

**Lander University
Pre-participation Medical History Evaluation**

Name _____ Sport _____
Birth Date _____ Sex _____ S.S.N. _____
Permanent Address _____ Home Phone _____

(City) (State) (Zip)
School Address (if known) _____ Cell Phone _____

Person to be notified in Case of Emergency:

Name _____ Relationship _____
Address _____ Phone _____

Parent Information

Father's Full Name _____
Mother's Full Name _____
Parent's Address _____
(Street) (City) (State) (Zip)
Parent's Home Phone _____ Father's Work _____ Mother's Work _____

I understand that participation in intercollegiate athletics exposes me to the risk of bodily injury and/or permanent disability. I also accept the responsibility for reporting injuries and illnesses to the institutional medical staff, including signs and symptoms of concussions. I am willing to accept the risks, inherent in the sport in which I participate. I hereby grant permission for Lander University or its consultants to render me any emergency care or other medical or surgical care that might be deemed necessary to my health and well-being. Also, when necessary for executivity of such care, permission for hospitalization at an accredited hospital is granted.

DATE

Signature of Athlete

Signature of Parent/Guardian (if minor)

MEDICAL HISTORY: All questions must be answered fully. Failure to disclose any medical information may invalidate insurance coverage.

	<u>Yes</u>	<u>No</u>	<u>If yes, When?</u>
1. Immunizations			
A. Have you been immunized against measles, mumps and rubella (MMR)?	_____	_____	_____
B. Have you had a tetanus shot in the last ten years?	_____	_____	_____
2. Has a doctor ever denied or restricted your participation in sports for any reason?	_____	_____	_____
3. Are you presently taking any medications or pills? (including birth control pills)	_____	_____	_____
3. Do you have any allergies (medicines, hay fever, bee stings)?	_____	_____	_____
4. Have you ever passed out or nearly passed out during or after exercise or at any time?	_____	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____	_____
Have you ever had a "racing heart"?	_____	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____	_____
Have you ever been told you have a heart murmur?	_____	_____	_____
Has anyone in your family experienced or died of heart problems before the age of 50?	_____	_____	_____
5. Have you ever been told you have or have been treated for high blood pressure, high cholesterol or heart infection?	_____	_____	_____
6. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	_____	_____	_____
7. Has anyone in your family died for no apparent reason?	_____	_____	_____
8. Does anyone in your family have a heart problem?	_____	_____	_____
9. Does anyone in your family have Marfan Syndrome?	_____	_____	_____
10. Have you ever had any type of problem with your heart or your lungs?	_____	_____	_____
11. Do you cough, wheeze or have difficulty breathing during or after exercise?	_____	_____	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
12. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?	___	___	_____
13. Have you had infectious mononucleosis (mono) within the last month?	___	___	_____
14. Do you have headaches with exercise?	___	___	_____
15. Have you ever had a head injury? Have you ever been knocked out or unconscious? Have you ever had a memory loss from any cause? Have you ever had a seizure or convulsion?	___ ___ ___ ___	___ ___ ___ ___	_____ _____ _____ _____
16. Have you ever had heat or muscle cramps?	___	___	_____
17. Have you had any problems with eyes or vision? Do you wear glasses, contact lens or protective eye wear?	___	___	_____ _____
18. Have you ever had a neck injury, numbness or tingling in your hands or feet or complete or partial weakness from a neck injury?	___	___	_____
19. Have you ever sprained/strained, dislocated, broken or had repeated swelling of any of the following? ___ Head ___ Shin/Calf ___ Shoulder ___ Back ___ Thigh ___ Wrist ___ Neck ___ Ankle ___ Elbow ___ Hip ___ Knee ___ Hand ___ Chest ___ Foot ___ Forearm	___	___	_____ _____ _____ _____ _____ _____ _____
20. Have you ever had surgery for any conditions?	___	___	_____
21. Have you had any other medical problems (mono, diabetes, asthma, etc.)?	___	___	_____
22. Have you ever been hospitalized?	___	___	_____
23. Have you ever been treated for a skin problem?	___	___	_____

- 24. Have you ever had any menstrual problems? (females) _____
- 25. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? _____
- 26. Are you happy with your weight? _____
- 27. Are you trying to gain or lose weight? _____
- 28. Has anyone recommended you change your weight or eating habits? _____
- 29. Do you limit or carefully control what you eat? _____
- 30. Do you have any concerns that you would like to discuss with a doctor? _____

I hereby certify that I have no congenital or pre-existing medical condition other than those identified above. Furthermore, I understand that injuries directly related to congenital or pre-existing conditions are not covered by Lander University athletic insurance.

Athlete's Signature _____

Date _____

Parent's Signature (if minor) _____

Date _____

Medical Examination

Name _____ Date _____ Date of Birth _____

Height _____ Weight _____ Blood pressure _____ Pulse _____

Vision (Snelling Chart) R 20/____ L 20/____ Corrected? Yes No

	Normal	Abnormal findings	Comments
1. Eyes, (pupils equal)?			
2. Ears, nose and throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular with squat or valsalva			
6. Chest and lungs			
7. Abdomen			
8. Skin			
9. Hernia (male)			
10. Musculoskeletal			
a. neck			
b. spine			
c. shoulders/elbow			
d. arms/hands			
e. hips			
f. thighs			
g. knees			
h. ankles			
I. feet			
11. Neurological			

Urinalysis

Urine Chemstrip 9:

Leukocytes _____	Urobilinogen _____
Nitrites _____	Bilirubin _____
Proteins _____	Blood _____
Glucose _____	pH _____
Ketones _____	

Physician Evaluation:

_____ No athletic participation _____

_____ Limited athletic participation _____

_____ Clearance withheld until _____

_____ Full, with the following rehabilitation recommended _____

_____ Full unlimited athletic participation _____

_____ Comments _____

Physician's Signature _____

Date _____

AUTHORIZATION TO RELEASE ATHLETE'S MEDICAL INFORMATION

I, _____ authorize the Lander University Athletic Training Department to disclose medical treatment information or personal health information concerning me to my coaches or Athletic Department administrators for the purpose of maintaining and improving my health and safety while participating in the athletic program at Lander University.

It is my understanding that the disclosure of such information will be limited to that which, in the opinion of the team physician or athletic medical staff, coaches or administrators "need to know" for my benefit or safety.

I expressly and voluntarily authorize disclosure of the above medical record(s) and/or information for the purpose(s) stated above. I further understand that I am not giving my permission for any disclosure other than described above.

I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

I understand that the parties in receipt of these records or information may not further disclose the medical information provided to them unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

I also agree that my medical records may be released to the Lander University Athletic Training Department for the sole purpose of filing insurance claims for the Lander University secondary insurance coverage.

This release is effective for the duration of my participation in varsity sports at Lander University commencing from the date it is signed unless otherwise specified as follows:

X _____
Signature of Athlete

DATE _____

Athlete SSN _____

Date of Birth _____