s), Were Any Diagnostic Tests Performed?	18	18.02	0
X-Ray	18	18.02	0
CT-Scan	18	18.02	0
MRI	18	18.02	0
Other	18	18.02	0
Have You Ever Had Surgery For A Foot / Toe Injury?	18	18.03	0
If Yes, Pelase List The Date, The Surgeon & Describe	18	18.03	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Foot and/or Toe Injury?	18	18.04	0
If Yes, Please Describe	18	18.04	0

Ribs / Thorax / Chest

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest?	19	19.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	19	19.01	0
If You Have Suffered An Injury to Your Ribs, Thorax Or Chest, Were Any Diagnostic Tests Performed?	19	19.02	0
X-Ray	19	19.02	0
CT-Scan	19	19.02	0
MRI	19	19.02	0
Other	19	19.02	0
Have You Ever Had Surgery For A Rib / Thorax / Chest Injury?	19	19.03	0
If Yes, Pelase List The Date, The Surgeon & Describe	19	19.03	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury?	19	19.04	0
If Yes, Please Describe	19	19.04	0

Abdomen

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum?	20	20.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	20	20.01	0

ATS Athlete Forms Library

Health History Questionnaire

	Section	Sub-Section	Q#
Have You Ever Suffered An Injury To Your Abdomen?	20	20.02	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	20	20.02	0
If You Have Suffered An Injury to Your Abdomen, Were Any Diagnostic Tests Performed?	20	20.03	0
X-Ray	20	20.03	0
CT-Scan	20	20.03	0
MRI	20	20.03	0
Other	20	20.03	0
Have You Ever Had Surgery For An Abdomen Injury?	20	20.04	0
If Yes, Pelase List The Date, The Surgeon & Describe	20	20.04	0
Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain?	20	20.05	0
If Yes, Please Describe	20	20.05	0
Do you Routinely Suffer From Chronic or Recurrent Diarrhea?	20	20.06	0
If Yes, Please Describe	20	20.06	0
Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)?	20	20.07	0
If Yes, Please Describe	20	20.07	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury?	20	20.08	0
If Yes, Please Describe	20	20.08	0

Medical Testing

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)?	21	21.01	0
If Yes, List Dates, Time Missed & A Description Of The Disorder	21	21.01	0

Dermatological

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)?	22	22.01	0
If Yes, Please Describe	22	22.01	0
Have you ever been under the care of a dermatologist for any condition?	22	22.02	0
If Yes, Please Describe	22	22.02	0
Have you ever been advised not to participate in athletic activities due to a skin condition?	22	22.03	0
If Yes, Please Describe	22	22.03	0

Prescription Medications

Have You Taken Any Prescription Medications During The Past Two Years?	23	23.01	0
If Yes, Please List ALL Prescription & Over-the-Counter Medications That You Are CURRENTLY Taking or Have Taken In The PAST Two (2) Years. For Each Medication, Please List the Medication's Name, Purpose, Dosage and Dates Taken.	23	23.01	0

ATS Athlete Forms Library

Health History Questionnaire

	Section	Sub-Section	Q#
Supplements / Ergogenic Aids			
Have You Taken Any Supplements Or Ergogenic Aids During The Past Two Years?	24	24.01	0
If Yes, Please List ALL Supplements / Ergogenic Aids That You Are CURRENTLY Taking or Have Taken In The PAST Two (2) Years, & For What Purpose:	24	24.01	0
Heat Related Problems			
Have You Ever Suffered From Any Of The Following Heat Related Injuries? If Yes, Please Explain	25	25.01	0
Heat Cramps	25	25.01	0
Heat Syncope (Fainting)	25	25.01	0
Heat Exhaustion	25	25.01	0
Heat Stroke	25	25.01	0
Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem?	25	25.02	0
If Yes, Please List The Date(s)	25	25.02	0
Have You Ever Been Hospitalized For a Heat-Related Problem?	25	25.03	0
If Yes, When, Where & Why?	25	25.03	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury?	25	25.04	0
If Yes, Please Explain	25	25.04	0
Diabetic History			
Have You Ever Been Diagnosed With Diabetes?	26	26.01	0
If Yes, Please List The Date Of The Diagnosis	26	26.01	0
Are You Presently Taking or Have You Taken Any Diabetic Medications?	26	26.02	0
If Yes, Please List Medication, The Form of Delivery, The Dosage & The Frequency The Medication Is Taken	26	26.02	0
Do You Daily Monitor Your Blood Sugar Level?	26	26.03	0
If Yes, How Many Times A Day Do You Check It & What Is Your Average Level?	26	26.03	0
Have You Had Your A1C Level Checked Within The Last Three (3) Months?	26	26.04	0
If Yes, What Was The Level?	26	26.04	0
Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months?	26	26.05	0
If Yes, Please Describe	26	26.05	0
Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes?	26	26.06	0
If Yes, Please Describe	26	26.06	0
	26	26.07	0
Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:	26	26.07	0
Sickle Cell Anemia			

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Health History Questionnaire

	Section	Sub-Section	Q#
Have you ever been tested for Sickle Cell Anemia that you are aware of?	27	27.01	0
If Yes, Please List The Date & Finding.	27	27.01	0
Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of?	27	27.02	0
If Yes, Please Describe	27	27.02	0
Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia?	27	27.03	0
If Yes, Please Describe	27	27.03	0

For Females Only

	28	28.01	0
At what age did you have your first menstrual period?	28	28.01	0
How Many Mentrual Periods Have You Had Within The Last 12 Months?	28	28.01	0
When was your most recent menstrual period?	28	28.01	0
How much time do you usually have from the start of one period to the start of another?	28	28.01	0
What Was The Longest Time Between Menstrual Periods Within The Past Year?	28	28.01	0
Do You Have Painful Or Heavy Menstrual Periods?	28	28.01	0
Do You Take Any Medications During Your Menstrual Periods?	28	28.02	0
If Yes, What Medication Do You Take	28	28.02	0
Do you take birth control pills?	28	28.03	0
If Yes, What Brand	28	28.03	0
Have you ever had any problems with your breasts?	28	28.04	0
If Yes, Please Describe	28	28.04	0
Have you had a pelvic examination within the last year?	28	28.05	0
If Yes, Please List Date & Findings	28	28.05	0

Miscellaneous

	29	29.01	0
All Answers Are Strictly Confidential & Will Not Be Shared With Parents Or Coaches.			
Have you ever had any injury or illness other than those already noted?	29	29.11	0
If Yes, Please Describe	29	29.11	0
Do you have any ongoing or chronic illnesses?	29	29.12	0
If Yes, Please Describe	29	29.12	0
Have you ever been hospitalized overnight?	29	29.13	0
If Yes, Please Describe	29	29.13	0
Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?	29	29.14	0
If Yes, Please Describe	29	29.14	0
Are you currently under a physician's care for any medical conditions?	29	29.15	0
If Yes, Please Describe	29	29.15	0

ATS Athlete Forms Library

Health History Questionnaire

	Section	Sub-Section	Q#
Have you consulted and/or been under the care of a hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?	29	29.16	0
If Yes, Please Describe	29	29.16	0
Are there any issues/concerns (i.e. death of significant person, relationship issues, divorce of parents, school difficulties) that may impact your ability to function at school?	29	29.17	0
If Yes, Please Describe	29	29.17	0
Have you ever been under the care of a psychiatrist, psychologist, or counselor?	29	29.18	0
If Yes, Please Describe	29	29.18	0
Have you ever had a rash or hives develop during and/or after exercise?	29	29.19	0
If Yes, Please Describe	29	29.19	0
Do you cough, wheeze, or have trouble breathing during or after exercise / practice?	29	29.20	0
If Yes, Please Describe	29	29.20	0
Have you ever been told that you have kidney disease?	29	29.21	0
If Yes, Please Describe	29	29.21	0
Have you ever had rubella (“German Measles”) and/or Rubeola (“red measles”)?	29	29.22	0
If Yes, Please Describe	29	29.22	0
Have you ever had a stomach and/or duodenal ulcer?	29	29.23	0
If Yes, Please Describe	29	29.23	0
Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?	29	29.24	0
If Yes, Please Describe	29	29.24	0
Have you ever had seizures, convulsions, and/or epilepsy?	29	29.25	0
If Yes, Please Describe	29	29.25	0
Have you ever had gall bladder disease and/or a urinary problem?	29	29.26	0
If Yes, Please Describe	29	29.26	0
Do you have ringing in your ears or trouble hearing?	29	29.27	0
If Yes, Please Describe	29	29.27	0
Do you have frequent ear infections or nosebleeds?	29	29.28	0
If Yes, Please Describe	29	29.28	0
Have you ever had an abnormal chest x-ray and/or pneumonia?	29	29.29	0
If Yes, Please Describe	29	29.29	0
Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)	29	29.30	0
If Yes, Please Describe	29	29.30	0
Have you ever had the chickenpox?	29	29.31	0
If Yes, When?	29	29.31	0
Are you aware of any reasons why you should not participate in intercollegiate athletics at the University of Akron at this time?	29	29.32	0
If Yes, Please Describe	29	29.32	0
Have you had a tetanus booster within the past five (5) years?	29	29.33	0

ATS Athlete Forms Library

Health History Questionnaire

	Section	Sub-Section	Q#
If Yes, When?	29	29.33	0
Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)?	29	29.34	0
If Yes, When?	29	29.34	0
Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?	29	29.35	0
If Yes, Please Describe	29	29.35	0
Do you use alcohol?	29	29.36	0
If Yes, How Often?	29	29.36	0
Have you ever used / tried marijuana, cocaine, or any other illicit “street” drugs?	29	29.37	0
If Yes, Please Describe	29	29.37	0
Do you have any questions regarding drugs, tobacco, or alcohol?	29	29.38	0
If Yes, Please Describe	29	29.38	0
Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?	29	29.39	0
If Yes, Please Describe	29	29.39	0
Are you a vegetarian?	29	29.40	0
If Yes, What Type?	29	29.40	0
Do you regularly lose weight to participate in your sport?	29	29.41	0
If Yes, Please Describe	29	29.41	0
Do you want to weigh more or less than you presently do?	29	29.42	0
If Yes, Please Describe	29	29.42	0
Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?	29	29.43	0
If Yes, Please Describe	29	29.43	0
Have you had a history of anorexia, bulimia, purging, and/or any other eating disorders?	29	29.44	0
If Yes, Please Describe	29	29.44	0
Would you like to meet with a sports nutrition expert to discuss your nutritional needs or eating habits?	29	29.45	0
If Yes, Please Describe	29	29.45	0
Do you feel stressed?	29	29.46	0
If yes, do you feel as you get necessary support to deal with your stress?	29	29.46	0
	29	29.47	0
How do you cope with stress?	29	29.47	0
	29	29.50	0
Please describe any further injury information, which is knowledgeable to you and not required on this form.	29	29.50	0

Statements

	30	30.01	0

ATS Athlete Forms Library

Health History Questionnaire

	Section	Sub-Section	Q#
I hereby acknowledge, affirm, and represent that all statements in this form are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted	30	30.01	0
By typing your full name here, you agree to the above statement.	30	30.01	0

ATS Athlete Forms Library

Health Improvement Program

CENTRAL HEALTH IMPROVEMENT PROGRAM

	Section	Sub-Section	Q#
	1	1.01	1
Date of Birth	1	1.01	1
	1	1.02	2
Campus ID# or Last 4 SS#	1	1.02	2
	1	1.03	3
Address	1	1.03	3
	1	1.04	4
Home Phone	1	1.04	4
	1	1.05	5
Work Phone	1	1.05	5
	1	1.06	6
Employee Group Classification	1	1.06	6
	1	1.07	7
Supervisor	1	1.07	7
	1	1.08	8
Department	1	1.08	8
	1	1.09	9
Shift	1	1.09	9
	1	1.10	10
Injured body part	1	1.10	10
	1	1.11	11
Cause of injury/problem	1	1.11	11
Have you ever had this problem before?	1	1.12	12
If yes, what was done for it?	1	1.12	12
Are you seeing any other health care professional about this problem now	1	1.13	13
If yes, from who?	1	1.13	13
	1	1.14	14
Please list all prescription medications you have taken in the past 6 months and the reason for taking them.	1	1.14	14
	1	1.15	15
Please list any information not already on this form we should be aware of prior to treating or rehabilitating your injury.	1	1.15	15
	1	1.16	16
The undersigned hereby affirms the above information is correct to the best of his/her knowledge:	1	1.16	16
	1	1.17	17
Please enter todays date	1	1.17	17

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Immunizations (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
	1	1.01	1
New York State Law requires compliance with the MMR and meningitis law. Furthermore, it is an institutional decision to mandate compliance with tetanus and diphtheria immunization, or booster, when appropriate. Student-athletes have 30 days from the start of the academic year to provide proof of current immunization. Failure to provide documentation of any New York State or Institutional required immunizations will result in removal of clearance from all varsity athletics. For more information on immunizations, please visit the Centers for Disease Control and Prevention (CDC) website at: www.cdc.gov/vaccines/pubs/vis/default.htm	1	1.01	1
The NCAA recommends all of the above immunizations as well as Hepatitis B. Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. For more information, please visit the Vaccine Information Statement (VIS) from the CDC regarding hepatitis B at: www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf	1	1.01	2
I have read the information regarding hepatitis B disease. I understand the risks of not receiving the vaccine, and can contact my health care provider or Student Health Services to schedule an appointment to receive the immunization.			
	1	1.10	4
Please choose one of the two options:	1	1.10	4

ATS Athlete Forms Library

ImPact Consent

	Section	Sub-Section	Q#
Information			
XXX is currently implementing an innovative program for our student-athletes. This program will assist our team physicians and athletic trainer in evaluating and treating concussions and other head injuries. In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized by most professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.	1	1.10	1
The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in “video-game” type format and takes about 15-20 minutes to complete. It is simple and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It is not an IQ test.			
If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to a local doctor to help evaluate the injury. The test data will enable concussion professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.			
I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. There is no cost to the parent for any ImPACT testing done on campus. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. XXX administration and coaching staff are striving to keep your child’s health and safety at the forefront of the student athletic experience. If you have any further questions regarding this program please feel free to contact me.			
Verification			
I have read the attached information regarding Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT) for use in the care and treatment of concussions and understand its contents. I understand I can contact the athletic trainer at XXX with any questions regarding ImPACT or the district’s Concussion Management Plan at any time. My signature below indicates my willingness to allow my son/daughter to participate in the baseline and, if required, post-concussion testing.	2	2.10	5

ATS Athlete Forms Library

Improvement Program Re-Treatment Form

	Section	Sub-Section	Q#
CENTRAL HEALTH IMPROVEMENT PROGRAM			
	1	1.01	1
Date of Birth	1	1.01	1
	1	1.02	2
Campus ID# or Last 4 SS#	1	1.02	2
	1	1.03	3
Address	1	1.03	3
	1	1.04	4
Home Phone	1	1.04	4
	1	1.05	5
Work Phone	1	1.05	5
	1	1.06	6
Employee Group Classification	1	1.06	6
	1	1.07	7
Supervisor	1	1.07	7
	1	1.08	8
Department	1	1.08	8
	1	1.09	9
Shift	1	1.09	9
	1	1.10	10
Injured body part	1	1.10	10
	1	1.11	11
Cause of injury/problem	1	1.11	11
Have you ever had this problem before?	1	1.12	12
If yes, what was done for it?	1	1.12	12
Are you seeing any other health care professional about this problem now	1	1.13	13
If yes, from who?	1	1.13	13
	1	1.14	14
Please list all prescription medications you have taken in the past 6 months and the reason for taking them.	1	1.14	14
	1	1.15	15
Please list any information not already on this form we should be aware of prior to treating or rehabilitating your injury.	1	1.15	15
	1	1.16	16
The undersigned hereby affirms the above information is correct to the best of his/her knowledge:	1	1.16	16
	1	1.17	17
Please enter todays date	1	1.17	17

ATS Athlete Forms Library

Insurance Questionnaire

	Section	Sub-Section	Q#
	1	1.01	1
Does this insurance cover durable medical equipment?	1	1.01	1
	1	1.02	2
Does this insurance require a referral for treatment?	1	1.02	2
	1	1.03	3
Does this insurance cover athletic related injuries?	1	1.03	3
	1	1.04	4
Does this insurance have out of network benefits?	1	1.04	4
	1	1.05	5
Does this insurance require co-pay for office visits?	1	1.05	5
Does this insurance require you to pay a deductible?	1	1.06	6
If so what is the deductible amount?	1	1.06	6
	1	1.07	7
Does this insurance require pre-authorization for service?	1	1.07	7
	1	1.08	8
Do you participate in a prescription medicine plan?	1	1.08	8
	1	1.09	9
Does this insurance have out of network benefits?	1	1.09	9

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Lower Extremity Functional Scale

	Section	Sub-Section	Q#
Instructions	1	1.10	1
We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.			
We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.			
Use the following scale when answering these questions: --- 0 = Extreme difficulty or unable to perform 1 = Quite a bit of difficulty 2 = Moderate difficulty 3 = A little bit of difficulty 4 = No difficulty			
Use the following scale when answering these questions: --- 0 = Extreme difficulty or unable to perform 1 = Quite a bit of difficulty 2 = Moderate difficulty 3 = A little bit of difficulty 4 = No difficulty			

Activities

Today, do you or would you have any difficulty at all with:	2	2.10	2
Any of your usual work, housework or school activities?	2	2.10	2
Any of your usual work, housework or school activities?	2	2.10	2
Your usual hobbies, recreational or sporting activities?	2	2.10	2
Your usual hobbies, recreational or sporting activities?	2	2.10	2
Getting into or out of the bath?	2	2.10	3
Getting into or out of the bath?	2	2.10	3
Walking between rooms?	2	2.10	4
Walking between rooms?	2	2.10	4
Putting on your shoes or socks?	2	2.10	5
Putting on your shoes or socks?	2	2.10	5
Squatting?	2	2.10	6
Squatting?	2	2.10	6
Lifting an object, like a bag of groveries from the floor?	2	2.10	7
Lifting an object, like a bag of groveries from the floor?	2	2.10	7
Performing light activities around your home?	2	2.10	8
Performing light activities around your home?	2	2.10	8
Perform heavy activities around your home?	2	2.10	9
Perform heavy activities around your home?	2	2.10	9
Getting into or out of a car?	2	2.10	10
Getting into or out of a car?	2	2.10	10
Walking 2 blocks?	2	2.10	11

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Lower Extremity Functional Scale

	Section	Sub-Section	Q#
Walking 2 blocks?	2	2.10	11
Walking a mile?	2	2.10	12
Walking a mile?	2	2.10	12
Going up or down 10 stairs (about 1 flight of stairs)?	2	2.10	13
Going up or down 10 stairs (about 1 flight of stairs)?	2	2.10	13
Standing for 1 hour?	2	2.10	14
Standing for 1 hour?	2	2.10	14
Sitting for 1 hour?	2	2.10	15
Sitting for 1 hour?	2	2.10	15
Running on even ground?	2	2.10	16
Running on even ground?	2	2.10	16
Running on uneven ground?	2	2.10	17
Running on uneven ground?	2	2.10	17
Making sharp turns while running fast?	2	2.10	18
Making sharp turns while running fast?	2	2.10	18
Hopping?	2	2.10	19
Hopping?	2	2.10	19
Rolling over in bed?	2	2.10	20
Rolling over in bed?	2	2.10	20

Activities Total

Today, do you or would you have any difficulty at all with:	3	3.10	21
Enter the sum/total of the previous 20 questions (Max is 80):	3	3.10	21
Enter the sum/total of the previous 20 questions (Max is 80):	3	3.10	21

Credits

Source: Binkley JM, Stratford PW, Lott SA, Riddle DL. The Lower Extremity Functional Scale (LEFS): scale development, measurement properties, and clinical application. North American Orthopaedic Rehabilitation Research Network. Phys Ther. 1999 Apr;79(4):371-83.	22	22.10	22
The Lower Extremity Functional Scale (LEFS) is a questionnaire containing 20 questions about a person's ability to perform everyday tasks. The LEFS can be used by clinicians as a measure of patients' initial function, ongoing progress and outcome, as well as to set functional goals. The LEFS can be used to evaluate the functional impairment of a patient with a disorder of one or both lower extremities. It can be used to monitor the patient over time and to evaluate the effectiveness of an intervention.			
The Lower Extremity Functional Scale (LEFS) is a questionnaire containing 20 questions about a person's ability to perform everyday tasks. The LEFS can be used by clinicians as a measure of patients' initial function, ongoing progress and outcome, as well as to set functional goals. The LEFS can be used to evaluate the functional impairment of a patient with a disorder of one or both lower extremities. It can be used to monitor the patient over time and to evaluate the effectiveness of an intervention.			

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Medical Consent

	Section	Sub-Section	Q#
TERMINOLOGY:			
	1	1.10	1

Medical Consent:
To permit the xxx University Athletic Training Staff, team physician(s), and University Health Center medical staff to treat any injury that may occur during your active enrollment and athletic participation at
xxx University.

Release of Information:
To permit the release of any medical information or records to the xxx University Athletic Training Staff, team physician(s), or consulting physicians from the University Health Center, which may be forwarded on to your coach or a professional scout concerning your health, welfare and your status for participation in your sport in
the immediate or distant future.

Shared Responsibility for Sport Safety:
Shows that you recognize that there are certain inherent risks that are possible when participating in intercollegiate athletics. As a xxx University athlete, you are willing to take responsibility for the potential risks that may occur while participating in xxx University Athletics.

MEDICAL CONSENT:

2 2.10 2

I give permission to the xxxUniversity team physician(s) and/or consulting physicians as well as the xxx University Athletic Training Staff to render any treatment that may be necessary to the health and well-being of my son, daughter, or myself. By authorizing the medical staff to render the necessary medical services, I understand that this may include treatment such as medical or surgical care that may need to be provided by the attending team physician(s) or consulting physician.

Also, by permitting necessary treatment for my son, daughter, myself, I realize that I am authorizing the xxx University Athletic Training Staff to render any treatment that may fall under the headings of preventive first-aid, rehabilitation, and emergency treatment. During these instances, the Certified Athletic Trainer will be working under the supervision of the xxx University team physician(s) and/or consulting physician(s).

I also realize that by giving my consent for the proper care of my son, daughter, or myself, I am giving consent for hospitalization when necessary at an accredited hospital.

AUTHORIZATION FOR RELEASE OF INFORMATION

3 3.10 3

ATS Athlete Forms Library

Medical Consent

	Section	Sub-Section	Q#
In signing the release of information form, I am authorizing the University Health Center to release medical information on my son, daughter, or myself to the xxx Athletic Training Staff, team physician(s), or consulting physician(s) concerning my health and welfare or status for participation in my sport. This medical information may relate to the student-athlete's past, present, and future injuries or illnesses that may occur or have already occurred while participating in intercollegiate athletics at xxx University. Also, by giving the authorization for the release of medical information, I am permitting the xxx University Athletic Training Staff, team physician(s), or consulting physician(s) to disclose information concerning my health and welfare or status for participation in my sport in the immediate or distant future to coaches or professional scouts if the need or opportunity arises. This information is normally confidential and will not be otherwise released. This release remains valid until revoked by the student-athlete in writing.	3	3.10	3

SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in sport requires an acceptance of risk or injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them. The NCAA and individual sport-governing bodies make periodic analysis of injury patterns, refinements in the rules, and other safety decisions. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself, and to rely on officials to enforce compliance with the rule book is insufficient as to rely on warning labels to produce compliance with safety guidelines . "Compliance" means respect on everyone's part for the intent and purpose of a rule of guideline. I have read the above shared responsibility statement. I understand there are certain inherent risks involved in participating in intercollegiate athletics such as physical injury, permanent disability, paralysis or possibly death. I acknowledge the responsibility for such risks while participating in xxx University Athletics.	4	4.10	4
If student ia a minor signature of parent guardian is required:	5	5.10	5

ATS Athlete Forms Library

Medical History

Questions

	Section	Sub-Section	Q#
	1	1.10	1
Are you currently under a physicians care?	1	1.10	1
Are you currently under a physicians care?	1	1.10	1
Are you currently under any resricitions for athletic participation?	1	1.10	2
Are you currently under any resricitions for athletic participation?	1	1.10	2
Have you ever been advised by a physician to not participate in sports?	1	1.10	3
Have you ever been advised by a physician to not participate in sports?	1	1.10	3
In the past year, have you had an illness that has required hospitalization?	1	1.10	4
In the past year, have you had an illness that has required hospitalization?	1	1.10	4
	1	1.11	5
Do you have one of any paired organs? (ie eye, kidneys, testicles,ovaries)	1	1.11	5
Do you have one of any paired organs? (ie eye, kidneys, testicles,ovaries)	1	1.11	5
If yes, please provide more details	1	1.11	6
If yes, please provide more details	1	1.11	6
	1	1.14	7
Do you have any skin conditions?	1	1.14	7
Do you have any skin conditions?	1	1.14	7
If yes, please provide more details	1	1.14	8
If yes, please provide more details	1	1.14	8
	1	1.15	9
Have you developed diabetes?	1	1.15	9
Have you developed diabetes?	1	1.15	9
If yes, please enter the type	1	1.15	10
If yes, please enter the type	1	1.15	10
	1	1.20	11
Do you have any medication or drug allergies?	1	1.20	11
Do you have any medication or drug allergies?	1	1.20	11
If yes, please provide more details	1	1.20	12
If yes, please provide more details	1	1.20	12
	1	1.22	13
Do you have any allergies to insect bites/stings?	1	1.22	13
Do you have any allergies to insect bites/stings?	1	1.22	13
If yes, please provide more details	1	1.22	14
If yes, please provide more details	1	1.22	14
	1	1.24	15
Are you allergic to anything else?	1	1.24	15
Are you allergic to anything else?	1	1.24	15
If yes, please provide the name of the medication used	1	1.24	16
If yes, please provide the name of the medication used	1	1.24	16
	1	1.27	17

ATS Athlete Forms Library

Medical History

	Section	Sub-Section	Q#
Do you wear corrective eyewear? (glasses, contacts, protective eyewear)	1	1.27	17
Do you wear corrective eyewear? (glasses, contacts, protective eyewear)	1	1.27	17
If yes, please provide more details	1	1.27	18
If yes, please provide more details	1	1.27	18
	1	1.30	19
Do you wear protective eyewear during athletic competition?	1	1.30	19
Do you wear protective eyewear during athletic competition?	1	1.30	19
	1	1.33	20
Do you have any hearing impairments?	1	1.33	20
Do you have any hearing impairments?	1	1.33	20
	1	1.36	19
Do you wear any dental appliances? (ie crown, bridge, full/partial plate)	1	1.36	19
Do you wear any dental appliances? (ie crown, bridge, full/partial plate)	1	1.36	19
If yes, please provide more details	1	1.36	20
If yes, please provide more details	1	1.36	20
	1	1.39	21
Have you ever been tested for or diagnosed with sickle cell trait?If yes, includedocumentation	1	1.39	21
Have you ever been tested for or diagnosed with sickle cell trait?If yes, includedocumentation	1	1.39	21
	1	1.42	22
Have you ever been told you have a hernia?	1	1.42	22
Have you ever been told you have a hernia?	1	1.42	22
if yes, was it surgically repaired?	1	1.42	23
if yes, was it surgically repaired?	1	1.42	23
	1	1.48	24
Have you ever been treated for anemia?	1	1.48	24
Have you ever been treated for anemia?	1	1.48	24
If yes, enter the dates here	1	1.48	25
If yes, enter the dates here	1	1.48	25
	1	1.51	26
Have you been treated for hepatitis?	1	1.51	26
Have you been treated for hepatitis?	1	1.51	26
If yes, enter the dates here	1	1.51	27
If yes, enter the dates here	1	1.51	27
	1	1.54	28
Have you ever been treated for mononucleosis?	1	1.54	28
Have you ever been treated for mononucleosis?	1	1.54	28
If yes, enter the dates here	1	1.54	29
If yes, enter the dates here	1	1.54	29
	1	1.57	30

ATS Athlete Forms Library

Medical History

	Section	Sub-Section	Q#
Have you ever have a positive TB skin test?	1	1.57	30
Have you ever have a positive TB skin test?	1	1.57	30
If yes, enter the dates here	1	1.57	31
If yes, enter the dates here	1	1.57	31
	1	1.60	32
Have you ever had chicken pox?	1	1.60	32
Have you ever had chicken pox?	1	1.60	32
If yes, enter the dates here	1	1.60	33
If yes, enter the dates here	1	1.60	33
	1	1.63	34
Have you ever been treated for Chron's disease/collitis?	1	1.63	34
Have you ever been treated for Chron's disease/collitis?	1	1.63	34
If yes, enter the dates here	1	1.63	35
If yes, enter the dates here	1	1.63	35
	1	1.66	36
Have you ever been treated for measles?	1	1.66	36
Have you ever been treated for measles?	1	1.66	36
If yes, enter the dates here	1	1.66	37
If yes, enter the dates here	1	1.66	37
	1	1.69	38
Have you ever been treated for H1N1?	1	1.69	38
Have you ever been treated for H1N1?	1	1.69	38
If yes, enter the dates here	1	1.69	39
If yes, enter the dates here	1	1.69	39
	1	1.72	40
Have you ever been treated for thyroid diease?	1	1.72	40
Have you ever been treated for thyroid diease?	1	1.72	40
If yes, enter the dates here	1	1.72	41
If yes, enter the dates here	1	1.72	41
	1	1.75	42
Have you ever been diagnosed with cancer?	1	1.75	42
Have you ever been diagnosed with cancer?	1	1.75	42
If yes, enter the dates here	1	1.75	43
If yes, enter the dates here	1	1.75	43
	1	1.78	44
Have you ever been treated for disordered eating?	1	1.78	44
Have you ever been treated for disordered eating?	1	1.78	44
If yes, enter the dates here	1	1.78	45
If yes, enter the dates here	1	1.78	45
	1	1.81	46
Have you ever been treated for anxiety/phobias?	1	1.81	46

ATS Athlete Forms Library

Medical History

	Section	Sub-Section	Q#
Have you ever been treated for anxiety/phobias?	1	1.81	46
If yes, enter the dates here	1	1.81	47
If yes, enter the dates here	1	1.81	47
	1	1.84	48
Have you ever been treated for depression?	1	1.84	48
Have you ever been treated for depression?	1	1.84	48
If yes, enter the dates here	1	1.84	49
If yes, enter the dates here	1	1.84	49
	1	1.87	50
Have you ever been treated for hepatitis?	1	1.87	50
Have you ever been treated for hepatitis?	1	1.87	50
If yes, include dates	1	1.87	51
If yes, include dates	1	1.87	51
	1	1.90	52
Have you ever been treated for marfan's?	1	1.90	52
Have you ever been treated for marfan's?	1	1.90	52
If yes, include dates	1	1.90	53
If yes, include dates	1	1.90	53
	1	1.91	54
Have you ever been treated for meningitis?	1	1.91	54
Have you ever been treated for meningitis?	1	1.91	54
If yes, include dates	1	1.91	55
If yes, include dates	1	1.91	55
	1	1.92	56
Have you ever been treated for pneumonia?	1	1.92	56
Have you ever been treated for pneumonia?	1	1.92	56
If yes, enter the dates here	1	1.92	57
If yes, enter the dates here	1	1.92	57
	1	1.93	58
Have you ever been treated for rheumatic fever?	1	1.93	58
Have you ever been treated for rheumatic fever?	1	1.93	58
If yes, include dates	1	1.93	59
If yes, include dates	1	1.93	59
	1	1.94	60
Have you ever been treated for mononucleosis?	1	1.94	60
Have you ever been treated for mononucleosis?	1	1.94	60
If yes, include dates	1	1.94	61
If yes, include dates	1	1.94	61
	1	1.95	62
Have you ever been treated for tuberculosis?	1	1.95	62
Have you ever been treated for tuberculosis?	1	1.95	62

ATS Athlete Forms Library

Medical History

	Section	Sub-Section	Q#
If yes, enter the dates here	1	1.95	63
If yes, enter the dates here	1	1.95	63
	1	2.00	64
Are you currently on a diet to change your body weight?	1	2.00	64
Are you currently on a diet to change your body weight?	1	2.00	64
Are you currently taking any form of diet pills?	1	2.00	65
Are you currently taking any form of diet pills?	1	2.00	65
Have you been diagnosed with ADD or ADHD	1	2.00	66
Have you been diagnosed with ADD or ADHD	1	2.00	66
Have you developed an irregula or absent menstrual period?	1	2.00	67
Have you developed an irregula or absent menstrual period?	1	2.00	67
Have you developed epilepsy/convulsions?	1	2.00	68
Have you developed epilepsy/convulsions?	1	2.00	68
Have you developed heart trouble/murmer?	1	2.00	69
Have you developed heart trouble/murmer?	1	2.00	69
Have you ever broken a bone?	1	2.00	70
Have you ever broken a bone?	1	2.00	70
Have you ever fainted?	1	2.00	71
Have you ever fainted?	1	2.00	71
Have you ever had a concussion?	1	2.00	72
Have you ever had a concussion?	1	2.00	72
Have you ever had problems breathing after a workout?	1	2.00	73
Have you ever had problems breathing after a workout?	1	2.00	73
Have you had any stress fractures?	1	2.00	74
Have you had any stress fractures?	1	2.00	74

ATS Athlete Forms Library

Medical History (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
Medical			
	1	1.01	1
What is the date of your last physical?	1	1.01	1
Have you ever failed a pre-participation exam for sports? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	2
Were you born without, or are you missing, a kidney, eye or any other paired organ? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	20
Has your appendix, gallbladder, or any other internal organ been removed? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	21
Have you had an injury to any internal organs such as your liver, spleen, kidney(s) or lung? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	22
Have you ever had an unexplained seizure? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	24
Are you currently using any prescription medications (including insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications, antibiotics, etc.)? Be as descriptive as possible (i.e. name, dosage)	1	1.01	36
Do you lose weight to meet requirements for your sport?	1	1.01	37
Do you currently struggle or have you ever struggled with disordered eating? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	38
Have you ever suffered from any psychological/emotional disorders? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	39
Do you have, or have you ever had any symptoms of medical problems such as:	1	1.02	23
Infectious mononucleosis (mono) within the past 3 month?	1	1.02	23
Blood disorders including anemia, low iron stores, abnormal bleeding, clotting disorder, blood clot (embolus), or any other blood disorder? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	25
Immune system disorders including current infections, recurrent infections, HIV/AIDS, leukemia, or are any other immune system disorders? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	26
Skin disorders including rashes, infections (fungus, herpes, MRSA) or other skin problems? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	27
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	28
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, Crohn's, Celiac's, weight loss or gain (> 10lbs), a change in bowel habits, chronic diarrhea, blood in the stools, past history of liver, pancreatic or gallbladder disease? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	29
Nervous system disorders including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, seizures, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	30
Metabolic or hormonal disease including diabetes melitus, thyroid gland disorders, or hypoglycemia (low blood sugar)? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	31

ATS Athlete Forms Library

Medical History (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
Infections including meningitis or hepatitis (jaundice)? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	32
Arthritis or joint pain not related to injury? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	33
Low blood pressure?	1	1.02	34
Headaches or migraines? Be as descriptive as possible (i.e. frequency, duration, treatment)	1	1.02	35
	1	1.03	40
Do you have any other ongoing medical conditions or illnesses not previously mentioned? Be as descriptive as possible	1	1.03	40

Family History

Do any of your family members have a history of the following before the age of 65:	2	2.01	41
Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)? Include relationship and age	2	2.01	41
Unexplained fainting, seizures, or near drowing? Include relationship and age	2	2.01	42
Died due to heart disease? Include relationship and age	2	2.01	43
Disability or symptoms from heart disease? Include relationship and age	2	2.01	44
Other heart problems including electrical problems (arrhythmia), heart enlargement, long QT syndrome, cardiomyopathy, heart surgery, pacemaker or defibulator? Include relationship and age	2	2.01	45
High blood pressure or high blood cholesterol? Include relationship and age	2	2.01	46
Do any of your family members have a history of:	2	2.02	47
Marfan Syndrome? Include relationship	2	2.02	47
Bleeding disorder, sickle cell trait or sickle cell disease? Include relationship	2	2.02	48
Tuberculosis or Hepatitis? Include relationship and date	2	2.02	49
Anaesthetic reaction or problem? Include relationship	2	2.02	50
Other conditions such as stroke, diabetes, cancer, depression, or arthritis? Include relationship and condition	2	2.02	51

Heart

	3	3.01	3
Chest pain, discomfort, tightness or pressure with exertion? Be as descriptive as possible (i.e. date)	3	3.01	3
Unexplained fainting or near fainting or passed out for no reason during or after exercise? Be as descriptive as possible (i.e. date)	3	3.01	4
Excessive or unexplained shortness of breath, lightheadedness, or fatigue with exercise? Be as descriptive as possible (i.e. date)	3	3.01	5
	3	3.02	6
Does your heart race or skip beats (irregular beats) during exercise? Be as descriptive as possible (i.e. frequency, duration, causes)	3	3.02	6
Have you ever been diagnosed with Marfan Syndrome?	3	3.02	6

ATS Athlete Forms Library

Medical History (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
Do you have Pectus Excavatum (concave chest)?	3	3.02	6
Have you ever been diagnosed with a heart murmur? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	7
Have you ever been diagnosed with high blood pressure or high cholesterol? Be as descriptive as possible (i.e. date, scores)	3	3.02	8
Have you ever been diagnosed with heart valve problems? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	9
Have you ever been diagnosed with a heart infection/inflammation or rheumatic fever? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	10
Have you ever had any tests for your heart (for example, ECG or EKG, echocardiogram)? Be as descriptive as possible (i.e. test, date, results)	3	3.02	11
Have you ever been diagnosed with any other heart related problem(s)? Be as descriptive as possible	3	3.02	12
Breathing			
	4	4.01	13
Do you have asthma? Be as descriptive as possible (i.e. triggers, frequency)	4	4.01	13
Do you currently have a prescription for asthma medication (such as an inhaler)? Please list medication(s)	4	4.01	14
Do you cough, wheeze or have more difficulty breathing than you think you should during or after exercise?	4	4.01	15
Have you ever been diagnosed with any other respiratory or breathing problem? Be as descriptive as possible	4	4.01	16
Heat			
	5	5.01	17
Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia? Be as descriptive as possible (i.e. diagnosis, date)	5	5.01	17
Do you get frequent muscle cramps while exercising? Be as descriptive as possible (i.e. frequency, location)	5	5.01	18
Have you ever had electrolyte (salt) or fluid imbalance? Be as descriptive as possible (i.e. diagnosis, date)	5	5.01	19
Allergies			
Do you have any allergies to:	8	8.01	52
Any medications? Be as descriptive as possible (i.e. name, types)	8	8.01	52
Any foods?	8	8.01	53
Pollens, stinging insects, plant materials or animal materials?	8	8.01	54
Medical supplies (latex, etc.)?	8	8.01	55
Do you have any allergies to:	8	8.02	55
Have you been prescribed an Epi-Pen and for what allergy?	8	8.02	55
Females			
	10	10.01	56
Do you have regular menstrual cycles?	10	10.01	56

ATS Athlete Forms Library

Medical History (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
How many menstrual cycles did you have in the last year?	10	10.01	57
Are you presently taking any female hormones (estrogen, pregesterone, birth control pills)? Be as descriptive as possible (i.e. name, dosage)	10	10.01	58
Are you currently pregnant?	10	10.01	59
Do you have a family history of osteoporosis? Include relationship and age	10	10.01	60

Males

	11	11.01	61
Do you have two normal testicles? READ CAREFULLY	11	11.01	61
Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	62
Have you ever had an injury to a testicle? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	63
Have you ever had surgery for a testicular problem? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	64

Head & Neck

	12	12.01	65
Have you ever had an eye injury, or other problems with your vision excluding contacts or glasses? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	65
Do you have, or have you ever had any symptoms of hearing loss or perforated an eardrum? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	66
Have you had an injury to your teeth? Be as descriptive as possible (i.e. which tooth)	12	12.01	67
Do you have a dental prosthesis or appliance? Be as descriptive as possible (i.e. type)	12	12.01	68
Have you ever been diagnosed with a concussion? Be as descriptive as possible (i.e. number, date)	12	12.01	69
Within the past 6 months, have you experienced trauma that caused symptoms of concussion such as headache, confusion, memory loss, loss of consciousness, dizziness, nauseau, etc.? Be as descriptive as possible (i.e. date)	12	12.01	70
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling? Be as descriptive as possible (i.e. date)	12	12.01	71
Have you ever had an injury to the neck or spine (including a 'stinger', or 'whiplash')? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	72
Do you have, or have you been x-rayed for neck (atlantoaxial) instability? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	73

Injury History

Have you ever had an injury such as a sprain, strain, tear, tendonitis, fracture or surgery to the following:	13	13.01	74
Upper back (thoracic spine)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	74

ATS Athlete Forms Library

Medical History (New/Transfer Athletes Only)

	Section	Sub-Section	Q#
Lower back (lumbar spine)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	75
Chest and ribs? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	76
Shoulder area (including collar bone)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	77
Upper arm? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	78
Elbow? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	79
Lower arm (forearm)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	80
Wrist? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	81
Hand or fingers? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	82
Pelvis, groin or hip (including sports hernia)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	83
Thigh (including hamstrings and quadriceps)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	84
Knee? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	85
Lower leg (calf or shin)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	86
Ankle? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	87
Foot, heel or toes? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	88
	13	13.02	89
Have you ever had a stress reaction/fracture? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.02	89
Have you ever had a cortisone injection? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.02	90

Questions & Concerns

	16	16.01	91
Do you have any religious convictions that could affect your medical treatment? Be as descriptive as possible	16	16.01	91
Have you ever been referred to a medical specialist (cardiologist, neurologist, or other medical person) for any condition not already mentioned? Be as descriptive as possible	16	16.01	92
Do you have any other concerns that you would like to discuss with a doctor? Be as descriptive as possible	16	16.01	94

ATS Athlete Forms Library

Medical History (Returning Athletes Only)

Medical

	Section	Sub-Section	Q#
	1	1.01	1
What is the date of your last physical?	1	1.01	1
Have you ever failed a pre-participation exam for sports? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	2
Were you born without, or are you missing, a kidney, eye or any other paired organ? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	20
Has your appendix, gallbladder, or any other internal organ been removed? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	21
In the LAST YEAR, have you had any changes (injury, surgery) to any internal organs such as your liver, spleen, kidney(s), lung(s), gallbadder, and appendix? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	22
In the LAST YEAR, have you ever had an unexplained seizure? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	24
Are you currently using any prescription medications (including insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications, antibiotics, birth control, etc.)? Be as descriptive as possible (i.e. name, dosage)	1	1.01	36
Do you lose weight to meet requirements for your sport?	1	1.01	37
Do you currently struggle or have you ever struggled with disordered eating? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	38
In the LAST YEAR, have you suffered from any psychological/emotional disorders (depression, anxiety, disordered eating)? Be as descriptive as possible (i.e. diagnosis, date)	1	1.01	39
In the LAST YEAR, have you had any symptoms of medical problems such as:	1	1.02	23
Infectious mononucleosis (mono)?	1	1.02	23
Blood disorders including anemia, low iron stores, abnormal bleeding, clotting disorder, blood clot (embolus), or any other blood disorder? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	25
Immune system disorders including current infections, recurrent infections, HIV/AIDS, leukemia, or are any other immune system disorders? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	26
Skin disorders including rashes, infections (fungus, herpes, MRSA) or other skin problems? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	27
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	28
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, Crohn's, Celiac's, weight loss or gain (> 10lbs), a change in bowel habits, chronic diarrhea, blood in the stools, past history of liver, pancreatic or gallbladder disease? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	29
Nervous system disorders including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, seizures, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	30

ATS Athlete Forms Library

Medical History (Returning Athletes Only)

	Section	Sub-Section	Q#
Metabolic or hormonal disease including diabetes melitus, thyroid gland disorders, or hypoglycemia (low blood sugar)? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	31
Infections including meningitis or hepatitis (jaundice)? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	32
Arthritis or joint pain not related to injury? Be as descriptive as possible (i.e. diagnosis, date)	1	1.02	33
Low blood pressure?	1	1.02	34
Headaches or migraines? Be as descriptive as possible (i.e. frequency, duration, treatment)	1	1.02	35
	1	1.03	40
Do you have any other ongoing medical conditions or illnesses not previously mentioned? Be as descriptive as possible	1	1.03	40

Family History

In the LAST YEAR, do any of your family members have a history of the following before the age of 65:	2	2.01	41
Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)? Include relationship and age	2	2.01	41
Unexplained fainting, seizures, or near drowing? Include relationship and age	2	2.01	42
Died due to heart disease? Include relationship and age	2	2.01	43
Disability or symptoms from heart disease? Include relationship and age	2	2.01	44
Other heart problems including electrical problems (arrhythmia), heart enlargement, long QT syndrome, cardiomyopathy, heart surgery, pacemaker or defibulator? Include relationship and age	2	2.01	45
High blood pressure or high blood cholesterol? Include relationship and age	2	2.01	46
Other conditions such as stroke, diabetes, cancer, depression, or arthritis? Include relationship and condition	2	2.01	51
Do any of your family members have a history of:	2	2.02	47
Marfan Syndrome? Include relationship	2	2.02	47
Bleeding disorder, sickle cell trait or sickle cell disease? Include relationship	2	2.02	48
Tuberculosis or Hepatitis? Include relationship and date	2	2.02	49
Anaesthetic reaction or problem? Include relationship	2	2.02	50

Heart

In the LAST YEAR, have you had any of the following heart or circulation related problems:	3	3.01	3
Chest pain, discomfort, tightness or pressure with exertion? Be as descriptive as possible (i.e. date)	3	3.01	3
Unexplained fainting or near fainting or passed out for no reason during or after exercise? Be as descriptive as possible (i.e. date)	3	3.01	4
Excessive or unexplained shortness of breath, lightheadedness, or fatigue with exercise? Be as descriptive as possible (i.e. date)	3	3.01	5

ATS Athlete Forms Library

Medical History (Returning Athletes Only)

	Section	Sub-Section	Q#
	3	3.02	6
In the LAST YEAR, has your heart raced or skipped beats (irregular beats) during exercise? Be as descriptive as possible (i.e. frequency, duration, causes)	3	3.02	6
Do you have Pectus Excavatum (concave chest)?	3	3.02	6
Have you ever been diagnosed with Marfan Syndrome?	3	3.02	6
In the LAST YEAR, have you been diagnosed with a heart murmur? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	7
In the LAST YEAR, have you been diagnosed with high blood pressure or high cholesterol? Be as descriptive as possible (i.e. date, scores)	3	3.02	8
In the LAST YEAR, have you been diagnosed with heart valve problems? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	9
In the LAST YEAR, have you been diagnosed with a heart infection/inflammation or rheumatic fever? Be as descriptive as possible (i.e. diagnosis, date)	3	3.02	10
In the LAST YEAR, have you had any tests for your heart (for example, ECG or EKG, echocardiogram)? Be as descriptive as possible (i.e. test, date, results)	3	3.02	11
In the LAST YEAR, have you been diagnosed with any other heart related problem(s)? Be as descriptive as possible	3	3.02	12

Breathing

	4	4.01	13
Do you have asthma? Be as descriptive as possible (i.e. triggers, frequency)	4	4.01	13
Do you currently have a prescription for asthma medication (such as an inhaler)? Please list medication(s)	4	4.01	14
Do you cough, wheeze or have more difficulty breathing than you think you should during or after exercise?	4	4.01	15
In the LAST YEAR, have you been diagnosed with any respiratory or breathing problem(s)? Be as descriptive as possible	4	4.01	16

Heat

	5	5.01	17
In the LAST YEAR, have you been diagnosed with any type of heat related illness? Be as descriptive as possible (i.e. diagnosis, date)	5	5.01	17
Do you get frequent muscle cramps while exercising? Be as descriptive as possible (i.e. frequency, location)	5	5.01	18
Have you ever had electrolyte (salt) or fluid imbalance? Be as descriptive as possible (i.e. diagnosis, date)	5	5.01	19

Allergies

	8	8.01	52
In the LAST YEAR, have you developed any new medication, food, and/or environmental allergies? Be as descriptive as possible (i.e. name, types)	8	8.01	52
Any foods?	8	8.01	53
Pollens, stinging insects, plant materials or animal materials?	8	8.01	54

ATS Athlete Forms Library

Medical History (Returning Athletes Only)

	Section	Sub-Section	Q#
Medical supplies (latex, etc.)?	8	8.01	55
Do you have any allergies to:	8	8.02	55
Have you been prescribed an Epi-Pen and for what allergy?	8	8.02	55

Females

	10	10.01	56
In the LAST YEAR, have you had any changes to your reproductive system/organs?	10	10.01	56
How many menstrual cycles did you have in the last year?	10	10.01	57
Are you presently taking any female hormones (estrogen, pregesterone, birth control pills)? Be as descriptive as possible (i.e. name, dosage)	10	10.01	58
Are you currently pregnant?	10	10.01	59
Do you have a family history of osteoporosis? Include relationship and age	10	10.01	60

Males

	11	11.01	61
Do you have two normal testicles? READ CAREFULLY	11	11.01	61
In the LAST YEAR, have you had any changes to your reproductive organs? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	62
Have you ever had an injury to a testicle? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	63
Have you ever had surgery for a testicular problem? Be as descriptive as possible (i.e. diagnosis, date)	11	11.01	64

Head & Neck

	12	12.01	65
In the LAST YEAR, have you had any changes to your vision or hearing excluding contacts or glasses prescriptions? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	65
Do you have, or have you ever had any symptoms of hearing loss or perforated an eardrum? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	66
In the LAST YEAR, have you had an injury to your teeth? Be as descriptive as possible (i.e. which tooth)	12	12.01	67
Do you have a dental prosthesis or appliance? Be as descriptive as possible (i.e. type)	12	12.01	68
In the LAST YEAR, have you had a head injury? Be as descriptive as possible (i.e. number, date)	12	12.01	69
Within the past 6 months, have you experienced trauma that caused symptoms of concussion such as headache, confusion, memory loss, loss of consciousness, dizziness, nauseau, etc.? Be as descriptive as possible (i.e. date)	12	12.01	70
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling? Be as descriptive as possible (i.e. date)	12	12.01	71

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Medical History (Returning Athletes Only)

	Section	Sub-Section	Q#
Have you ever had an injury to the neck or spine (including a 'stinger', or 'whiplash')? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	72
Do you have, or have you been x-rayed for neck (atlantoaxial) instability? Be as descriptive as possible (i.e. diagnosis, date)	12	12.01	73

Injury History

In the LAST YEAR, have you had an injury such as a sprain, strain, tear, tendonitis, fracture or surgery to the following:	13	13.01	74
Upper back (thoracic spine)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	74
Lower back (lumbar spine)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	75
Chest and ribs? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	76
Shoulder area (including collar bone)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	77
Upper arm? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	78
Elbow? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	79
Lower arm (forearm)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	80
Wrist? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	81
Hand or fingers? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	82
Pelvis, groin or hip (including sports hernia)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	83
Thigh (including hamstrings and quadriceps)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	84
Knee? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	85
Lower leg (calf or shin)? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	86
Ankle? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	87
Foot, heel or toes? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.01	88
	13	13.02	89
In the LAST YEAR, have you had a stress reaction/fracture? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.02	89
In the LAST YEAR, have you had a cortisone injection? Be as descriptive as possible (i.e. R/L, diagnosis, date)	13	13.02	90

Questions & Concerns

	16	16.01	91
Do you have any religious convictions that could affect your medical treatment? Be as descriptive as possible	16	16.01	91
In the LAST YEAR, have you been referred to a medical specialist (cardiologist, neurologist, or other medical person) for any condition not already mentioned? Be as descriptive as possible	16	16.01	92
Do you have any other concerns that you would like to discuss with a doctor? Be as descriptive as possible	16	16.01	94

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Medical History (Returning Athletes Only)

Section	Sub-Section	Q#

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Medical History Questionnaire

Medical History Questionnaire

	Section	Sub-Section	Q#
Explain "Yes" Answers in the space provided	1	1.01	1
Do you have any known allergies with medicines ect..?	1	1.01	1
	1	1.02	2
Do you have any known past or current medial problems or injuries?	1	1.02	2
	1	1.03	3
Have you ever had a head injury that knocked you out or concussion if so how many times?	1	1.03	3
	1	1.04	4
Have you ever been told you have sickle cell trait?	1	1.04	4
	1	1.05	5
Have you ever been told you had high blood pressure?	1	1.05	5
	1	1.06	6
Have you ever been told you had a heart murmur or any other heart condition?	1	1.06	6
	1	1.07	7
Have you ever been told you have asthma?	1	1.07	7
	1	1.08	8
Do you have vision or hearing problems?	1	1.08	8
	1	1.09	9
Are you currently taking any medications?	1	1.09	9
	1	1.10	10
Are you missing any or implanted any organs?	1	1.10	10
	1	1.11	11
Have you ever had surgery if so what procedure?	1	1.11	11
	1	1.12	12
Have you ever used steroids or other performance enhancement aids such as creatine ect...?	1	1.12	12
	1	1.13	13
If you are under 18 you will NEED to have a parent or guardian sign this form!			
	1	1.14	14
I give consent to release any of my health information to healthcare professionals, insurance agencies and other college personnel. I have included all the necessary information about my health. I do realize failure to mention any health problems could jeopardize my health.			

ATS Athlete Forms Library

Medical Policy Student Athletes

	Section	Sub-Section	Q#
The Student Athletes and Parents			
The xxx University Athletic Department has obtained the services of xxx / xxx, xxx Sports Medicine, and xxx Medical Group as primary team physicians to treat student-athletes for sports related injuries. In the event of an emergency, every effort will be made to contact you about treatment of your son or daughter. Note: The procedures outlined below must be followed by the athlete and guarantor. Failure to do so will result in a denial of xxx secondary coverage. To ensure complete understanding and agreement to these policies, parents/guardians please initial the “left column” next to each item and sign the page at the bottom. Make a copy, retain one for your records, and return the other with this health packet.	1	1.01	1
All insurance history and medical history forms (see attached) must be completed and returned to the Sports Medicine Department prior to the start of physicals and any supervised practice or competition.	1 1	1.02 1.02	2 2
Any student athlete wishing to participate in the intercollegiate athletic program at xxx must have a physical examination from the xxx Sports Medicine Department. No other physician’s physical will be accepted. These physicals will be arranged for the students when they arrive on campus. The athletic physicals are independent of the University’s student entrance physical requirements. Please do not return the immunization forms to the Sports Medicine department.	1 1	1.03 1.03	3 3
All athletic related injuries/illnesses must be managed through the Sports Medicine Department prior to seeing any doctor. All orthopedic exams and diagnostic testing must be authorized by the sports medicine department prior to appointment. If the athlete does not follow this procedure, you will be responsible for all bills incurred. No Head Coach or Assistant Coach will take it upon themselves to recommend or personally acquire an appointment for any student athlete without authorization from the Sports Medicine Department.	1 1	1.04 1.04	4 4
The team physicians must authorize all prescriptions prior to visiting the pharmacy. Valid prescriptions must be for treatment of athletic injuries only. Not following this procedure will result in the athlete being financially responsible for the entire prescription. General medical illness prescriptions are not cover by xx secondary insurance carrier.	1 1	1.05 1.05	5 5
Dental expenses may be covered by our insurance if dental work is required as a direct result of injuries received while participating in formal, supervised intercollegiate games or practices. Toothaches, dental caries, abscesses, root canals, etc., are the responsibility of the student athlete or their parents.	1 1	1.06 1.06	6 6
	1	1.07	7

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Medical Policy Student Athletes

	Section	Sub-Section	Q#
Any situation not covered in the above regulations must first be presented to the Head Athletic Trainer to obtain approval by the office of athletic insurance before any fees, charges, or prescription costs are incurred. If procedure is not followed, the athlete and/or parents will be responsible for payment of all medical bills.	1	1.07	7
	1	1.08	8
In compliance with the NCAA recommendations, Lipscomb University shall be responsible for providing athletic accident insurance coverage for only those injuries that are directly related to the participation in intercollegiate varsity competition or practice for xxx. All other injuries or illnesses and/or pre-existing conditions are the responsibility of the student athlete and his/her family. (example: asthma)	1	1.08	8
	1	1.09	9
All student athletes must carry medical health insurance.	1	1.09	9
	1	1.10	10
I understand that it is my responsibility to notify the Sports Medicine Department ASAP if my Primary Health Care Provider changes or is terminated. Failure to provide current insurance information will result in the denial of secondary coverage.	1	1.10	10
	1	1.11	11
	1	1.11	11

ATS Athlete Forms Library

Medical Questionnaire

	Section	Sub-Section	Q#
Administration			
Please read the following statement. Check Yes to agree and type your full name in the box.	1	1.02	3
Prior to your participation in University athletics, the following form must be completed. Please read each section carefully and answer every question with as much detail as possible. If any questions are unanswered, the questionaire will be considered incomplete and will delay your participation. Health problems/injuries not disclosed or misrepresented in this form will result in loss of scholarship and relieve Western Carolina University of medical responsibility. If you have any questions regarding this form, please contact the xxx By clicking "Yes" and typing your name in the box you affirm that you have read and agree to the above statement.	1	1.02	3
Consent to Release Personal Health Information			
Please read the following statements. Check Yes to agree and type your full name in the box.	2	1.01	3
While competing in the Intercollegiate Athletic program representing xxx I expressly authorize the release of medical records, medical claims and insurance explanation of benefits from the xxxStudent Health Service,xxxHospital, and any other Institution which might render medical treatment to me. The said medical records will be released directly to the xxx Athletic Department, Sports Medicine Director, Team Physician(s), Insurance Coordinator and its insurance carrier in order to better inform the related personnel of my medical condition(s), capabilities and progress as well as processing the payment of any medical claims for injuries that occurred while participating in the Intercollegiate Athletic Program at xxx. By typing your name in the following box, you affirm that you have read and agree to the Consent to Release Information	2	1.01	3
This is to authorize xxx University athletic trainers, university physicians, athletic administration and athletic coaches to release any medical information regarding my son, daughter, or myself, to various media outlets, concerning illness or injury relative to my past, present or future participation in athletics at xxx By typing your name in the following box, you affirm that you have read and agree to the Consent to Release Information	2	1.01	4
This is to authorize xxx athletic trainers, university physicians, athletic administration and athletic coaches to release any medical information regarding my son, daughter, or myself, to professional teams, concerning illness or injury relative to my past, present, or future participation in athletics at xxx By typing your name in the following box, you affirm that you have read and agree to the Consent to Release Information	2	1.01	5

ATS Athlete Forms Library

Medical Questionnaire

	Section	Sub-Section	Q#
Please read the following statements. Check Yes to agree and type your full name in the box.	2	1.02	5
Permission is granted to the Athletic Department of xxx to contact and receive information from my private insurance company described on the Insurance Notification form pertaining to payments, authorizations and/or action taken by my personal insurance company.	2	1.02	5

Personal History

The following questions ask for information regarding your personal background	3	1.01	2
Have you participated in other sports in the past (including competitively)?	3	1.01	2
What is your ethnic origin?	3	1.01	3
Do you have any religious convictions that could affect your medical treatment?	3	1.01	4
What is the date of your last physical?	3	1.01	5
Have you ever failed a pre-participation exam for sports, or has your doctor ever stopped you from participating in sports for any reason?	3	1.01	6
In total, how many days have you missed practice or competition in the past year because of injury or illness?	3	1.01	7

Cardiac

Have you ever had any of the following heart or circulation related problems:	4	2.01	8
Chest pain, discomfort, tightness or pressure with exercise?	4	2.01	8
Unexplained fainting or near fainting or passed out for no reason during or after exercise?	4	2.01	9
Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise?	4	2.01	10
Do you get more tired or short of breath more quickly than your friends during exercise?	4	2.01	11
Does your heart race or skip beats (irregular beats) during exercise?	4	2.01	12
Have you ever had a heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem?	4	2.01	13
Have you ever had a seizure?	4	2.01	14
Have you ever had any tests for your heart (for example, ECG or EKG, echocardiogram)?	4	2.01	15

Respiratory

Have you ever had any of the following respiratory or breathing problems:	5	3.01	16
Do you have asthma? If "Yes," please list medication and date of last episode	5	3.01	16
Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu-like illness?	5	3.01	17
Do you cough, wheeze or have more difficulty breathing than you should during or after exercise?	5	3.01	18
Have you ever used asthma medication (such as an inhaler)?	5	3.01	19

ATS Athlete Forms Library

Medical Questionnaire

	Section	Sub-Section	Q#
Have you ever had bronchitis, pneumonia, tuberculois, cystic fibrosis or other repiratory or other breathing problem?	5	3.01	20

Sickle-cell

Have you ever had any of the following:	6	2.01	15
Has anyone in your family been diagnosed with sickle-cell anemia or sickle-cell trait? If so, please list the date.	6	2.01	15
Have you ever been diagnosed with sickle-cell anemia or sickle-cell trait? If so, please list date.	6	2.01	15
Do you commonly cramp and/or experience shortness of breath during activity? If "Yes," how long does this normally last? What makes it feel better?	6	2.01	16

Heat

The following questions are about exercise in the heat:	7	4.01	21
Have you ever become ill while exercising in the heat? If "Yes," please list date of last occurence and symptoms	7	4.01	21
Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia? If "Yes," please list date of last occurence	7	4.01	22
Do you get frequent muscle cramps while exercising?	7	4.01	23
Have you ever had electrolyte (salt) or fluid imbalance? If "Yes," please list date of last occurence	7	4.01	24

Medical

	8	5.01	25
Do you have any ongoing medical conditions or illness?	8	5.01	25
Do you have, or have you ever had any symptoms of medical problems such as:	8	5.02	26
Infections mononucleosis (mono), flu like symptoms or viral illness within the past month?	8	5.02	26
Disease of the ears (infections, hearing loss, pain), nose (sneezing, itchy nose, sinusitis, blocked nose) or throat (sore throat, hoase voice, swollen glands in the neck)?	8	5.02	27
Blood disorders such as anemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder?	8	5.02	28
Immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication?	8	5.02	29
Skin problems such as rashes, infections (fungus, herpes, MRSA) or other skin problems?	8	5.02	30
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?	8	5.02	31
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhea, blood in the stools, or past history of liver, pancreatic or gallbladder disease?	8	5.02	32

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Medical Questionnaire

	Section	Sub-Section	Q#
Nervous system including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue?	8	5.02	33
Metabolic or hormonal disease including diabetes melitus, thyroid gland disorders, or hypoglycemia (low blood sugar)?	8	5.02	34
Infections such as meningitis, hepatitis (jaundice), or chicken pox?	8	5.02	35
Arthritis or joint pain, swelling and redness not related to injury?	8	5.02	36
Were you born without, or are you missing, a kidney, eye or any other organ?	8	5.02	37
Have you had an injury to any internal organs such as your liver, spleen, kidney(s) or lung?	8	5.02	38
Have you ever had surgery? (explain)	8	5.02	39
Do you get motion sickness (car, air or sea sickness)?	8	5.02	40
Do you have any additional medical problems?	8	5.02	41
Hearing loss or perforated eardrum?	8	5.02	136
Headaches or migraines?	8	5.02	137

Medications

Medications/supplements you have taken in the past month:	9	7.01	54
Medications prescribed by a doctor (including insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications, etc.)? Explain	9	7.01	54
Non-prescription medications (include pain killers, anti-inflammatories, etc.)? Explain	9	7.01	55
Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)? Explain	9	7.01	56
Have you ever been offered or encouraged to use banned performance enhancing drugs? Explain	9	7.01	57
Indicate which immunizations you have recieved:	9	9.01	60
Tetanus/Diptheria (Td or Tdap)? (no/yes & last shot)?	9	9.01	60
Measles/Mumps/Rubella (2 shots)?	9	9.01	61
Chicken Pox (Varicella)?	9	9.01	62
Meningitis (Menimune or Menactra)?	9	9.01	63
Hepatitis A (2 shots)?	9	9.01	64
Hepatitis B (3 shots)?	9	9.01	65
Malaria?	9	9.01	66
Have you had a TB Test (PPD)? Result?	9	9.01	67
Have you had any other imunizations? Explain:	9	9.01	68

Allergies

The following questions pertain to allergies:	10	9.02	58
Do you have any medication allergies?	10	9.02	58
Do you have any allergies to foods, pollens, stinging insects, any plant material or any animal material?	10	9.02	59

ATS Athlete Forms Library

Medical Questionnaire

	Section	Sub-Section	Q#
Family			
Do any of your family members have a history of the following (male < 55, female < 65):	11	6.01	42
Sudden death for no apparent reason (including drowning, unexplained or explained car accident, or sudden infant death syndrome)?	11	6.01	42
Fainting, seizures, or near drowing?	11	6.01	43
Died before age 50 due to heart disease?	11	6.01	44
Disability or symptoms from heart disease before age 50?	11	6.01	45
Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, hearth surgery, pacemaker or defibulator?	11	6.01	46
High blood pressure or high blood cholesterol?	11	6.01	47
Marfan's Syndrome?	11	6.01	48
Bleeding disorder, Sickle cell trait or sickle cell disease?	11	6.01	49
Tuberculosis or Hepatitis?	11	6.01	50
Anaesthetic reaction or problem?	11	6.01	51
Other condition such as stroke, diabetes, cancer, arthritis (describe)?	11	6.01	52
Are you unsure of your family history?	11	6.01	53
Females			
These questions are for females only:	12	10.01	69
Date of your last OB/GYN exam?	12	10.01	69
Have you ever had an abnormal OB/GYN exam?	12	10.01	69
Have you ever had a menstrual period?	12	10.01	69
At what age did you have your first menstrual cycle?	12	10.01	70
Do you have regular menstrual cycles?	12	10.01	71
How many menstrual cycles did you have in the last year?	12	10.01	72
When was your most recent menstrual period?	12	10.01	73
Typically, how many days is your menstrual cycle?	12	10.01	73
Longest time (Days) between menstrual cycles?	12	10.01	74
Are you presently taking any female hormones (estrogen, pregesterone, birth control pills)?	12	10.01	76
Have you ever had a sexually transmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	12	10.01	77
Any history of urinary tract infections (UTI)?	12	10.01	78
Does your family has a history of osteoporosis?	12	10.01	135
Have you had a stress fracture in the past?	12	10.01	136
Any previous pregnancies?	12	10.01	137
These questions are for males only:	12	11.01	78
Do you have two normal testicles?	12	11.01	78
Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)?	12	11.01	79
Have you ever had an injury to a testicle?	12	11.01	80

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Medical Questionnaire

	Section	Sub-Section	Q#
Have you ever had surgery for an undescended testicle, testicular injury or problem?	12	11.01	81
Have you ever had a sexually transmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	12	11.01	82
Have you or do you now have kidney disease or damage?	12	11.01	133

Head & Neck

Have you ever had any of the following problems related to your head or neck:	13	12.01	83
Eye injury, or other problems with your vision?	13	12.01	83
Headaches with exercise?	13	12.01	84
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling?	13	12.01	85
Do you have, or have you been x-rayed for, neck (atlantoaxial) instability?	13	12.01	86
Have you had an injury to your teeth?	13	12.01	87
Do you have any other decayed, missing or filled teeth?	13	12.01	88
Do you have a dental prosthesis or appliance?	13	12.01	89
Have you had your wisdom teeth removed? If yes, when?	13	12.01	90

Injury History

Have you ever had an injury to your:	14	13.01	91
Face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to the head)? Explain (Include date of injury and severity)	14	13.01	91
Neck or spine (including a 'stinger', or 'whiplash')?	14	13.01	92
Upper back (thoracic spine)?	14	13.01	93
Lower back (lumbar spine)?	14	13.01	94
Chest and ribs?	14	13.01	95
Shoulder area (including collar bone)?	14	13.01	96
Upper arm?	14	13.01	97
Elbow?	14	13.01	98
Lower arm (forearm)?	14	13.01	99
Wrist?	14	13.01	100
Hand or fingers?	14	13.01	101
Pelvis, groin or hip (including sports hernia)?	14	13.01	102
Thigh (including hamstrings and quadriceps)?	14	13.01	103
Knee?	14	13.01	104
Lower leg (calf or shin)?	14	13.01	105
Ankle?	14	13.01	106
Foot, heel or toes?	14	13.01	107

Other

Have you had any other tests for any injury or condition	15	14.01	108
Including blood tests, x-rays, MRI, CT scan, bone scan, ultrasound, EEG, EMG, ECG/EKG, or stress test?	15	14.01	108

ATS Athlete Forms Library

Medical Questionnaire

	Section	Sub-Section	Q#
Have you ever received treatment for the following:	15	14.02	109
Surgery?	15	14.02	109
Been you ever been prescribed a brace, sling, cast, walking boot, orthotic, crutches or other appliance?	15	14.02	110
Have you ever had a cortisone injection?	15	14.02	111
Been prescribed other rehabilitation or therapy?	15	14.02	112
Have you ever spent the night in a hospital or been admitted to a hospital as an inpatient or outpatient?	15	14.02	113
Have you ever been referred to a medical specialist (cardiologist, neurologist, or other medical person) for any condition not already mentioned?	15	14.02	114
Equipment	15	14.03	115
Do you wear eye glasses or contact lenses?	15	14.03	115
Are you currently using any protective equipment?	15	14.03	116
Do you use protective eyewear?	15	14.03	117
Do you use special equipment (pads, braces, etc.)?	15	14.03	118
Do you use a mouth guard for sports?	15	14.03	119
If you wear a helmet for sports, how old is it?	15	14.03	120

Nutrition

	16	15.01	121
Do you worry about your weight or body composition?	16	15.01	121
Are you satisfied with your eating pattern?	16	15.01	122
Do you lose weight to meet weight requirements for your sport?	16	15.01	124
Does your weight affect the way that you feel about yourself?	16	15.01	125
Do you worry that you have lost control over how much you eat?	16	15.01	126
Do you make yourself sick when you are uncomfortably full?	16	15.01	127
Do you ever eat in secret?	16	15.01	128
Do you currently suffer or have you ever suffered in the past with an eating disorder?	16	15.01	129
What is your current weight?	16	15.01	130
What is your current height without shoes?	16	15.01	131

Questions & Concerns

	17	16.01	132
Do you have any other concerns that you would like to discuss with a doctor?	17	16.01	132
Do you have any other nutritional concerns that you would like to discuss with a dietician?	17	16.01	132
Do you have any other emotional issues that you would like to discuss with a counselor?	17	16.01	150
Do you have any other concerns that you would like to discuss with an athletic trainer?	17	16.01	150

ATS Athlete Forms Library

NCAA Concuss Sheet

	Section	Sub-Section	Q#
NCAA fact sheet for student-athletes			
	1	1.10	1

What is a concussion?
A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

How can i prevent a concussion?
Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

What are the symptoms of a concussion?
You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

ATS Athlete Forms Library

NCAA Concuss Sheet

	Section	Sub-Section	Q#
What should I do if I think I have a concussion? Don’t hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out. Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play. Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance. Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.			
It’s better to miss one game than the whole season. When in doubt, get checked out. For more information and resources, visit: * NCAA Health-Safety * CDC Concussion Page			
By signing below I certify that I have read the NCAA concussion sheet and understand the information as presented.	1	1.10	6
Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.			

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NCAA Video Sample

	Section	Sub-Section	Q#
Sickle Cell Video	1	1.10	1
You are required to watch & certify that you understand the content of this video. Please click on the link shown below, then complete this form once you are done watching the video. If you have any questions contact the sports medicine staff. Click here to see the NCAA Sickel Cell video...			
By clicking "Yes" and signing below I certify that I have watched the video, understand the content, and have no questions.	1	1.10	2
Concussion Video	2	2.10	3
You are required to watch & certify that you understand the content of this video. Please click on the link shown below, then complete this form once you are done watching the video. If you have any questions contact the sports medicine staff. Click here to see the NCAA Concussion video...			
By clicking "Yes" and signing below I certify that I have watched the video, understand the content, and have no questions.	2	2.10	4

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
	1	0.05	5
Does your heart race or skip beats (irregular beats) during or after exercise/practice? (If YES Please Explain Below)	1	0.05	5
	1	1.01	1
Have you ever had chest pain, discomfort, tightness, or pressure during or after exercise/practice? (If YES Please Explain Below)	1	1.01	1
	1	1.02	2
Have you ever missed practice/games for chest pain, discomfort, tightness or pressure? (If YES Please Explain Below)	1	1.02	2
	1	1.03	3
Have you ever had excessive or unexplained shortness of breath, dizziness, lightheadedness, or fatigue with exercise? (If YES Please Explain Below)	1	1.03	3
	1	1.04	4
Have you ever had explained fainting or near-fainting or passed out for no reason during or after exercise/practice? (If YES Please Explain Below)	1	1.04	4
	1	1.06	6
Do you get more tired or short of breath more quickly than your teammates/friends during exercise/ practice? (If YES Please Explain Below)	1	1.06	6
	1	1.07	7
Do you parcipate in a minimum of 30 minutes of moderate intensity (40-60%) exercise on at least 3 days for 3 months? (If YES Please Explain Below)	1	1.07	7
	1	1.08	8
Have you ever been told that you have a heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart condition? (If YES Please Explain Below)	1	1.08	8
	1	1.09	9
Has any family member or relative died of heart problems and/or of sudden death before age 50?	1	1.09	9
	1	1.10	10
Does your family have a history of Marfan syndrome?	1	1.10	10
	1	1.11	11
Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems?	1	1.11	11
	1	1.12	12
Have you ever had any tests for your heart (e.g., ECG/EKG (electrocardiogram), ECHO (echocardiogram)?	1	1.12	12
	1	1.13	13
Are you currently taking any medications for high blood pressure or high cholesterol? If yes, please list the medication(s)	1	1.13	13
	1	1.14	14
Does anyone in your family have high blood pressure or high cholesterol?	1	1.14	14
	1	1.15	15

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever had an unexplained seizure?	1	1.15	15

Allergies

	2	2.01	1
Have you ever been diagnosed with seasonal allergies?	2	2.01	1
	2	2.02	2
Are you presently taking any prescription and/or over-the-counter allergy medications?	2	2.02	2
	2	2.03	3
Are you allergic to and/or ever had unfavorable/allergic reaction to any medications (e.g., Penicillin, etc.)?	2	2.03	3
	2	2.04	4
Are you allergic to and/or ever had an unfavorable/allergic reacton to any food items (e.g., seafood, nuts, dairy, etc.)?	2	2.04	4
	2	2.05	5
Are you allergic to and/or ever had an unfavorable/allergic reaction to bee stings, insect bites, etc.?	2	2.05	5
	2	2.06	6
Do you carry an Epi-Pen? If yes, you are REQUIRED to bring an extra Epi-Pen with you for the Athletic Trainer's medical kit. Make certain it will not expire within 10 months.	2	2.06	6
	2	2.07	7
Have you ever had an allergic reaction requiring emergency care?	2	2.07	7
	2	2.08	8
Have you ever been hospitalized for allergies or anaphylaxis?	2	2.08	8
	2	2.09	9
Do you have any other allergies (e.g., pets, etc.)?	2	2.09	9

Respiratory

	3	3.01	1
Do you cough, wheeze, or have more trouble breathing than you should during or after exercise/practice?	3	3.01	1
	3	3.02	2
Do you currently have asthma or exercised-induced asthma?	3	3.02	2
	3	3.03	3
Is there a family history of asthma or exercised-induced asthma?	3	3.03	3
	3	3.04	4
Are you currently taking any asthma medications or using a rescue inhaler? If yes, please list the medication(s). You are REQUIRED to bring an extra rescue inhaler for the Athletic Trainer's medical kit. Please make certain it will not expire within 10 months.	3	3.04	4

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
	3	3.05	5
How many times during the week do you use your inhaler (e.g. , Albuterol, Ventolin, Proventil, etc.) for exercising?	3	3.05	5
	3	3.06	6
How many times a week do you use your rescue inhaler during exercise/practice for trouble breathing?	3	3.06	6
	3	3.07	7
How many asthma attacks have you had in the past 12 months?	3	3.07	7
	3	3.08	8
Have you ever been hospitalized as a result of asthma and/or exercised-induced asthma?	3	3.08	8
	3	3.09	9
Have you ever been advised not to participate in sport activities due to asthma or any breathing-related condition?	3	3.09	9
	3	3.10	10
Do you have any other symptoms of respiratory (lung) disease including post-nasal drip, hay fever, or repeated flu-like illness?	3	3.10	10
	3	3.11	11
Have you ever had bronchitis, pneumonia, tuberculosis, cystic fibrosis or other respiratory problems?	3	3.11	11

Head Injuries/Concussions

	4	4.01	1
Have you ever suffered a mild traumatic brain injury (MTBI), concussion, or head injury of any kind - regardless of how minor (e.g., playing sports, automobile crash, diving accident, etc.)?	4	4.01	1
If yes, please list the dates			
	4	4.02	2
Have you ever been evaluated by a doctor for a mild traumatic brain injury/concussion/head injury?	4	4.02	2
	4	4.03	3
Select all diagnostic tests performed.	4	4.03	3
	4	4.04	4
Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to a head injury/concussion?	4	4.04	4
	4	4.05	5
Have you ever suffered a head injury or concussion resulting in a seizure?	4	4.05	5
	4	4.06	6
Have you ever suffered a head injury or concussion resulting in numbness, tingling, or weakness in arms or legs?	4	4.06	6
	4	4.07	7

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever been advised not to participate in athletic activities due to a head injury or concussion?	4	4.07	7
	4	4.08	8
Do you suffer from headaches?	4	4.08	8
	4	4.09	9
Do you suffer from headaches with exercise?	4	4.09	9
	4	4.10	10
Select where your headaches are located.	4	4.10	10
	4	4.11	11
Do you have a history of migraine headaches?	4	4.11	11
List any medications taken for migraines			
	4	4.12	12
Have you had headaches for more than three (3) months?	4	4.12	12

Medical

	5	5.01	1
Have you ever been diagnosed with a communicable disease (e.g., STD, HIV Hepatitis A,B,C, Herpes Simplex/Zoster, Syphilis, Tuberculosis)?	5	5.01	1
	5	5.02	2
Do you have hemophilia?	5	5.02	2
	5	5.03	3
Have you ever been diagnosed with a thyroid disorder?	5	5.03	3
	5	5.04	4
Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?	5	5.04	4
	5	5.05	5
Have you ever had chickenpox?	5	5.05	5
	5	5.06	6
Have you had a viral infection (e.g., mononucleosis, myocarditis, etc) within the past six(6) months?	5	5.06	6
	5	5.07	7
Do you or have you ever had hepatitis or jaundice?	5	5.07	7
	5	5.08	8
Do you regularly have fever, chills, and/or night sweats?	5	5.08	8
	5	5.09	9
Have you ever had seizures, convulsions, and/or epilepsy?	5	5.09	9

Eyes

	6	6.01	2
When was your last eye exam?	6	6.01	2
	6	6.02	2

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease?	6	6.02	2
	6	6.03	3
Select all diagnostic tests performed.	6	6.03	3
	6	6.04	4
Have you ever been hospitalized and/or seen an ophthalmologist for an eye injury/disease?	6	6.04	4
	6	6.05	5
Have you ever had eye surgery?	6	6.05	5
	6	6.06	6
Have you ever been advised not to participate in athletic activities due to an eye injury?	6	6.06	6
	6	6.07	7
Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other vision problems?	6	6.07	7
	6	6.08	8
Do you have dyslexia?	6	6.08	8
	6	6.09	9
I routinely wear:	6	6.09	9
	6	6.10	10
Do you require any special devices/equipment?	6	6.10	10
	6	6.11	11
Do you wear protective eyewear while playing sports?	6	6.11	11

Ear / Nose / Throat

	7	7.01	1
Have you suffered an injury to your ear(s), nose, and/or throat?	7	7.01	1
	7	7.02	2
Select all diagnostic tests performed.	7	7.02	2
	7	7.03	3
Have you ever been hospitalized for an ear, nose, and/or throat injury?	7	7.03	3
	7	7.04	4
Have you ever had surgery on your ear(s), nose, or throat?	7	7.04	4
	7	7.05	5
Have you ever been advised not to participate in athletic activities due to an ear, nose, and/or throat injury?	7	7.05	5
	7	7.06	6
Do you have frequent colds or sore throats?	7	7.06	6
	7	7.07	7
Do you have frequent ear infections or nosebleeds?	7	7.07	7
	7	7.08	8

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Do you currently have a sore or scratchy throat?	7	7.08	8

Dental

	8	8.01	1
When was your last dental exam?	8	8.01	1
	8	8.02	2
Have you ever suffered an injury to your mouth, jaw, and/or teeth?	8	8.02	2
	8	8.03	3
Select all diagnostic tests performed.	8	8.03	3
	8	8.04	4
Have you ever been hospitalized for a month, jaw, and/or tooth injury?	8	8.04	4
	8	8.05	5
Have you ever had surgery on your mouth, jaw, and/or teeth?	8	8.05	5
	8	8.06	6
Do you have any permanent dental appliances (e.g., retainers)?	8	8.06	6

Cervical Spine / Neck

	9	9.01	1
Have you ever suffered an injury to your cervical spine and/or neck?	9	9.01	1
	9	9.03	3
Have you ever been hospitalized for a cervical spine/neck injury?	9	9.03	3
	9	9.04	4
Have you ever had a "burner", "stinger", or brachial plexus injuries?	9	9.04	4
	9	9.05	5
Have you ever experienced numbness and/or tingling in your arms / fingers?	9	9.05	5
	9	9.06	6
Have you ever had surgery of any kind on your cervical spine/neck?	9	9.06	6
If yes, Dates? Surgeon? Hospital?			
	9	9.07	7
Have you ever been advised not to participate in athletic activities due to a cervical spine/neck injury?	9	9.07	7
	9	9.08	8
When playing sports, I wear a:	9	9.08	8
	9	9.09	9
Have you ever worn or been advised to wear a neck roll, neck collar, "Cowboy collar", and/or helmet restrictor plate?	9	9.09	9

Shoulder / Upper Arm

	10	10.01	1
Have you ever suffered an injury to your shoulder or upper arm?	10	10.01	1
	10	10.02	2

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever suffered a dislocated shoulder?	10	10.02	2
	10	10.03	3
Select all diagnostic tests performed.	10	10.03	3
	10	10.04	4
Have you ever been hospitalized for a shoulder or upper arm injury?	10	10.04	4
	10	10.06	6
Have you ever been advised not to participate in athletic activities due to a shoulder or upper arm injury?	10	10.06	6
	10	10.50	5
Have you ever had surgery of any kind on your shoulder or upper arm?	10	10.50	5

Elbow / Forearm

	11	11.01	1
Have you ever suffered an injury to your elbow(s) or forearm(s)?	11	11.01	1
	11	11.02	2
Select all diagnostic tests performed.	11	11.02	2
	11	11.03	3
Have you ever been hospitalized for an elbow or forearm injury?	11	11.03	3
	11	11.04	4
Have you ever had surgery of any kind on your elbow(s) or forearm(s)?	11	11.04	4
	11	11.05	5
Have you ever been advised not to participate in athleltic activities due to an elbow or forearm injury?	11	11.05	5

Wrist, Hand, & Fingers

	12	12.01	1
Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)?	12	12.01	1
	12	12.02	2
Select all diagnostic tests performed.	12	12.02	2
	12	12.03	13
Have you ever been hospitalized for a wrist, hand, and/or finger injury?	12	12.03	13
	12	12.04	4
Have you ever had surgery of any kind on your wrist, hand, and/or finger(s)?	12	12.04	4
	12	12.05	5
Have you ever been advised not to participate in athletic activities due to a wrist, hand, and/or finger injury?	12	12.05	5
	13	13.02	2
Select all disgnostic tests performed.	13	13.02	2
	13	13.03	3
Have you ever been hospitalized for a spine/low back or sacroiliac joint injury?	13	13.03	3

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New/Transfer Health History

	Section	Sub-Section	Q#
	13	13.04	4
Have you ever had surgery of any kind on your spine/low back or sacroiliac joint?	13	13.04	4
	13	13.05	5
Have you ever had numbness/tingling down one (1) or both legs?	13	13.05	5
	13	13.06	6
Have you ever been to a spine clinic or had a spinal injection?	13	13.06	6
	13	13.07	7
Have you ever had formal physical therapy for your spine/low back or sacroiliac joint?	13	13.07	7
	13	13.08	8
Have you ever been advised not to participate in athletic activities due to a spine/low back or sacroiliac joint injury?	13	13.08	8

Hip / Groin

	14	14.01	1
Have you ever suffered an injury to your hip(s) or groin (including hernia and/or sports hernias)?	14	14.01	1
	14	14.02	2
Select all diagnostic tests performed.	14	14.02	2
	14	14.03	3
Have you ever had surgery for a hip or groin injury?	14	14.03	3
	14	14.04	4
Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury?	14	14.04	4

Thigh / Hamstring / Quadriceps

	15	15.01	1
Have you ever suffered an injury to your thigh, hamstring(s), and/or quadriceps?	15	15.01	1
	15	15.02	2
Select all diagnostic tests performed.	15	15.02	2
	15	15.03	3
Have you ever been hospitalized for a thigh, hamstring(s), and/of quadriceps injury? Have you ever been hospitalized for a thigh, hamstring(s), and/of quadriceps injury?	15	15.03	3
	15	15.04	4
Have you ever had surgery for a thigh, hamstring(s), and/or quadriceps injury?	15	15.04	4
	15	15.05	5
Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, and/or quadriceps injury?	15	15.05	5

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New/Transfer Health History

	Section	Sub-Section	Q#
Knee / Patella			
	16	16.01	1
Have you ever suffered an injruy to your knee(s) and/or patella (kneecap)?	16	16.01	1
	16	16.02	2
Select all diagnostic tests performed.	16	16.02	2
	16	16.03	3
Have you ever been hospitalized for a knee and/or patella injury?	16	16.03	3
	16	16.04	4
Have you ever had surgery for a knee and/or patella injury?	16	16.04	4
	16	16.05	5
Have you ever been advised not to participate in athletic activities due to a knee and/or patella injury?	16	16.05	5
	16	16.06	6
Do you presently wear a knee brace for playing sports?	16	16.06	6
Ankle / Lower Leg			
	17	17.01	1
Have you ever suffered an injury to your ankle(s) or lower leg?	17	17.01	1
	17	17.02	2
Select all diagnostic tests performed.	17	17.02	2
	17	17.03	3
Have you ever been hospitalized for an ankle or lower leg injury?	17	17.03	3
	17	17.04	4
Have you ever had surgery for an ankle or lower leg injury?	17	17.04	4
	17	17.06	6
When playing sports, do you presently:	17	17.06	6
Foot / Toes			
	18	18.01	1
Have you ever suffered an injury to your foot or toes?	18	18.01	1
	18	18.02	2
Select all diagnostic tests performed.	18	18.02	2
	18	18.03	3
Have you ever had surgery for a foot or toe injury?	18	18.03	3
	18	18.04	4
Have you ever been advised not to participate in athletic activities due to a foot or toe injury?	18	18.04	4
Ribs / Thorax / Chest			
	19	19.01	1
Have you ever suffered an injury to your rib(s), thorax or chest?	19	19.01	1

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
	19	19.02	2
Select all diagnostic tests performed.	19	19.02	2
	19	19.03	3
Have you ever had an abnormal chest x-ray and/or pneumonia?	19	19.03	3
	19	19.04	4
Have you ever been hospitalized for a rib, thorax or chest injury?	19	19.04	4
	19	19.05	5
Have you ever had surgery for a rib, thorax or chest injury?	19	19.05	5
	19	19.06	6
Have you ever been advised not to participate in athletic activities due to a rib, thorax, and/or chest injury?	19	19.06	6

Abdomen

	20	20.01	1
Have you ever been told that you have kidney disease?	20	20.01	1
	20	20.02	2
Have you ever had a stomach and/or duodenal ulcer?	20	20.02	2
	20	20.03	3
Have you ever had gallbladder disease?	20	20.03	3
	20	20.04	4
Have you ever been diagnosed with an injury &/or problems with your stomach, abdomen, intestines, or rectum?	20	20.04	4
	20	20.05	5
Select all diagnostic tests performed.	20	20.05	5
	20	20.06	6
Have you ever been hospitalized for an abdominal injury or problem?	20	20.06	6
	20	20.07	7
Have you ever had surgery for an abdominal injury or problem?	20	20.07	7
	20	20.09	9
Do you routinely suffer from chronic or recurrent diarrhea, or irritable bowel syndrome?	20	20.09	9
	20	20.10	10
Do you have only one of two paired functioning organs (e.g.,eyes, kidneys, testicles, ovaries, etc)?	20	20.10	10
	20	20.11	11
Do you suffer from any type of urological or genital disorder?	20	20.11	11
	20	20.12	12
Have you ever been advised not to participate in athletic activities due to an abdominal injury or problem?	20	20.12	12

Dermatological

	21	21.01	1

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Do you suffer from any skin condiitions? (e.g., itching, rashes, acne, plantar warts, eczema, fungus, etc)	21	21.01	1
	21	21.02	2
Have you ever been diagnosed with MRSA or Staphylococcus infection?	21	21.02	2
	21	21.03	3
Are you currently under the care of a dermatologist for any condition?	21	21.03	3
	21	21.04	4
Have you been advised not to participate in athletic activities due to a skin condition? (e.g., herpes, impetigo, athlete's foot, etc.)	21	21.04	4
	21	21.22	22
I, the undersigned, hereby acknowldege, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statments are false and/or have been omitted in refernce to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm. If any information and/or statements are false and/or have been omitted in refernce to my past and/or present medical history, I understand and acknowledge that I will be responsible for any medical charges incurred.	21	21.22	22

Sickle Cell Trait

	22	22.01	1
Other than at birth, have you ever been tested for Sickle Cell Trait?	22	22.01	1
	22	22.02	2
Does any member of your family carry the Sickle Cell Trait or have Sickle Cell disease?	22	22.02	2
	22	22.03	3
It is MANDATORY that you complete the Sickle Cell Waiver under the Athlete Forms section when you have completed this questionnire!			

Heat-Related Problems

	23	23.01	1
Have you ever become ill while exercising in the heat? If so, please list the type in the explanation section: Heat cramps, Heat syncope (fainting), Heat exhaustion, or Heat stroke	23	23.01	1
	23	23.02	2
Have you ever had electrolyte (salt) or fluid imbalance?	23	23.02	2
	23	23.03	3
Have you ever received intravenous fluids (IV) for a heat-related problem?	23	23.03	3
	23	23.04	4

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever been hospitalized for a heat-related problem?	23	23.04	4
	23	23.05	5
Have you ever been advised not to participate in athletic activities due to a heat-related illness?	23	23.05	5

Diabetic History

	24	24.01	1
Have you been diagnosed with diabetes mellitus?	24	24.01	1
If yes, Type 1 or Type 2			
	24	24.02	2
Do you have a family history of diabetes?	24	24.02	2
	24	24.03	3
Are you presently taking any diabetic medications (e.g., insulin)?	24	24.03	3
If yes, please list the names			
	24	24.05	5
During the day, how often do you monitor your blood sugar levels?	24	24.05	5
	24	24.06	6
How often is your A1C level checked?	24	24.06	6
	24	24.07	7
Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months?	24	24.07	7
	24	24.08	8
Have you ever been advised not to participate in athletic activities due to diabetes?	24	24.08	8
	24	24.09	9
Please list any precautions that you take and/or additional information not mentioned above.	24	24.09	9

Nutrition

	25	25.01	1
Have you ever been treated for iron-deficiency anemia?	25	25.01	1
	25	25.02	2
How many meals do you eat daily (in 24 hrs.)?	25	25.02	2
	25	25.03	3
How many snacks do you eat daily (in 24 hrs.)?	25	25.03	3
	25	25.04	4
Are there certain food groups that you refuse to eat (e.g., meats, dairy)? Please list them.	25	25.04	4
	25	25.05	5
Are you a vegetarian? If yes, what type?	25	25.05	5

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
	25	25.06	6
What have you eaten in the last 24 hours?	25	25.06	6
	25	25.07	7
Are you currently dieting to lose weight?	25	25.07	7
	25	25.08	8
What is your present weight?	25	25.08	8
	25	25.09	9
Are you happy with this weight? If not, what would you like to weigh?	25	25.09	9
	25	25.10	10
Have you ever been at your ideal weight?	25	25.10	10
	25	25.11	11
Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?	25	25.11	11
	25	25.12	12
Have you tried to control your weight by vomiting, fasting, laxatives, skipping meals, diuretics, diet pills, weight-loss programs (i.e. Jenny Craig, Weight Watchers), liquid diet supplements, very low calorie diet (<800 cal/day), high protein/low carb diet? If yes, please list	25	25.12	12
	25	25.13	13
Do you take a multiple vitamin with iron daily?	25	25.13	13
	25	25.14	14
Do you take a calcium supplement daily?	25	25.14	14
	25	25.15	15
If you are taking any herbal or dietary supplement(s), please list them here:			
	25	25.16	16
Would you like to meet with a Registered Dietician to discuss your nutritional needs, goals or eating habits?	25	25.16	16

Prescription Medications

	26	26.01	1
List ALL Prescription & Over-the-Counter Medications that you are CURRENTLY taking:			

Gynecology

	27	27.01	1
How old were you when you had your first menstrual period?	27	27.01	1
	27	27.02	2
How often do you have a period?	27	27.02	2
	27	27.03	3
How long do your periods last?	27	27.03	3
	27	27.04	4

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
How many periods have you had in the last twelve (12) months?	27	27.04	4
	27	27.05	5
When was your last menstrual period?	27	27.05	5
	27	27.06	6
Do you ever suffer from irregular, painful and/or heavy menstrual periods?	27	27.06	6
	27	27.07	7
Do you ever suffer from cramping with your periods?	27	27.07	7
	27	27.08	8
Do your periods fluctuate with changes in your training regimen?	27	27.08	8
	27	27.09	9
Have you ever gone more than two (2) months without having a period? If yes, how long?	27	27.09	9
	27	27.10	10
Did you see a physician when you missed your period?	27	27.10	10
	27	27.11	11
Do you take birth control pills or hormones?	27	27.11	11
	27	27.12	12
Do you ever have any unusual discharge from your vagina?	27	27.12	12
	27	27.13	13
When was your last pelvic examination/Pap smear?	27	27.13	13
	27	27.14	14
Have you ever had an abnormal Pap smear?	27	27.14	14
	27	27.15	15
Have you been tested for the Human Papillomavirus (HPV)?	27	27.15	15
	27	27.16	16
Have you had the Human Papillomavirus vaccine (e.g., Gardasil)?	27	27.16	16
	27	27.17	17
Have you ever noticed any problems with your breasts? (e.g., lumps, discharge)	27	27.17	17
	27	27.18	18
Have you had any previous stress fractures?	27	27.18	18
	27	27.19	19
Do you ever get urinary tract infections (UTIs) (e.g., bladder or kidney)?	27	27.19	19
	27	27.20	20
Have you ever been pregnant?	27	27.20	20
	27	27.21	21
Are you pregnant at this time?	27	27.21	21

Confidential

	28	28.01	1

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you ever had any injury or illness other than those already disclosed?	28	28.01	1
	28	28.02	2
Do you have an ongoing or chronic illness?	28	28.02	2
	28	28.03	3
Have you ever been told by a physician to restruct your sports activity or not to participate in a sport?	28	28.03	3
	28	28.04	4
Are you currently under a physician's care for any medical conditions?	28	28.04	4
	28	28.05	5
Have you ever been under the care of a psychiatrist and/or psychologist?	28	28.05	5
	28	28.06	6
Have you ever been treated for anxiety, depression or any mental illness? Counseling Services at CUC are available by appointment by calling 708-209-3229.	28	28.06	6
	28	28.07	7
Are you currently being treated for anxiety, depression or any other mental illness?	28	28.07	7
	28	28.08	8
When you feel stressed out, do you feel as though you get the necessary support to deal with your stress?	28	28.08	8
	28	28.09	9
Do you have Attention-Deficit Hyperactivity Disorder (ADD/ADHD)? If yes, please list your medications: If you take medications for this illness, it is MANDATORY that your prescribing physician complete the ADHD Medical Exception Information Form that is under the Ahlete Forms section. You will need to download the form for your physician. Most ADHD medications are NCAA Banned Substances and if the ADHD Medical Exception Information Form is not completed and returned, it could result in a 1 year suspension from play if you are drug tested.	28	28.09	9
	28	28.10	10
Have you had a history of anorexia nervosa, bulimia, and/or any other eating disorder?	28	28.10	10
	28	28.11	11
Are you currently undergoing treatment for anorexia nervosa, bulimia, and/or any other eating disorder?	28	28.11	11
	28	28.12	12
Do you regularly lose weight to participate in your sport(s)?	28	28.12	12
	28	28.13	13

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?	28	28.13	13
	28	28.14	14
Are you sexually active?	28	28.14	14
	28	28.15	15
Do you use protection during sexual intercourse (e.g. pill, condom, IUD, diaphragm)?	28	28.15	15
	28	28.16	16
Do you smoke cigarettes, use smokeless tobacco, or use tobacco products in any form?	28	28.16	16
	28	28.17	17
How often do you use alcohol?	28	28.17	17
	28	28.18	18
Have you ever used/tried marijuana, cocaine, or any other illicit "street" drugs?	28	28.18	18
	28	28.19	19
Do you currently use marijuana, cocaine, or any other illicit "street" drugs?	28	28.19	19
	28	28.20	20
Do you have any questions regarding drugs, tobacco, or alcohol?	28	28.20	20
	28	28.21	21
Are you aware of any reasons why you should NOT participate in intercollegiate athletics at Concordia University Chicago at this time?	28	28.21	21
	29	29.01	1
I, the undersigned, hereby acknowldege, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that I will be responsible for any medical charges incurred. I have read and signed this document will full knowledge of its significance. IF MINOR, (17	29	29.01	1

ATS Athlete Forms Library

New/Transfer Health History

	Section	Sub-Section	Q#
I, the undersigned, hereby acknowldege, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that I will be responsible for any medical charges incurred. I have read and signed this document will full knowledge of its significance. IF MINOR, (17 yo and UNDER) PARENT/GUARDIAN SIGNATURE IS REQUIRED!	29	29.01	1
	30	30.01	1
Today's Date	30	30.01	1

ATS Athlete Forms Library

Policies & Procedures (All Athletes)

	Section	Sub-Section	Q#
Medical Insurance			
	1	1.01	1
In order to be eligible to participate in varsity athletics, all student-athletes must have primary health insurance in his or her name or through a parent/guardian. The State University of xxx at xxx Athletics Department participates in the “NCAA Catastrophic Athletic Injury Insurance Program.” This program provides lifetime medical benefits to student-athletes who are catastrophically injured during competition, and/or practice, related to intercollegiate athletic participation. The NCAA Catastrophic Athletic Injury Insurance Program has a $90,000 deductible. For more information, visit: www.ncaa.org.	1	1.01	1
xxx has a secondary athletic insurance policy for any injuries that should occur during a supervised official team practice/competition or travel to/from one of these, orthopedic in nature, not pre-existing and deemed medically necessary by the providing physician. Currently, our secondary insurance has a zero dollar deductible. Secondary insurance deductibles can change year to year. Accident/injury benefits for student-athletes are provided on an excess basis. This means the student-athlete's own personal health insurance must be billed first. If there is a balance due on any bills from an injury after the student-athlete’s insurance company has made payment to the maximum allowable limit, the student and/or parents must provide the athletic training staff with copies of all original itemized bills (HCFA, UB-04, UB-92 forms) and copies of all insurance company Explanation of Benefits Statement (EOBs) within 90 days of treatment; failure to do so may affect whether a bill is paid by the Athletics Department. The EOBs should indicate original charges, amount paid by the insurance company and balance still due.	1	1.01	2
The secondary athletic insurance policy will cover injuries to the mouth and to sound natural teeth incurred while participating in an official practice or game. In those sports where mouthpieces are mandatory (i.e. field hockey, women’s lacrosse), the policy will provide coverage ONLY if the protective device is worn by the student-athlete in accordance with the guidelines set by the manufacturer.	1	1.01	3
It is the recommendation of xzxx that all jewelry be removed for practice and competition. If all jewelry, including, but not limited to earrings, rings, necklaces, belly button rings or bars, and tongue rings, is not removed, the student-athlete will be solely responsible for any medical or dental costs resulting from any injury consequential to jewelry being worn.	1	1.01	4
It is the responsibility of the student-athlete to notify the Athletic Training Department of any changes in personal health insurance or emergency contact information throughout the school year.	1	1.01	5
	1	1.01	6
Medical Screenings			
	2	2.01	1

ATS Athlete Forms Library

Policies & Procedures (All Athletes)

	Section	Sub-Section	Q#
Prior to participation in athletics at xxx, all new student-athletes who will be competing in intercollegiate athletics are required to have a physical exam completed by their own physician or qualified health care provider. The examination or evaluation must be administered within six months prior to participation in any practice, competition or out-of-season conditioning activities (NCAA Bylaw 17.1.6.4) for all (1) incoming freshman, (2) current xxx students who have not played in the previous athletic season, and (3) transfers who have not played in the previous athletic season. For all returning and transfer student-athletes, the initial physical exam performed prior to commencement of NCAA athletics will suffice.	2	2.01	1
Student Health Services will mail all student-athletes a Health Report (HR). This document will serve as a record of your physical examination. It needs to be completed by the individual's primary health care provider and returned to Student Health Services ASAP. Transfer student-athletes must include the Health History Form of the HR when submitting documentation. Once a student-athlete's physical is received, it is reviewed for completeness and accuracy. If there are unresolved issues with the information, the student-athlete will be notified by Student Health Services by mail. Additional health screening will be conducted by the athletic training staff which will include a review of all submitted medical document, a cardiovascular screening, and baseline concussion assessments. All medical documents and screenings must be completed before participation in any varsity practice or competition.	2	2.01	2
	2	2.01	3

Reporting Procedures

	3	3.01	1
All athletic-related injuries, including signs and symptoms of concussions, must be reported to the Athletic Training staff immediately, except in the case of an emergency or in the absence of an athletic trainer in which case the athlete must report the injury within two school days and/or prior to any further athletic participation. Failure to do so may result in loss of benefits through the secondary athletic insurance policy. In the event of an injury, the athletic trainer will make all necessary referrals to the appropriate medical provider (emergency room, physician, etc.). The host athletic trainer should be consulted at away contests in the absence of a xxx athletic trainer.	3	3.01	1
	3	3.01	2

Clearance Following Injury/Illness

	4	4.01	1

ATS Athlete Forms Library

Policies & Procedures (All Athletes)

	Section	Sub-Section	Q#
All student-athletes receiving medical attention from a licensed physician (i.e. Emergency Room physician, Family physician, etc.), regardless of injury or illness, must provide the xxx Athletic Training Staff with a signed note from the attending physician indicating the specific injury or illness and the athlete's eligibility for athletic participation. Doctor's office notes, imaging reports, and operation reports that include diagnosis, treatment (previous/ongoing/future), and restrictions (general/sport specific) are acceptable forms of documentation. Simple clearance notes will only be accepted once all other reports are on file. Written medical clearance must be obtained prior to the student-athletes' return to athletic participation. However, Student Health Services, the team orthopedist and the athletic training staff have the final decision in return to athletic participation.	4	4.01	1
	4	4.01	2

Equipment

	5	5.01	1
Any equipment (i.e. crutches, ace wraps, splints, slings, etc.) loaned to a student-athlete by the xxx Athletic Training Staff must be returned to the athletic training office or a charge may be placed on the student's account.	5	5.01	1
	5	5.01	2

ATS Athlete Forms Library

Pre-Participation High School (GA)

	Section	Sub-Section	Q#
General Questions			
Has a doctor ever denied or restricted your participation in sports for any reasons?	1	1.00	1
	1	1.00	1
Do you have any ongoing medical conditions?	1	2.00	2
Asthma?	1	2.00	2
Anemia?	1	2.00	3
Diabetes?	1	2.00	4
Infections?	1	2.00	5
Other?	1	2.00	6
Have you ever spent the night in the hospital?	1	3.00	7
	1	3.00	7
Have you ever had surgery?	1	4.00	8
	1	4.00	8
Heart health Questions About You			
Have you ever passed out or nearly passed out DURING or AFTER exercise?	2	4.00	9
	2	4.00	9
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	2	4.01	10
	2	4.01	10
Does your heart ever race or skip beats (irregular beats) during exercise?	2	4.02	11
	2	4.02	11
Has a doctor ever told you that you have any heart Problems? Specifically:	2	4.03	12
High blood pressure	2	4.03	12
High cholesterol	2	4.03	13
Kawasaki disease	2	4.03	14
A heart murmur	2	4.03	15
A heart infection	2	4.03	16
Other:	2	4.03	17
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	2	4.04	18
	2	4.04	18
Do you get lightheaded or feel more short of breath than expected during exercise?	2	4.05	19
	2	4.05	19
Have you ever had an unexplained seizure?	2	4.06	20
	2	4.06	20
Do you get more tired or short of breath more quickly than your friends during exercise?	2	4.07	21
	2	4.07	21
Heart Health Questions About Your Family			

ATS Athlete Forms Library

Pre-Participation High School (GA)

	Section	Sub-Section	Q#
Has any family member or relative died of heart problems or had any unexpected or unexplained sudden death before 50? (including drowning, unexplained card accident, or suddent infant death syndrome)?	3	5.00	22
	3	5.00	22
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	3	5.01	23
	3	5.01	23
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	3	5.02	24
	3	5.02	24
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowing?	3	5.03	25
	3	5.03	25

Bone and Joint Questions

Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?	4	6.00	26
	4	6.00	26
Have you ever had any broken or fractured bones or dislocated joints?	4	6.01	27
	4	6.01	27
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	4	6.02	28
	4	6.02	28
Have you ever had a stress fracture?	4	6.03	29
	4	6.03	29
Have you ever been told taht you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	4	6.04	30
	4	6.04	30
Do you regularly use a brace, orthotics, or other assistive device?	4	6.05	31
	4	6.05	31
do you have a bone, muscle, or joint injury that bothers you?	4	6.06	32
	4	6.06	32
Do any of your joints become painful, swollen, feel warm, or look red?	4	6.07	33
	4	6.07	33
Do you have any history of juvenile arthritis or connective tissue disease?	4	6.08	34
	4	6.08	34

Medical Questions

Do you cough, wheeze, or have difficulty breathing during or after exercise?	5	7.00	35
	5	7.00	35
Have you ever used an inhaler or taken asthma medicine?	5	7.01	36
	5	7.01	36

ATS Athlete Forms Library

Pre-Participation High School (GA)

	Section	Sub-Section	Q#
Is there anyone in your family who has asthma?	5	7.02	37
	5	7.02	37
Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	5	7.03	38
	5	7.03	38
Do you have groin pain or a painful buldge or hernia in the groin area?	5	7.04	39
	5	7.04	39
Have you had infectious mononucleosis (mono) within the last month?	5	7.05	40
	5	7.05	40
Do you have any rashes, pressure sores, or other skin problems?	5	7.06	41
	5	7.06	41
Have you had a herpes or MRSA skin infection?	5	7.07	42
	5	7.07	42
Have you ever had a head injury or concussion?	5	7.08	43
	5	7.08	43
Have you ever had a hit or blow to the the head that caused confusion, prolonged headache, or memory problems?	5	7.09	44
	5	7.09	44
Do you have a history of seizure disorder?	5	7.10	45
	5	7.10	45
Do you have headaches with exercise?	5	7.11	46
	5	7.11	46
Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	5	7.12	47
	5	7.12	47
Have you ever been unable to move your arms or legs after being hit or falling?	5	7.13	48
	5	7.13	48
Have you ever become ill while exercising in the heat?	5	7.14	49
	5	7.14	49
Do you get frequent muscle cramps when exercising?	5	7.15	50
	5	7.15	50
Do you or someone in your family have sickle cell trait or disease?	5	7.16	51
	5	7.16	51
Have you had any problems with your eyes or vision?	5	7.17	52
	5	7.17	52
Have you had any eye injuries?	5	7.18	53
	5	7.18	53
Do you wear glasses or contact lenses?	5	7.19	54
	5	7.19	54
Do you wear protective eyewear, such as goggles or a face shield?	5	7.20	55
	5	7.20	55
Do you worry about your weight?	5	7.21	56
	5	7.21	56

ATS Athlete Forms Library

Pre-Participation High School (GA)

	Section	Sub-Section	Q#
Are you trying to or has anyone recommended that you gain or lose weight?	5	7.22	57
	5	7.22	57
Are you on a special diet or do you avoid certain types of foods?	5	7.23	58
	5	7.23	58
Have you ever had an eating disorder?	5	7.24	59
	5	7.24	59
Do you have any concerns that you would like to discuss with a doctor?	5	7.25	59
	5	7.25	59

Females Only

Have you ever had a menstrual period?	6	8.00	60
	6	8.00	60
How old were you when you had your first menstrual period?	6	8.01	61
	6	8.01	61
How many periods have you had in the last 12 months?	6	8.02	62

Special Needs Supplemental History

Type of disability	7	9.00	63
Date of disability	7	9.01	64
Classification (if available)	7	9.02	65
Cause of disability (birth, disease, accident/trauma, other)	7	9.03	66
List the sports you are interested in playing	7	9.04	67
Do you regularly use a brace, assistive device, or prosthetic?	7	9.05	68
Do you use any special brace or assistive device for sports?	7	9.06	69
do you have any rashes, pressure sores, or any other skin problems?	7	9.07	70
Do you have a hearing loss? Do you use a hearing aid?	7	9.08	71
Do you have a visual impairment?	7	9.09	72
Do you use any special devices for bowel or bladder function?	7	9.10	73
Do you have burning or discomfort when urinating?	7	9.11	74
Have you had autonomic dysreflexis?	7	9.12	75

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Pre-Participation High School (GA)

	Section	Sub-Section	Q#
Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?	7	9.13	76
Do you have muscle spasticity?	7	9.14	77
Do you have frequent seizures that cannot be controlled by medication?	7	9.15	78
Please indicate if you have ever had any of the following:	7	9.16	78
Atlantoaxial instability			
X-ray evaluation for atlantoaxial instability			
Dislsocated joints (more than one)			
Easy bleeding			
Enlarged spleen			
Hepatitis			
Osteopenia or osteoporosis			
Difficulty controlling bowel			
Difficulty controlling bladder			
Numbness or tingling in arms or hands			
Numbness or tingling in legs or feet			
Weakness in arms or hands			
Weakness in legs or feet			
Recent change in coordination			
Recent change in ability to walk			
Spina bifida			
Latex allergy			

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Pre-Participation Physical Evaluation

	Section	Sub-Section	Q#
KANSAS STATE HIGH SCHOOL ACTIVITIES ASSOCIATION			
PPE shall not be taken earlier than May 1 preceding the school year for which it is applicable. **STUDENT/PARENT/GUARDIAN - answer questions below PRIOR TO EXAMINATION by physician.** **Explain "YES" answers in space below. Circle the number of the questions you do not know.** TO BE COMPLETED ANNUALLY BY EVERY PARTICIPANT AND PARENT OR GUARDIAN	1	1.10	1
	2	2.01	2
Have you had a medical illness or injury since your last check up or sports physical?	2	2.01	2
	2	2.02	3
Do you have an ongoing or chronic illness?	2	2.02	3

ATS Athlete Forms Library

Pre-Participation Questionnaire for New Student-Athletes

	Section	Sub-Section	Q#
PERSONAL DEMOGRAPHICS			
	1	1.01	1
Full Name:	1	1.01	1
Date of Birth:	1	1.01	2
Age:	1	1.01	3
Current College Classification	1	1.02	4
Freshman	1	1.02	4
Sophomore	1	1.02	4
Junior	1	1.02	4
Senior	1	1.02	4
5th Year	1	1.02	4
	1	1.03	5
Cell Phone:	1	1.03	5
Sport(s):	1	1.03	6
Campus/Local Address:	1	1.03	7
Parent/Guardian Address:	1	1.03	8
Parent/Guardian Phone:	1	1.03	9
Emergency Contact Name:	1	1.03	10
Emergency Contact's Phone:	1	1.03	11
Emergency Contact's Relationship to You:	1	1.03	12
GENERAL MEDICAL HISTORY			
Do you currently or ever had any of the following....	2	2.01	1
Take over-the-counter medications (please list medication and reason):	2	2.01	1
Take prescription medications and/or any nutritional supplements (please list medication and reason):	2	2.01	2
Allergies to any foods and/or medications (please list):	2	2.01	3
Epilepsy or history of seizures (provide dates of last 2 seizures):	2	2.01	4
Been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD):	2	2.01	5
Asthma:	2	2.01	6
Heart murmur or other heart condition (provide details):	2	2.01	7
Diabetes (provide type and date of diagnosis):	2	2.01	8
Anemia:	2	2.01	9
Has a doctor/physician sent you for an ECG, EKG, echocardiogram, etc (provide timeframe, reason, test type, and test result):	2	2.01	10
Hemophilia or other bleeding disorder (provide name and details):	2	2.01	11
Sickle Cell Disease or Trait (which one):	2	2.01	12
Absence of any organ or body part (please identify):	2	2.01	13
High Blood Pressure:	2	2.01	14
Kidney/bladder disease (details):	2	2.01	15
Cancer (details):	2	2.01	16
HIV infection:	2	2.01	17

	Section	Sub-Section	Q#
Hernia (date of repair):	2	2.01	18
Thyroid problem (details):	2	2.01	19
Marfan Syndrome (date of diagnosis):	2	2.01	20
Double-jointedness:	2	2.01	21
Depression, anxiety, psychological or mental health issue:	2	2.01	22
Ongoing diarrhea or blood in stool:	2	2.01	23
Suffered from heat stroke or other heat-related illness (provide dates and details):	2	2.01	24
Number of menstrual periods in the past 12 months:	2	2.01	25
Date of last menstrual period:	2	2.01	26
Has a doctor/physician recommended and/or disqualified you from participating in sports for any reason (explain):	2	2.01	27
Have you ever been hospitalized (when and for what):	2	2.01	28
MRSA (Methicillin-resistant Staphylococcus aureus) (when):	2	2.01	30
Have you been diagnosed with mono or hepatitis within the last 2 months (details):	2	2.01	31
Have you ever suffered from any of the following either during or after exercise (provide details).....	2	2.02	32
Asthma:	2	2.02	32
Wheezing and/or coughing:	2	2.02	33
Passed out or nearly passed out:	2	2.02	34
Experienced pain, discomfort, heaviness, or pressure in your chest:	2	2.02	35
Experienced palpitations, racing, or skipped beats of your heart:	2	2.02	36

MUSCULOSKELETAL INJURY HISTORY

Have you ever had an injury and/or surgery to the following (provide date, side, specific type of injury, and surgery performed):	3	3.01	1
Neck or cervical spine (including a 'stinger' or 'whiplash'):	3	3.01	1
Upper back (thoracic spine):	3	3.01	2
Lower back (lumbar spine):	3	3.01	3
Chest or ribs:	3	3.01	4
Shoulder (including collar bone):	3	3.01	5
Upper arm:	3	3.01	6
Elbow:	3	3.01	7
Lower arm (forearm):	3	3.01	8
Wrist:	3	3.01	9
Hand or fingers:	3	3.01	10
Hip or pelvis:	3	3.01	11
Thigh (including hamstrings and quadriceps):	3	3.01	12
Knee:	3	3.01	13
Lower leg (including calf or shin):	3	3.01	14
Ankle:	3	3.01	15
Heel, foot, or toes:	3	3.01	16

ATS Athlete Forms Library

Pre-Participation Questionnaire for New Student-Athletes

	Section	Sub-Section	Q#
Abdomen:	3	3.01	17
Any metal implants (pin, screw, or plate, and where):	3	3.01	18
Have you ever needed extra protective equipment during sport participation:	3	3.01	19
Been "knocked out" unconscious (list date(s) and how long unconscious):	3	3.01	20
Had a concussion (list date(s) and severity of ALL concussions):	3	3.01	21
Been hospitalized due to a head injury (list date(s) of hospitilization):	3	3.01	22
Ever unable to move arms or legs after an injury:	3	3.01	23
Still experience symptoms related to a previous concussion or head injury (list symptoms):	3	3.01	24
Been told by a physician you needed surgery, MRI, CT scan, bone scan, etc for an injury and declined the recommendation (list injury and test):	3	3.01	25
Stress fracture:	3	3.01	26
Injury to your eye(s):	3	3.01	27

LIFESTYLE HABITS

Do you currently have or had any of the following.....	4	4.01	1
Dissatisfaction with your eating patterns (details):	4	4.01	1
Times when you eat in secret:	4	4.01	2
Vomiting because you feel uncomfortably full:	4	4.01	3
Greatly restrict food intake:	4	4.01	4
A sense that your weight affects the way you feel about yourself:	4	4.01	5
Diagnosed with an eating disorder or disordered eating:	4	4.01	6
History of use of performance enhancing substances:	4	4.01	7
History of use of tobacco:	4	4.01	8
History of alcohol or other substance abuse:	4	4.01	9
Do you fast for religious or other reasons (explain):	4	4.01	10
Are you a vegan or vegetarian:	4	4.01	11

FAMILY MEDICAL HISTORY

Has any member of your family suffered from or past away from the following (provide relationship to you and details of condition):	5	5.01	1
Heart Disease	5	5.01	1
Stroke	5	5.01	2
Cancer	5	5.01	3
Heart Attack	5	5.01	4
Other heart problems including arrhythmia, enlargement, cardiomyopathy, etc (details):	5	5.01	5
Sudden death:	5	5.01	6
Sickle cell disease or trait:	5	5.01	7
Eating disorder	5	5.01	8

FINAL WRAP-UP

	6	6.01	1

ATS Athlete Forms Library

Pre-Participation Questionnaire for New Student-Athletes

	Section	Sub-Section	Q#
Do you have any other medical issues/concerns not already addressed (explain):	6	6.01	1
Do you have any medical illnesses, injuries, or concerns that have arisen since your last physical (explain):	6	6.01	2
Do you have any other concerns you would like to discuss with a physician:	6	6.01	3
Would you like a member of the Simmons College Counseling or Health Center to contact you:	6	6.01	4

ATS Athlete Forms Library

Pre-Participation Questionnaire for Returning Student-Athletes

	Section	Sub-Section	Q#
	1	1.09	1
Failure to report a special condition listed in this form will release the College from any liability in the event of injury or illness caused by or related to the unreported condition. xxx will not be held financially responsible for any tests (x-rays included) or referrals to medical consultants to complete the physical examination or review. Any tests or referrals are the responsibility of the student and her family. Furthermore, xxx will not be responsible for any care that may be required to treat a medical condition that is not reported at the time of the sports physical or submission of the Pre-Participation Questionnaire form.	1	1.09	1
	1	1.10	1
Full Name:	1	1.10	1
Date of Birth (mm/dd/year):	1	1.10	2
Age:	1	1.10	3
Current College Classification	1	1.20	4
Freshman	1	1.20	4
Sophomore	1	1.20	4
Junior	1	1.20	4
Senior	1	1.20	4
5th Year	1	1.20	4
	1	1.30	5
Cell Phone:	1	1.30	5
Sport(s):	1	1.30	6
Campus/Local Address:	1	1.30	7
Parent/Guardian Address:	1	1.30	8
Parent/Guardian Phone:	1	1.30	9
Emergency Contact Name:	1	1.30	10
Emergency Contact's Phone:	1	1.30	11
Emergency Contact's Relationship to You:	1	1.30	12

GENERAL MEDICAL HISTORY

Do you currently or ever had any of the following....	2	2.10	1
Take over-the-counter medications (please list medication and reason):	2	2.10	1
Take prescription medications and/or any nutritional supplements (please list medication and reason):	2	2.10	2
Allergies to any foods and/or medications (please list):	2	2.10	3
Epilepsy or history of seizures (provide dates of last 2 seizures):	2	2.10	4
Been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD):	2	2.10	5
Asthma:	2	2.10	6
Thyroid problem (details):	2	2.10	7
Depression, anxiety, psychological or mental health issue:	2	2.10	8
Number of menstural periods in the past 12 months:	2	2.10	9
Date of last menstural period:	2	2.10	10
Have you ever been hospitalized (when and for what):	2	2.10	11

	Section	Sub-Section	Q#
MRSA (Methicillin-resistant Staphylococcus aureus) (when):	2	2.10	12
Have you been diagnosed with mono or hepatitis within the last 2 months (details and date):	2	2.10	13
Have you ever suffered from any of the following either during or after exercise within the last academic year (provide details)....	2	2.20	14
Asthma:	2	2.20	14
Wheezing and/or coughing:	2	2.20	15
Passed out or nearly passed out:	2	2.20	16
Experienced pain, discomfort, heaviness, or pressure in your chest:	2	2.20	17
Experienced palpitations, racing, or skipped beats of your heart:	2	2.20	18

MUSCULOSKELETAL and HEAD INJURY HISTORY

Have you had an injury and/or surgery within the last academic year to the following (provide date, side, specific type of injury, and surgery performed):	3	3.10	1
Neck or cervical spine (including a 'stinger' or 'whiplash'):	3	3.10	1
Upper back (thoracic spine):	3	3.10	2
Lower back (lumbar spine):	3	3.10	3
Chest or ribs:	3	3.10	4
Shoulder (including collar bone):	3	3.10	5
Upper arm:	3	3.10	6
Elbow:	3	3.10	7
Lower arm (forearm):	3	3.10	8
Wrist:	3	3.10	9
Hand or fingers:	3	3.10	10
Hip or pelvis:	3	3.10	11
Thigh (including hamstrings and quadriceps):	3	3.10	12
Knee:	3	3.10	13
Lower leg (including calf and shin):	3	3.10	14
Ankle:	3	3.10	15
Heel, foot, or toes:	3	3.10	16
Abdomen:	3	3.10	17
Any metal implants (pin, screw, or plate, and where):	3	3.10	18
Have you ever needed extra protective equipment during sport participation:	3	3.10	19
Been "knocked out" unconscious (list date(s) and how long unconscious):	3	3.10	20
Had a concussion (list date(s) and severity of ALL concussions):	3	3.10	21
Been hospitalized due to head injury (list date(s) of hospitilization):	3	3.10	22
Ever unable to move arms or legs after an injury:	3	3.10	23
Still experience symptoms related to a previous concussion or head injury (list symptoms):	3	3.10	24
Been told by a physician you needed surgery, MRI, CT scan, bone scan, etc. for an injury and declined the recommendation (list injury and test):	3	3.10	25
Stress fracture (body part and when):	3	3.10	26
Injury to your eye(s):	3	3.10	27

ATS Athlete Forms Library

Pre-Participation Questionnaire for Returning Student-Athletes

	Section	Sub-Section	Q#
LIFESTYLE HABITS			
Do you currently have any of the following....	4	4.10	1
Dissatisfaction with your eating patterns (details):	4	4.10	1
Times when you eat in secret:	4	4.10	2
Vomitting because you feel uncomfortably full:	4	4.10	3
Greatly restrict food intake:	4	4.10	4
A sense that your weight affects the way you feel about yourself:	4	4.10	5
Diagnosed with an eating disorder or disordered eating (when):	4	4.10	6
History of use of performance enhancing substances:	4	4.10	7
History of use of tobacco:	4	4.10	8
History of alcohol or other substance abuse:	4	4.10	9
Do you fast for religious or other reasons (explain):	4	4.10	10
Are you a vegan or vegetarian:	4	4.10	11
FAMILY MEDICAL HISTORY			
	5	5.10	1
Has any member of your family been diagnosed with any medical condition within the last academic year (provide details):	5	5.10	1
FINAL WRAP-UP			
	6	6.10	1
Do you have any other medical issues not already addressed (explain):	6	6.10	1
Do you have any other concerns you would like to discuss with a physician:	6	6.10	2
Would you like a member of the Simmons College Counseling or Health Center to contact you:	6	6.10	3

ATS Athlete Forms Library

Pre-Participation Sample 1

	Section	Sub-Section	Q#
Personal History			
The following questions ask for information regarding your personal background	1	1.01	1
What is your primary sport?	1	1.01	1
Have you participated in other sports in the past (including competitively)?	1	1.01	2
What is your ethnic origin?	1	1.01	3
Do you have any religious convictions that could affect your medical treatment?	1	1.01	4
What is the date of your last physical?	1	1.01	5
Have you ever failed a pre-participation exam for sports, or has your doctor ever stopped you from participating in sports for any reason?	1	1.01	6
In total, how many days have you missed practice or competition in the past year because of injury or illness?	1	1.01	7
Heart			
Have you ever had any of the following heart or circulation related problems:	2	2.01	8
Chest pain, discomfort, tightness or pressure with exercise?	2	2.01	8
Unexplained fainting or near fainting or passed out for no reason during or after exercise?	2	2.01	9
Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise?	2	2.01	10
Do you get more tired or short of breath more quickly than your friends during exercise?	2	2.01	11
Does your heart race or skip beats (irregular beats) during exercise?	2	2.01	12
Have you ever had a heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem?	2	2.01	13
Have you ever had an unexplained seizure?	2	2.01	14
Have you ever had any tests for your heart (for example, ECG or EKG, echocardiogram)?	2	2.01	15
Breathing			
Have you ever had any of the following respiratory or greathing problems:	3	3.01	16
Do you have asthma?	3	3.01	16
Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu-like illness?	3	3.01	17
Do you cough, wheeze or have more difficulty breathing than you should during or after exercise?	3	3.01	18
Have you ever used asthma medication (such as an inhaler)?	3	3.01	19
Have you ever had bronchitis, pneumonia, tuberculois, cystic fibrosis or other repiratory or other breathing problem?	3	3.01	20
Heat			
The following questions are about exercise in the heat:	4	4.01	21
Have you ever become ill while exercising in the heat?	4	4.01	21

ATS Athlete Forms Library

Pre-Participation Sample 1

	Section	Sub-Section	Q#
Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia?	4	4.01	22
Do you get frequent muscle cramps while exercising?	4	4.01	23
Have you ever had electrolyte (salt) or fluid imbalance?	4	4.01	24

Medical

	5	5.01	25
Do you have any ongoing medical conditions or illness?	5	5.01	25
Do you have, or have you ever had any symptoms of medical problems such as:	5	5.02	26
Infections mononucleosis (mono), flu like symptoms or viral illness within the past month?	5	5.02	26
Disease of the ears (infections, hearing loss, pain), nose (sneezing, itchy nose, sinusitis, blocked nose) or throat (sore throat, hoase voice, swollen glands in the neck)?	5	5.02	27
Blood disorders such as anemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder?	5	5.02	28
Immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication?	5	5.02	29
Skin problems such as rashes, infections (fungus, herpes, MRSA) or other skin problems?	5	5.02	30
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?	5	5.02	31
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhea, blood in the stools, or past history of liver, pancreatic or gallbladder disease?	5	5.02	32
Nervous system including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue?	5	5.02	33
Metabolic or hormonal disease including diabetes melitus, thyroid gland disorders, or hypoglycemia (low blood sugar)?	5	5.02	34
Infections such as meningitis, hepatitis (jaundice), or chicken pox?	5	5.02	35
Arthritis or joint pain, swelling and redness not related to injury?	5	5.02	36
Were you born without, or are you missing, a kidney, eye or any other organ?	5	5.02	37
Have you had an injury to any internal organs such as your liver, spleen, kidney(s) or lung?	5	5.02	38
Have you ever had surgery? (explain)	5	5.02	39
Do you get motion sickness (car, air or sea sickness)?	5	5.02	40
Do you have any additional medical problems?	5	5.02	41
Hearing loss or perforated eardrum?	5	5.02	136
Headaches or migraines?	5	5.02	137

Family

ATS Athlete Forms Library

Pre-Participation Sample 1

	Section	Sub-Section	Q#
Do any of your family members have a history of the following (male < 55, female < 65):	6	6.01	42
Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)?	6	6.01	42
Unexplained fainting, seizures, or near drowing?	6	6.01	43
Died before age 50 due to heart disease?	6	6.01	44
Disability or symptoms from heart disease before age 50?	6	6.01	45
Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, hearth surgery, pacemaker or defibulator?	6	6.01	46
High blood pressure or high blood cholesterol?	6	6.01	47
Marfan's Syndrome?	6	6.01	48
Bleeding disorder, Sickle cell trait or sickle cell disease?	6	6.01	49
Tuberculosis or Hepatitis?	6	6.01	50
Anaesthetic reaction or problem?	6	6.01	51
Other condition such as stroke, diabetes, cancer, arthritis (describe)?	6	6.01	52
Are you unsure of your family history?	6	6.01	53

Medications

Medications/supplements you have taken in the past month:	7	7.01	54
Medications prescribed by a doctor (including insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications, etc.)?	7	7.01	54
Non-prescription medications (include pain killers, anti-inflammatories, etc.)?	7	7.01	55
Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)?	7	7.01	56
Have you ever been offered or encouraged to use banned performance enhancing drugs?	7	7.01	57

Allergies

	8	8.01	58
Do you have any medication allergies?	8	8.01	58
Do you have any allergies to foods, pollens, stinging insects, any plant material or any animal material?	8	8.01	59

Immunizations

Indicate which immunizations you have recieved:	9	9.01	60
Tetanus/Diptheria (Td or Tdap)? (no/yes & last shot)?	9	9.01	60
Measles/Mumps/Rubella (2 shots)?	9	9.01	61
Chicken Pox (Varicella)?	9	9.01	62
Meningitis (Menimune or Menactra)?	9	9.01	63
Hepatitis A (2 shots)?	9	9.01	64
Hepatitis B (3 shots)?	9	9.01	65
Malaria?	9	9.01	66
Have you had a TB Test (PPD)? Result?	9	9.01	67
Have you had any other imunizations? Explain:	9	9.01	68

ATS Athlete Forms Library

Pre-Participation Sample 1

	Section	Sub-Section	Q#
Females			
These questions are for females only:	10	10.01	69
Have you ever had a menstrual period?	10	10.01	69
At what age did you have your first menstrual cycle?	10	10.01	70
Do you have regular menstrual cycles?	10	10.01	71
How many menstrual cycles did you have in the last year?	10	10.01	72
When was your most recent menstrual period?	10	10.01	73
Have you had a stress fracture in the past?	10	10.01	74
Are you presently taking any female hormones (estrogen, pregesterone, birth control pills)?	10	10.01	76
Have you ever had a sexually transmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	10	10.01	77
Typically, how many days is your menstrual cycle?	10	10.01	134
Does your family has a history of osteoporosis?	10	10.01	135
Males			
These questions are for males only:	11	11.01	78
Do you have two normal testicles?	11	11.01	78
Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)?	11	11.01	79
Have you ever had an injury to a testicle?	11	11.01	80
Have you ever had surgery for an undescended testicle, testicular injury or problem?	11	11.01	81
Have you ever had a sexually tarnsmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	11	11.01	82
Have you or do you now have kidney disease or damage?	11	11.01	133
Head & Neck			
Have you ever had any of the following problems related to your head or neck:	12	12.01	83
Eye injury, or other problems with your vision?	12	12.01	83
Headaches with exercise?	12	12.01	84
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling?	12	12.01	85
Do you have, or have you been x-rayed for, neck (atlantoaxial) instability?	12	12.01	86
Have you had an injury to your teeth?	12	12.01	87
Do you have any other decayed, missing or filled teeth?	12	12.01	88
Do you have a dental prosthesis or appliance?	12	12.01	89
Have you had your wisdom teeth removed?	12	12.01	90
Injury History			
Have you ever had an injury to your face, head, skull or brain	13	13.01	91
(including a concussion, confusion, memory loss or headache from a hit to the head)?	13	13.01	91
Neck or spine (including a 'stinger', or 'whiplash')?	13	13.01	92

	Section	Sub-Section	Q#
Upper back (thoracic spine)?	13	13.01	93
Lower back (lumbar spine)?	13	13.01	94
Chest and ribs?	13	13.01	95
Shoulder area (including collar bone)?	13	13.01	96
Upper arm?	13	13.01	97
Elbow?	13	13.01	98
Lower arm (forearm)?	13	13.01	99
Wrist?	13	13.01	100
Hand or fingers?	13	13.01	101
Pelvis, groin or hip (including sports hernia)?	13	13.01	102
Thigh (including hamstrings and quadriceps)?	13	13.01	103
Knee?	13	13.01	104
Lower leg (calf or shin)?	13	13.01	105
Ankle?	13	13.01	106
Foot, heel or toes?	13	13.01	107

Other

Have you had any other tests for any injury or condition	14	14.01	108
Including blood tests, x-rays, MRI, CT scan, bone scan, ultrasound, EEG, EMG, ECG/EKG, or stress test?	14	14.01	108
Have you ever received treatment for the following:	14	14.02	109
Surgery?	14	14.02	109
Been you ever been prescribed a brace, sling, cast, walking boot, orthotic, crutches or other appliance?	14	14.02	110
Have you ever had a cortisone injection?	14	14.02	111
Been you ever been prescribed other rehabilitation or therapy?	14	14.02	112
Have you ever spent the night in a hospital or been admitted to a hospital as an inpatient or outpatient?	14	14.02	113
Have you ever been referred to a medical specialist (cardiologist, neurologist, or other medical person) for any condition not already mentioned?	14	14.02	114
Equipment	14	14.03	115
Do you wear eye glasses or contact lenses?	14	14.03	115
Are you currently using any protective equipment?	14	14.03	116
Do you use protective eyewear?	14	14.03	117
Do you use special equipment (pads, braces, etc.)?	14	14.03	118
Do you use a mouth guard for sports?	14	14.03	119
If you wear a helmet for sports, how old is it?	14	14.03	120

Nutrition

	15	15.01	121
Do you worry about your weight or body composition?	15	15.01	121
Are you satisfied with your eating pattern?	15	15.01	122
Are you satisfied with your eating pattern?	15	15.01	123

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Pre-Participation Sample 1

	Section	Sub-Section	Q#
Do you lose weight to meet weight requirements for your sport?	15	15.01	124
Does your weight affect the way that you feel about yourself?	15	15.01	125
Do you worry that you have lost control over how much you eat?	15	15.01	126
Do you make yourself sick when you are uncomfortably full?	15	15.01	127
Do you ever eat in secret?	15	15.01	128
Do you currently suffer or have you ever suffered in the past with an eating disorder?	15	15.01	129
What is your current weight?	15	15.01	130
What is your current height without shoes?	15	15.01	131

Questions & Concerns

	16	16.01	132
Do you have any other concerns that you would like to discuss with a doctor?	16	16.01	132

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Pre-Participation Sample 2

	Section	Sub-Section	Q#
Personal History			
The following questions ask for information regarding your personal background	1	1.01	1
What is your primary sport?	1	1.01	1
Have you participated in other sports in the past (including competitively)?	1	1.01	2
What is your ethnic origin?	1	1.01	3
Do you have any religious convictions that could affect your medical treatment?	1	1.01	4
What is the date of your last physical?	1	1.01	5
Have you ever failed a pre-participation exam for sports, or has your doctor ever stopped you from participating in sports for any reason?	1	1.01	6
In total, how many days have you missed practice or competition in the past year because of injury or illness?	1	1.01	7
Heart			
Have you ever had any of the following heart or circulation related problems:	2	2.01	8
Chest pain, discomfort, tightness or pressure with exercise?	2	2.01	8
Unexplained fainting or near fainting or passed out for no reason during or after exercise?	2	2.01	9
Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise?	2	2.01	10
Do you get more tired or short of breath more quickly than your friends during exercise?	2	2.01	11
Does your heart race or skip beats (irregular beats) during exercise?	2	2.01	12
Have you ever had a heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem?	2	2.01	13
Have you ever had an unexplained seizure?	2	2.01	14
Have you ever had any tests for your heart (for example, ECG or EKG, echocardiogram)?	2	2.01	15
Breathing			
Have you ever had any of the following respiratory or greathing problems:	3	3.01	16
Do you have asthma?	3	3.01	16
Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu-like illness?	3	3.01	17
Do you cough, wheeze or have more difficulty breathing than you should during or after exercise?	3	3.01	18
Have you ever used asthma medication (such as an inhaler)?	3	3.01	19
Have you ever had bronchitis, pneumonia, tuberculois, cystic fibrosis or other repiratory or other breathing problem?	3	3.01	20
Heat			
The following questions are about exercise in the heat:	4	4.01	21
Have you ever become ill while exercising in the heat?	4	4.01	21

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Pre-Participation Sample 2

	Section	Sub-Section	Q#
Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia?	4	4.01	22
Do you get frequent muscle cramps while exercising?	4	4.01	23
Have you ever had electrolyte (salt) or fluid imbalance?	4	4.01	24

Medical

	5	5.01	25
Do you have any ongoing medical conditions or illness?	5	5.01	25
Do you have, or have you ever had any symptoms of medical problems such as:	5	5.02	26
Infections mononucleosis (mono), flu like symptoms or viral illness within the past month?	5	5.02	26
Disease of the ears (infections, hearing loss, pain), nose (sneezing, itchy nose, sinusitis, blocked nose) or throat (sore throat, hoase voice, swollen glands in the neck)?	5	5.02	27
Blood disorders such as anemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder?	5	5.02	28
Immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication?	5	5.02	29
Skin problems such as rashes, infections (fungus, herpes, MRSA) or other skin problems?	5	5.02	30
Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?	5	5.02	31
Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhea, blood in the stools, or past history of liver, pancreatic or gallbladder disease?	5	5.02	32
Nervous system including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue?	5	5.02	33
Metabolic or hormonal disease including diabetes melitus, thyroid gland disorders, or hypoglycemia (low blood sugar)?	5	5.02	34
Infections such as meningitis, hepatitis (jaundice), or chicken pox?	5	5.02	35
Arthritis or joint pain, swelling and redness not related to injury?	5	5.02	36
Were you born without, or are you missing, a kidney, eye or any other organ?	5	5.02	37
Have you had an injury to any internal organs such as your liver, spleen, kidney(s) or lung?	5	5.02	38
Have you ever had surgery? (explain)	5	5.02	39
Do you get motion sickness (car, air or sea sickness)?	5	5.02	40
Do you have any additional medical problems?	5	5.02	41
Hearing loss or perforated eardrum?	5	5.02	136
Headaches or migraines?	5	5.02	137

Family

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Pre-Participation Sample 2

	Section	Sub-Section	Q#
Do any of your family members have a history of the following (male < 55, female < 65):	6	6.01	42
Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)?	6	6.01	42
Unexplained fainting, seizures, or near drowing?	6	6.01	43
Died before age 50 due to heart disease?	6	6.01	44
Disability or symptoms from heart disease before age 50?	6	6.01	45
Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, hearth surgery, pacemaker or defibulator?	6	6.01	46
High blood pressure or high blood cholesterol?	6	6.01	47
Marfan's Syndrome?	6	6.01	48
Bleeding disorder, Sickle cell trait or sickle cell disease?	6	6.01	49
Tuberculosis or Hepatitis?	6	6.01	50
Anaesthetic reaction or problem?	6	6.01	51
Other condition such as stroke, diabetes, cancer, arthritis (describe)?	6	6.01	52
Are you unsure of your family history?	6	6.01	53

Medications

Medications/supplements you have taken in the past month:	7	7.01	54
Medications prescribed by a doctor (including insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications, etc.)?	7	7.01	54
Non-prescription medications (include pain killers, anti-inflammatories, etc.)?	7	7.01	55
Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)?	7	7.01	56
Have you ever been offered or encouraged to use banned performance enhancing drugs?	7	7.01	57

Allergies

	8	8.01	58
Do you have any medication allergies?	8	8.01	58
Do you have any allergies to foods, pollens, stinging insects, any plant material or any animal material?	8	8.01	59

Immunizations

Indicate which immunizations you have recieved:	9	9.01	60
Tetanus/Diptheria (Td or Tdap)? (no/yes & last shot)?	9	9.01	60
Measles/Mumps/Rubella (2 shots)?	9	9.01	61
Chicken Pox (Varicella)?	9	9.01	62
Meningitis (Menimune or Menactra)?	9	9.01	63
Hepatitis A (2 shots)?	9	9.01	64
Hepatitis B (3 shots)?	9	9.01	65
Malaria?	9	9.01	66
Have you had a TB Test (PPD)? Result?	9	9.01	67
Have you had any other imunizations? Explain:	9	9.01	68

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Pre-Participation Sample 2

	Section	Sub-Section	Q#
Females			
These questions are for females only:	10	10.01	69
Have you ever had a menstrual period?	10	10.01	69
At what age did you have your first menstrual cycle?	10	10.01	70
Do you have regular menstrual cycles?	10	10.01	71
How many menstrual cycles did you have in the last year?	10	10.01	72
When was your most recent menstrual period?	10	10.01	73
Have you had a stress fracture in the past?	10	10.01	74
Are you presently taking any female hormones (estrogen, pregesterone, birth control pills)?	10	10.01	76
Have you ever had a sexually transmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	10	10.01	77
Typically, how many days is your menstrual cycle?	10	10.01	134
Does your family has a history of osteoporosis?	10	10.01	135
Males			
These questions are for males only:	11	11.01	78
Do you have two normal testicles?	11	11.01	78
Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)?	11	11.01	79
Have you ever had an injury to a testicle?	11	11.01	80
Have you ever had surgery for an undescended testicle, testicular injury or problem?	11	11.01	81
Have you ever had a sexually tarnsmitted disease such as gonorrhea, syphillis, venereal warts, chlamydia or other infection?	11	11.01	82
Have you or do you now have kidney disease or damage?	11	11.01	133
Head & Neck			
Have you ever had any of the following problems related to your head or neck:	12	12.01	83
Eye injury, or other problems with your vision?	12	12.01	83
Headaches with exercise?	12	12.01	84
Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling?	12	12.01	85
Do you have, or have you been x-rayed for, neck (atlantoaxial) instability?	12	12.01	86
Have you had an injury to your teeth?	12	12.01	87
Do you have any other decayed, missing or filled teeth?	12	12.01	88
Do you have a dental prosthesis or appliance?	12	12.01	89
Have you had your wisdom teeth removed?	12	12.01	90
Injury History			
Have you ever had an injury to your face, head, skull or brain	13	13.01	91
(including a concussion, confusion, memory loss or headache from a hit to the head)?	13	13.01	91
Neck or spine (including a 'stinger', or 'whiplash')?	13	13.01	92

	Section	Sub-Section	Q#
Upper back (thoracic spine)?	13	13.01	93
Lower back (lumbar spine)?	13	13.01	94
Chest and ribs?	13	13.01	95
Shoulder area (including collar bone)?	13	13.01	96
Upper arm?	13	13.01	97
Elbow?	13	13.01	98
Lower arm (forearm)?	13	13.01	99
Wrist?	13	13.01	100
Hand or fingers?	13	13.01	101
Pelvis, groin or hip (including sports hernia)?	13	13.01	102
Thigh (including hamstrings and quadriceps)?	13	13.01	103
Knee?	13	13.01	104
Lower leg (calf or shin)?	13	13.01	105
Ankle?	13	13.01	106
Foot, heel or toes?	13	13.01	107

Other

Have you had any other tests for any injury or condition	14	14.01	108
Including blood tests, x-rays, MRI, CT scan, bone scan, ultrasound, EEG, EMG, ECG/EKG, or stress test?	14	14.01	108
Have you ever received treatment for the following:	14	14.02	109
Surgery?	14	14.02	109
Been you ever been prescribed a brace, sling, cast, walking boot, orthotic, crutches or other appliance?	14	14.02	110
Have you ever had a cortisone injection?	14	14.02	111
Been you ever been prescribed other rehabilitation or therapy?	14	14.02	112
Have you ever spent the night in a hospital or been admitted to a hospital as an inpatient or outpatient?	14	14.02	113
Have you ever been referred to a medical specialist (cardiologist, neurologist, or other medical person) for any condition not already mentioned?	14	14.02	114
Equipment	14	14.03	115
Do you wear eye glasses or contact lenses?	14	14.03	115
Are you currently using any protective equipment?	14	14.03	116
Do you use protective eyewear?	14	14.03	117
Do you use special equipment (pads, braces, etc.)?	14	14.03	118
Do you use a mouth guard for sports?	14	14.03	119
If you wear a helmet for sports, how old is it?	14	14.03	120

Nutrition

	15	15.01	121
Do you worry about your weight or body composition?	15	15.01	121
Are you satisfied with your eating pattern?	15	15.01	122
Are you satisfied with your eating pattern?	15	15.01	123

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Pre-Participation Sample 2

	Section	Sub-Section	Q#
Do you lose weight to meet weight requirements for your sport?	15	15.01	124
Does your weight affect the way that you feel about yourself?	15	15.01	125
Do you worry that you have lost control over how much you eat?	15	15.01	126
Do you make yourself sick when you are uncomfortably full?	15	15.01	127
Do you ever eat in secret?	15	15.01	128
Do you currently suffer or have you ever suffered in the past with an eating disorder?	15	15.01	129
What is your current weight?	15	15.01	130
What is your current height without shoes?	15	15.01	131

Questions & Concerns

	16	16.01	132
Do you have any other concerns that you would like to discuss with a doctor?	16	16.01	132

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Research Privacy Application

Waiver of Authorization

	Section	Sub-Section	Q#
Research Staff needing access to protected health			
Bill's University Medical Center Institutional Review Board (Federalwide Assurance Number 00000301) may waive or alter the requirement to obtain authorization from research subjects in order to use or disclose their protected health information, provided that the investigator justifies, and the IRB agrees, that specific criteria have been met. Please explain how your research study meets the criteria by answering each of the following questions:	1	1.10	1
	1	1.20	1
What is your plan to protect identifiable health information from improper use and disclosure?	1	1.20	1

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Sickle Cell

	Section	Sub-Section	Q#
	1	1.01	1

II.SICKLE CELL SOLUBILITY TEST (SST) OPTIONS

NOTE: Select and initial one of the options in this section II. If option 3 is selected, the Release of Liability in Section III must also be executed.

I, the undersigned student (or parent/legal guardian on behalf a minor student), have been provided information regarding the sickle cell trait. I understand that I am required by the NCAA Division I to make one selection from among the options provided to participate in any NCAA athletics program offered at the College of BLA BLA BLA

I further understand that should I select Option 3, I must also execute the Release of Liability that is provided in Section III of this form. If I select Option I, the SST will be paid for by the College of BLA BLA BLA.

NCAA Fact Sheets containing information about the sickle cell trait is attached to this form . Additional information is provided by the NCAA on its website at www.NCAA.org/health-safety.

Please Select "YES" to one of the following options:	1	1.03	3
I agree to submit to a SST during the pre-participation medical examination	1	1.03	3
	1	1.04	4
I do not agree to submit to a SST but I will provide documented results of a prior SST test	1	1.04	4
	1	1.05	5
I do not agree to submit to a SST nor provide results of a prior SST to the College of Bla Bla Bla but I will sign the Release,	1	1.05	5

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Sickle Cell Sample

	Section	Sub-Section	Q#
Sickle Cell Testing			
	1	1.01	1
The NCAA requires that all incoming student-athletes must be tested for sickle cell trait or show proof of a prior sickle cell trait testing. This legislation requires student-athletes to be tested before participating in athletically related activities. Please provide the tests results below:			
Prior test results (if applicable)			
	2	2.01	2
Enter the test date	2	2.01	2
	2	2.02	3
Enter the test results	2	2.02	3
	2	2.03	4
Where was the test performed?	2	2.03	4
	2	2.04	5
What was the physician's name?	2	2.04	5
	2	2.05	6
What is the physician's phone number?	2	2.05	6
	2	2.06	7
Enter the address where the test was conducted	2	2.06	7
Waiver, Release of Liability			
	3	3.01	8
I attest that I DO NOT have sickle cell trait and decline sickle testing.	3	3.01	8
	3	3.02	9
I attest that I have sickle cell trait and decline sickle testing.	3	3.02	9
	4	4.01	10

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Sickle Cell Sample

Section	Sub-Section	Q#

I acknowledge that by declining sickle cell testing, I assume all risk of injury or consequences to my health arising from my participation in athletically related activities while having the sickle cell trait. I further agree to release XYZ School from any liability for any injury I sustain or any consequences to my health I incur as a result of my participation in athletically related activities while having the sickle cell trait. I further agree to defend, indemnify and hold XYZ School harmless for any claims I assert or anyone else asserts, including, but not limited to liens asserted for the cost of medical care incurred as a result of injury I sustain or any consequences to my health I incur as a result of my participation in athletically related activities while having the sickle cell trait.

Please Note: For student athletes under 18 years of age, the signature of a parent or legal guardian is required.

As the parent of this athlete, I acknowledge that that by his/her declining sickle cell testing, I agree to defend, indemnify and hold XYZ School harmless for any claims he/she asserts due to injury or consequences to his/her health arising from his/her participation in athletically related activities while having the sickle cell trait. I further agree to defend, indemnify and hold XYZ School harmless from any claims I assert or anyone else asserts, including, but not limited to liens asserted for the cost of medical care incurred as a result of injury he/she sustains or any consequences to his/her health he/she incurs as a result of his/her participation in athletically related activities while having the sickle cell trait.

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Sickle Cell Trait

	Section	Sub-Section	Q#
Sickle Cell Trait			
I have read the NCAA Fact Sheet regarding Sickle Cell Trait that was provided to me, and recognize that, as a student-athlete at xxx College, I can request to be tested, at my own expense, for sickle cell trait (SCT), show proof of a prior test, or sign a waiver releasing the institution from liability if I decline to be tested.	1	1.01	1
Please choose one of the following: Option 1 - I want to be tested	1	1.02	2
Option 2 - I do NOT want to be tested	1	1.03	3
Option 3 - I have SCT*	1	1.04	4
Option 4 - I do not have SCT* *Please provide documentation to the Athletic Training Staff	1 1	1.05 1.05	5 5
Please choose the option that applies;	1 1	1.06 1.06	6 6
If you are under 18 years of age PLEASE have your parents sign this form!	1	1.07	7

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Sickle Cell Trait Waiver

	Section	Sub-Section	Q#
SCT Information, Testing Declaration, and Waiver			
	1	0.01	1
Sickle Cell Trait	1	0.01	1
Sickle cell trait is the inheritance of one gene for normal oxygen-carrying protein (hemoglobin), and one for sickle hemoglobin in red blood cells. During high intensity exercise the red blood cells sickle (shape of a quarter moon) and can create a “logjam” in blood vessels, decreasing blood flow and oxygen to the body’s tissues and muscles. The result typically presents as fatigue, ischemic muscle pain, muscle weakness, and even collapse. Sickle cell trait has been associated with a condition known as exertional rhabdomyolysis, renal failure and death. Heat, dehydration, altitude, and asthma increase the risk in athletes with sickle cell train and worsen complications even in non-intense exercise. High risk athletes have ancestry from Africa, South and Central America, Caribbean, Mediterranean countries, India, and Saudi Arabia. Sickle cell trait occurs in about 8 percent of U.S. African American population. **Further information can be found in on the Athletic Training link at xxx			
Sickle Cell Trait Testing Declaration Options			
The NCAA and CUC recommend all students that will be participating in intercollegiate athletics have knowledge of their sickle cell trait status as part of the mandatory medical examination. After reading the above information I elect to (PLEASE CHOOSE ONE):	2	0.02	2
Sickle Cell Trait Testing Declaration Option # 1			
	3	0.03	3
I will provide xxx Athletic Training documented results of a sickle cell test: Each person was screened for sickle cell traits when we were born and can be obtained from the hospital you were born or from your family doctor office.			
Sickle Cell Trait Testing Declaration Option # 2			
	4	0.04	4
I will perform a current sickle cell solubility test and sign the waiver below until the results confirm sickle cell trait status: This can be scheduled at your family doctor or at the xxx to test your blood. THIS EXPENSE IS THE RESPONSIBILITY OF THE STUDENT-ATHLETE.			
Sickle Cell TraitTesting Declaration Option # 3			
	5	0.05	5
I decline testing and will sign a written release waiver declining the blood test for sickle cell: If you are unable to obtain prior sickle cell trait information or do not want to have the blood test done you may sign a waiver declining the test.			
	6	0.06	6
Please pick one of the three above choices	6	0.06	6

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Sickle Cell Trait Waiver

	Section	Sub-Section	Q#
Sickle Cell Trait Testing Waiver			
	7	0.07	7
I have read the information provided above regarding sickle cell trait status and the risk it could pose to me if I have sickle cell trait and participate in intercollegiate athletics at the xxx xxx. I understand that the NCAA and xxx University xxx recommend that all student-athletes undergo sickle cell trait testing. I DO NOT wish to undergo sickle cell trait testing as part of my pre-participation medical exam and clearance and I voluntarily agree to release, discharge, indemnify and hold harmless xxx University xxx employees, agents, and insurers from any and all costs, liabilities, expenses, claims, demands, or causes of action for any loss or personal injury, up to and including death, that might result from not undergoing sickle cell trait testing although recommended by the NCAA and xxx University xxxAthletics. I have not undergone prior testing for sickle cell trait and have no prior knowledge that I have the sickle cell trait.			
	7	0.08	8
	7	0.08	8

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Student-Athlete Consent for Medical Treatment (age 18 or older)

	Section	Sub-Section	Q#
Student-Athlete Consent for Medical Treatment & Release of Medical Information	1	1.10	1
	1	1.10	1
	2	2.10	2
Please enter your full name with middle initial:	2	2.10	2
	2	2.30	3
Please enter your date of birth:	2	2.30	3
	2	2.40	4
please enter your academic year:	2	2.40	4
	2	2.50	5
Please enter your Sport:	2	2.50	5
	3	3.10	6

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Student-Athlete Consent for Medical Treatment (age 18 or older)

	Section	Sub-Section	Q#
I authorize the xx Athletic Training staff, xxxx counseling and nursing staff, team or consulting physicians and the athletic training staff, team or consulting physicians and other medical personnel at host schools to perform or initiate medical treatment as may be necessary for my health and welfare. This consent is effective with respect to injuries occurring during practices for, and participation in various athletic contests and events, as well as injuries occurring during transportation to or from such practice or contest sessions. This authorization includes preventive treatment, immediate first aid and emergency treatment, x-rays, physical exams, emergency surgery, physical therapy, hospitalization, follow-up care, and rehabilitation in the xxxx athletic training room or the xxxx Student Health Center. I consent for the xxxx Athletic Training staff or team or referring physicians to prohibit me from further participation in athletic practices or contests because of injury or an undue risk of harm, provided this does not constitute any waiver of my rights under Section 504 of the Rehabilitation Act. I authorize UMHB and any health care provider to release to: xxxx employees or agents (including administration, athletic training staff, team or consulting physicians, coaches, athletics compliance officer, counseling and nursing staff); to my parent, legal guardian, or spouse; NCAA, and to any designee of the foregoing, any medical records or information which may have a bearing on my ability to safely participation in intercollegiate athletics at xxxx. I authorize xxxx to release to news media representatives general information regarding any injury or illness which I may have, if that injury or illness affects my ability to participate in xxxx athletic programs. These authorizations shall remain in effect until revoked by me in a written document delivered to the Vice President for Athletics. This consent is provided in accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, as amended (the Buckley Amendment). I understand that I have the right to inspect my education records, including any records covered by this consent.	3	3.10	6
	3	3.20	7
I am 18 years of age or older and I have read this Agreement carefully before signing it. I understand this Agreement is a binding contract which waives and releases legal rights which I might otherwise have.	3	3.20	7

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Student-Athlete Consent for Medical Treatment (minor)

	Section	Sub-Section	Q#
Student-Athlete Consent for Medical Treatment & Release of Medical Information	1	1.10	1
	1	1.10	1
	2	2.10	2
Please enter your full name with middle initial:	2	2.10	2
	2	2.30	3
Please enter your date of birth:	2	2.30	3
	2	2.40	4
please enter your academic year:	2	2.40	4
	2	2.50	5
Please enter your Sport:	2	2.50	5
	3	3.10	6

I authorize the xxxx Athletic Training staff, xxxx counseling and nursing staff, team or consulting physicians and the athletic training staff, team or consulting physicians and other medical personnel at host schools to perform or initiate medical treatment as may be necessary for my health and welfare. This consent is effective with respect to injuries occurring during practices for, and participation in various athletic contests and events, as well as injuries occurring during transportation to or from such practice or contest sessions.

This authorization includes preventive treatment, immediate first aid and emergency treatment, x-rays, physical exams, emergency surgery, physical therapy, hospitalization, follow-up care, and rehabilitation in the xxx athletic training room or the xxxx Student Health Center. I consent for the xxx Athletic Training staff or team or referring physicians to prohibit me from further participation in athletic practices or contests because of injury or an undue risk of harm, provided this does not constitute any waiver of my rights under Section 504 of the Rehabilitation Act.

I authorize xxxx and any health care provider to release to: xxxx employees or agents (including administration, athletic training staff, team or consulting physicians, coaches, athletics compliance officer, counseling and nursing staff); to my parent, legal guardian, or spouse; NCAA, and to any designee of the foregoing, any medical records or information which may have a bearing on my ability to safely participation in intercollegiate athletics at xxxx.

I authorize xxxx to release to news media representatives general information regarding any injury or illness which I may have, if that injury or illness affects my ability to participate in xxxx athletic programs .

These authorizations shall remain in effect until revoked by me in a written document delivered to the Vice President for Athletics. This consent is provided in accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, as amended (the Buckley Amendment). I understand that I have the right to inspect my education records, including any records covered by this consent.

	3	3.20	7
I have read this Agreement carefully before signing it. I understand this Agreement is a binding contract which waives and releases legal rights which I might otherwise have.	3	3.20	7
	3	3.40	8

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Student-Athlete Consent for Medical Treatment (minor)

	Section	Sub-Section	Q#
As the parent or legal guardian of the student named above, who is under the age of 18, I have read this Agreement carefully before signing it. I accept this Agreement on behalf of myself and the student-athlete. I understand this Agreement is a binding contract which waives and releases legal rights which I might otherwise have.	3	3.40	8

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Student-Athlete HIPAA Authorization

	Section	Sub-Section	Q#
STUDENT-ATHLETE HIPAA AUTHORIZATION FORM			
	1	1.01	1

I understand my rights under the federal regulations mandated by the Health Insurance Portability and Accounting Act (HIPAA). I authorize xxx Athletic Training Department to provide all information concerning my health care, injury, rehabilitation, treatment, and health status to the following listed below. It is important this form is signed by the student-athlete or legal guardian. It affects the documentation and communication forms which are used in the athletic training room with team physicians, coaches, and support staff. The signature authorizes the members of the Athletic Training Department, team physicians and allied health care providers to communicate and view medical records pertaining to health-related issues of the student-athletes. The methods of injury documentation and communication used will be oral, written, and electronic to the following:

- Outside health care providers associated with the xxx Athletics Department for the purpose of providing me with treatment and coordinating and managing my health care with others.
- Insurance companies associated with the xxx Athletics Department for the purpose of collecting payment for the treatment and services provided to me by the University or by another provider.
- Scouts or representatives from any professional or amateur organization for the purposes of assisting the organization in making a determination as to the offering of employment.
- Coaching staff advising them of my health status and restrictions on my ability to participate in athletics
- Athlete's parents regarding injuries and health issues.
- The university compliance personnel, conference officials and NCAA officials if the student-athlete is seeking a hardship waiver, extension, medical disqualification, or other NCAA waiver.
- Academic Services staff, faculty, Dean of Students and/or Disability Services if the injury/illness impacts your ability to attend class and/or fulfill other academic obligations.
- Injury Tracking Software in regards to documenting injuries and health issues as well as progress notes and rehabilitation protocols.

I understand that my injury/illness information is protected by federal regulations under the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my consent under the Buckley Amendment. I understand that my signing of this Consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide consent requested for this disclosure. I also understand that I am not required to sign this Consent in order to be eligible for participation in NCAA or conference athletics.

This Consent expires at the time that my eligibility in intercollegiate athletics at xxxx has exhausted, but I have the right to revoke it in writing at any time by sending written notification to the Head Athletic Trainer at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

	1	1.02	2

If you are under 18 years of age PLEASE have your parent sign this form also.

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Supplements (All Athletes)

	Section	Sub-Section	Q#
Please read the following statement: Before consuming any nutritional/dietary supplement product, review the product and its label with your athletics department staff. Dietary supplements are not well regulated and may cause a positive drug test result. Any product containing a dietary supplement ingredient is taken at your own risk. I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NCAA endorses a product or approves its usage. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for a NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics should I fail to report a prescribed medication containing an NCAA banned substance to the proper personnel prior to participation in SUNY New Paltz intercollegiate athletics. For more information, please visit http://nphawks.com/HawksAT/education	1	1.01	1
	1	1.01	2
Have you taken any supplements in the last 6 months, or are you currently taking any supplements, or are you planning on taking any supplements in the upcoming academic year:	2	2.01	1
	2	2.01	1
List below any and all supplements you have taken in the last 6 months, are currently taking, or plan on taking in the next year:	2	2.02	1
Supplement #1	2	2.02	1
Supplement #2	2	2.02	2
Supplement #3	2	2.02	3
Supplement #4	2	2.02	4
Supplement #5	2	2.02	5