AFTER COMPLETING ALL FORMS, PLEASE RETURN AS INDICATED TO:

Brian Coble, ATC
Or
Stephanie Depew, ATC
Carroll College
1601 N. Benton Ave.
Helena, MT 59625

ALL FORMS MUST BE RECEIVED AND APPROVED BY THE ATHLETIC TRAINING STAFF BEFORE BEING ALLOWED TO PARTICIPATE IN THE 2008 -2009 athletic year**. Physician physicals completed prior to May 15th will not be accepted**. Please have all forms completed and mailed before July 21st! If you have had any significant medical injuries or procedures please include copies of all medical documentation.

ANY QUESTIONS? CALL US: 406-447-5524

Date __________

Carroll College
Athletic Training
1601 N. Benton Ave.
Helena, MT59601
406-447-5524 (office)
406-447-4955 (fax)

Athletic Medical Clearance

Forms must be turned into the training room by July 21, 2008. All of this information must be properly completed before the athlete can participate in any activity related to their sport This includes, but is not limited to; weightlifting, skill development, open gym, camp, equipment check-out, and conditioning. **Student-athletes younger than 18 years of age must have parent's signature on forms.**

Parent Information Forms:

The parent information form is to be used in the event of an injury. After the 08-09 school year returning players will only need to update any changes to this information, insurance included.

Medical History:

The medical history form must be filled out as completely and accurately as possible before a student can participate. Omission or false representation of injuries or severity of health conditions is grounds to have the student-athlete's medical eligibility revoked.

Physical Forms:

The athletic physical must be completed every year. ***An MD, PA, or NP must complete the physical.*** No other Healthcare professional may clear you to participate in Carroll College athletics. We are not currently set-up to do team physicals on campus so they must be completed before they get here. **Completing a physical does not ensure clearance for participation**. The athletic trainer must approve the physicals before the athlete is cleared. If there is a question regarding the ability of the athlete to participate, the team doctor will be called in. **The team doctor has the final say in terms of ability to participate or medical disqualification**.

As with all medical files, the information contained within these forms is private and confidential. Information is shared with the coaches at the

Date __________

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Athlete Demographic Information

Athlete Name: **Date of Birth**:

Student ID #: **Social Security #**:

Sport: Football

Phone #: Cellular

Home

Permanent Address: Street:

City: State: Zip:

School Address: Street:

City: State: Zip:

Emergency Contact Information:

Name:

Relationship to Athlete: Parent

Phone Number: Cellular

Home

Work

Date __________

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Athlete Health Information

Athlete Name: **Sex:** Male **Age:**

Height: ft. in. **Weight**: lbs.

Handedness: Right

Disability: No If yes, please list:

Health Alerts:

- ☐ Allergies
- ☐ Heart Condition
- ☐ Asthma
- ☐ Chronic Illness
- ☐ High Blood Pressure

If you checked yes to any of the above choices please list:

****** *Please complete the information on the following pages to the best of your ability****

Date __________

Carroll College
Athletic Training
1601 N. Benton Ave.
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Athlete Pre-Participation Health Record

Please review and answer each question below (every question must be answered). Explain all "YES" answers. Be specific and include dates whenever possible.

YES	NO	
☐	☐	1. Have you had an illness or injury since your last check up or sports physical?
☐	☐	2. Do you have an ongoing or chronic illness?
☐	☐	3. Have you ever been hospitalized overnight?
☐	☐	4. Have you ever had surgery?
☐	☐	5. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?
☐	☐	6. Have you ever taken any supplements or vitamins to help gain or lose weight to improve your performance?
☐	☐	7. Do you have any allergies (i.e. pollen, medicine, food, stinging insects)?
☐	☐	8. Have you ever had a rash or hives develop during or after exercise?
☐	☐	9. Have you ever passed out during or after exercise?
☐	☐	10. Have you ever been dizzy during or after exercise?
☐	☐	11. Have you ever had chest pain during or after exercise?
☐	☐	12. Do you get tired more quickly than your friends do during exercise?
☐	☐	13. Have you ever had racing of your heart or skipped heartbeats?
☐	☐	14. Have you ever had high blood pressure or high cholesterol?
☐	☐	15. Have you been told you have a heart murmur?
☐	☐	16. Has any family member or relative died of heart problems or of sudden death before age 50?
☐	☐	17. Have you had a severe viral infection (i.e. myocarditis or mononucleosis) within the last month?
☐	☐	18. Has a physician ever denied or restricted your participation in sports for any heart problem?
☐	☐	19. Do you have any current skin problems (i.e. itching, rashes, acne, warts, fungus, or blisters)?
☐	☐	20. Have you ever had a head injury or concussion?
☐	☐	21. Have you ever been knocked out, become unconscious, or lost your memory?
☐	☐	22. Have you ever had a seizure?
☐	☐	23. Do you have frequent or severe headaches?
☐	☐	24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?
☐	☐	25. Have you ever had a stinger, burner, or pinched nerve?
☐	☐	26. Have you ever become ill from exercising in the heat?
☐	☐	27. Do you cough, wheeze, or have trouble breathing during or after activity?
☐	☐	28. Do you have asthma?
☐	☐	29. Do you have seasonal allergies that require medical treatment?
☐	☐	30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
☐	☐	31. Have you had problems with your eyes or vision?
☐	☐	32. Do you wear glasses, contacts, or protective eyewear?
☐	☐	33. Do you want to weigh more or less than you do now?
☐	☐	34. Do you lose weight regularly to meet weight requirements for your sport?
☐	☐	35. Do you have a single eye or kidney?
☐	☐	36. FEMALES ONLY – Do you have a regular menstrual period?
☐	☐	37. MALES ONLY – Do you have a single testicle?

Date __________

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Athlete Pre-Participation Health Record Continued

YES	NO	
☐	☐	38. Do you have Sickle Cell Trait?
☐	☐	39. Do you have a Bone Disease?
☐	☐	40. Have you ever experienced more than one concussion?
☐	☐	41. Do you have any impaired function of any paired organ (i.e. eye, kidney, lung, testicle)?
☐	☐	42. Do you require any special adhesive taping, wrapping, or protection devices (braces) for participation?

Please check those illnesses in which you have had:

- ☐ Allergies
- ☐ Appendicitis
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Heat Exhaustion
- ☐ Hepatitis
- ☐ Hernia
- ☐ Hives
- ☐ Kidney Disease
- ☐ Bladder Disease
- ☐ Malaria
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Polio
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tonsillitis
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Ulcer

Please check those symptoms in which you have had:

- ☐ Aching eyes
- ☐ Sties
- ☐ Blurred vision
- ☐ Inflamed eyelids
- ☐ Ringing ears
- ☐ Hearing difficulty
- ☐ Ear discharges
- ☐ Nose discharges
- ☐ Sinus infection
- ☐ High BP
- ☐ Sore throat
- ☐ Prolonged cough
- ☐ Hoarseness
- ☐ Headaches
- ☐ Blackouts
- ☐ Fainting spells
- ☐ Toothaches
- ☐ Painful joints
- ☐ Backache
- ☐ Leg pains
- ☐ Breathing difficulties
- ☐ Chest pains
- ☐ Frequent nosebleeds
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Abdominal Pains
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Vomiting
- ☐ Constipation
- ☐ Indigestion
- ☐ Boils
- ☐ Acne
- ☐ Eczema
- ☐ Cold sores
- ☐ Hemorrhoids
- ☐ Sugar in urine

Date __________

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Athlete Pre-Participation Health Record Continued

Please list and explain, beside the appropriate body area, any previous orthopedic injury. These injuries include, but are not limited to, sprains, strains, fractures, dislocations, and swelling.

Head/Neck:

Shoulder/Upper Arm:

Elbow:

Forearm/Wrist:

Hand/Finger:

Hip/Thigh:

Knee:

Lower Leg:

Ankle:

Foot:

Date __________

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Athlete Pre-Participation Health Record Continued

If you have answered "YES" to any of the above health questions, please place the question number below and explain.

Explanation of answers:

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

Athlete Signature ____________________ Parent/Guardian Signature _____________________

Date __________

PHYSICAL EXAMINATION FORM

Name:				**Sport:**
Height (in)	**Weight** (1/4 lb)	**Pulse**	**Peak Flow (if asthma/inhaler):** **Trial 1:** **Trial 2:** **Trial 3:**	
BP1:	**BP2:**		**BP: Normal Elevated (>140/90)**	
Vision: R 20/	**L 20/**	**Corrected: Y N**	**Pupils: Equal Unequal**	
Allergies :				

MEDICAL EXAM

	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Auscultations			
Lungs			
Abdomen			
Genitalia (males only prn)			

MUSCULOSKELETAL

Physicians please check for normal ROM and Function:	
Head/C-Spine:	
Shoulders:	
Elbows:	
Wrist/Hands	
Thoracic Spine	
Lumbar Spine	
Hips	
Knees	
Lower legs	
Ankles	
Feet	

CLEARANCE RECOMMENDATION: (Please check the appropriate box and specify any limitations)

	Cleared
	Cleared with the following recommendation:
	Cleared after completing evaluation/rehabilitation for:
	Not cleared/Fail (please specify reason):

Additional Recommendations:

Physician Name (print/type): ______________________________**contact #:**________________________

Signature of Physician: ____

Date Exam Completed: _______________________

Date __________

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Athlete Insurance Information

PRIMARY

Policy # :	Insurance Company:	
Effective Date:	Group #:	Group Name:

Policy Holder:					Date of Birth:		
Phone #:	cell			work			home
Policy Holder's SSN:							
Address:							
Relationship to Athlete:Self				Employer:			
Employer's Address:							
Insurance Type (please circle one): ☐PPO ☐HMO							

Insurance Company Information:
Company Address:
City: State: Zip:
Company Phone #:
Company Fax #:

SECONDARY

Policy # :	Insurance Company:	
Effective Date:	Group #:	Group Name:

Policy Holder:					Date of Birth:		
Phone #:	cell			work			home
Policy Holder's SSN:							
Address:							
Relationship to Athlete:Mother				Employer:			
Employer's Address:							
Insurance Type (please circle one): ☐PPO ☐HMO							

Insurance Company Information:
Company Address:
City: State: Zip:
Company Phone #:
Company Fax #:

Date ___________

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Athlete Insurance Information Continued

Please make a front and back photo copy of the current insurance card for this athlete and attach it to this piece of paper. Thank you.

Date __________

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ATHLETIC PARTICIPATION RISK ACKNOWLEDGEMENT

Warning: By its nature participation in intercollegiate athletics includes a risk of injury, which may range in severity from minor to long-term catastrophic, including permanent paralysis or even death. Although serious injuries are not common in supervised school athletic programs, it is only possible to reduce the risk, not to completely eliminate the risk.

Athletes at Carroll College can, and have the responsibility to reduce the chance of injury. Carroll athletes' must obey all rules, report all physical problems to their coach and athletic trainer, follow proper conditioning and strength training guidelines, and inspect their equipment daily.

By signing this statement, I (we) acknowledge that we have read and understand this warning.

Student Athlete Signature	Date	Parent/Guardian Signature	Date

---

CONSENT FOR TREATMENT

Permission is granted to the medical personnel Certified Athletic Trainers, Team Physicians of Carroll College to seek, initiate, and/or coordinate emergency medical treatment, hospitalization, or any other medical treatment as may be necessary for the immediate welfare of:

Student Athlete Print Full Name	Date of Birth	Social Security #

Student Athlete Signature	Date	Parent/Guardian Signature	Date

---

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, nurse, physical therapist, or athletic trainer, who has attended me or any hospital or infirmary at which I have been treated or admitted to furnish Carroll College through its designated medical personnel (Certified Athletic Trainers, Team Physicians) copies of any information, notes, hospital records concerning the attendance upon, treatment, care, or confinement of the student athlete undersigned. This authority extends to all records to all records including history, diagnostic, tests, and copies, of findings, x-rays, examination or treatment of the student athlete undersigned.

Student Athlete Print Full Name	Date of Birth	Social Security #

Student Athlete Signature	Date	Parent/Guardian Signature	Date

Date __________