



*****NOTE TO EXAMINER***:**

Please Review History (pp. 2-9) and fill out/sign page 10 – the athlete can be:
“Cleared” – Full Participation
“Conditionally Cleared” – Some type of follow-up testing required before participation
“Not Cleared” - Athlete may not participate, no follow-up required

PERSONAL INFORMATION (To be completed by athlete):

PLEASE PRINT CLEARLY AND LEGIBLY

Name: _____
Last First Middle

SSN: _____ Banner/Student ID#: _____

Sex (Circle One): Male Female Date of Birth (mm/dd/yy): _____

Sport: _____ Eligibility (circle one): Fr So Jr Sr Grad

Address (While at school): _____
Street City/State Zip Code

Phone Number: Home-() Cell-()

Permanent Address (Parent/Guardian):

Street City/State Zip Code

Emergency Contacts (MUST LIST AT LEAST ONE)

Name: _____ Phone (home): _____

Relation: _____ (work): _____

Name: _____ Phone (home): _____

Relation: _____ (work): _____

MEDICAL INFORMATION (To be completed by athlete):

Special Medical Information (Medications, Allergies, Medic Alert, etc...)

Physical Examination Consent

I, the above named athlete, do hereby consent to having a physical examination by a qualified physician for the express purpose of obtaining medical clearance to participate in organized athletics at Fayetteville State University.

I understand such an examination is a requirement of any and all students prior to participation in intercollegiate athletics.

I also understand that all medical records pertaining to my participation at Fayetteville State University are confidential, and cannot be released outside the athletic department without my prior written approval.

Athlete Signature: _____

Date: _____

Fayetteville State University Sports Medicine

Shared Responsibility for Sport Safety

Participation in sports requires an acceptance of risk of injury. Student-athletes rightfully assume that those who are responsible for the conduct of the sport have taken reasonable precautions to minimize the risk of significant injury. Periodic analysis of injury patterns continuously leads to refinements in the rules and/or other safety guidelines.

However, to legislate safety via the rule book and equipment standards alone, while often necessary, is seldom entirely effective. To rely on officials to enforce compliance with the rule book is an insufficient as to rely on warning labels to produce behavioral compliance with safety guidelines. Compliance implies respect on everyone's part (student-athlete, coach, athletic trainer, physician, athletic director) for the intent and purpose of the rules and guidelines.

Student-athletes, for their part, should comply with and understand the rules and standards that govern their sports. Coaches should appropriately acquaint the student-athlete with risks of injury and with the rules and practices they are employing to minimize the student-athlete's risk of significant injury while pursuing the many benefits of the sport. The athletic trainer and team physician are also partly responsible for developing injury-prevention strategies (where possible) and the care of those injuries that occur. The athletics program, via the athletic director and coaches, should be responsible for providing a safe environment. The student-athlete and the athletics program have a mutual need for an informed awareness for the risks being accepted and for sharing the responsibility for minimizing those risks. Your signature below indicates that you understand this shared responsibility process; including the role you play, in attempting to prevent injuries to yourself, your teammates and your opponents.

Signature of athlete/and parent if athlete is under age 18

Date

Assumption of Risk

I understand that while I am participating in intercollegiate athletics, there is a risk of injury. I understand that there is always the possibility of injuries when you place extra demands on the muscles, bones, joints, and ligaments in a competitive environment. Injuries that can occur in varsity athletics include by are not necessarily limited to the following: blisters, muscle strains, ligament and joint sprains, joint soreness, abrasions, contusions, stress fractures, broken bones, head, neck and spinal cord injuries involving paralysis and even death. However, if you exercise care for your safety and the safety of your teammates and your opponents, the likelihood of such injuries can be greatly reduced.

I hereby accept and assume the risk of injury and understand the possible consequences of such injury.

Signature of athlete/and parent if athlete is under age 18

Date

Consent for Treatment and Duty to Report Injury

I understand that I may be injured while participating in intercollegiate athletics at Fayetteville State University. I authorize the school to obtain, through a physician of its choice, any emergency care that may become necessary while participating in or traveling under Fayetteville State University's intercollegiate athletics program. I also authorize the University athletic team physician and athletics trainers to administer those treatments as necessary.

I also understand that it is my responsibility to report any injury, illness and symptoms to the Fayetteville State University Sports Medicine staff as soon as the injury/illness occurs or as soon as symptoms are experienced. I understand that failure to report an injury, illness or symptoms increases the risk of serious complications and inhibits the ability of the Fayetteville State University Sports Medicine staff to provide timely and adequate treatment.

Signature of athlete/and parent if athlete is under age 18

Date

GENERAL MEDICAL HEALTH HISTORY (To be completed by athlete)

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS?:

	YES	NO		YES	NO
Frequent Headaches			Abdominal Pain		
Visual Changes			Muscle Cramps		
Ringing in Ears			Frequent Nausea		
Sore Throats			Frequent Vomiting		
Sinus Congestion			Frequent Diarrhea		
Breathing Difficulty			Rectal Bleeding		
Recurring Coughing			Unusual Fatigue		
Chest Pain			Trouble Sleeping		

INTERNAL

Were you born with a **complete and functional set of paired organs** (eyes, ears, kidneys, ovaries/testicles, lungs)?

Yes No

If not, which organs were involved? _____

CARDIAC	YES	NO
Have you ever felt dizzy, light-headed or passed out during or after exercise?		
Have you ever had chest pain while exercising?		
Have you ever had irregular heart beats or heart palpitations?		
Have you ever been told you have a heart murmur?		
Have you ever been seen by a heart specialist (cardiologist)?		
If yes, Who: _____ Date: _____		
Have you ever had an echo-cardiogram?		
Have you ever had a stress (heart) exam?		
Do you have a history of heart disease in your family?		
If yes, Who: _____		

VISION	YES	NO	
Have you ever been to an eye doctor?			Date of last visit:
Do you wear glasses now?			Physician's name:
If yes, Reading Only			Rx: R _____ L _____
Distance Only			
All the time			
Do you wear contacts lenses?			Rx: R _____ L _____
If yes, Soft lenses			
Hard lenses			
Do you have a second pair?			
Do you wear contact lenses/glasses to participate?			Date of incident:
Have you ever had an eye injury?			Explain:
Is your color vision normal?			
Have you ever worn a false eye?			

DENTAL	YES	NO	COMMENTS
Do you have a bridge or false teeth?			
Have you ever fractured a tooth?			
Have you had a tooth knocked out?			
Do you wear a mouth protector?			

HEAT – Have you ever experienced any of the following?	YES	NO
Trouble with dehydration (Excessive loss of salt and water)		
Heat Stroke		
Heat Cramps (Due to fluid loss because of excessive heat)		
Heat Intolerance		

GENERAL MEDICAL HEALTH HISTORY (Continued)

ALLERGIES – Are you allergic to...?	YES	NO		YES	NO
Aspirin			Insect Bites/Stings		
Codeine			Tetanus Antitoxin or Serums		
Cortisone			Nail Polish or Cosmetics		
Sulfa			Any Foods, Which?:		
Anti-Inflammatory			Any Other Drug:		
Penicillin			Other:		
Hay Fever					

DRUG, FOOD SUPPLEMENTS AND MISCELLANEOUS AGENTS

Check the appropriate space according to YOUR use of the following items:

	Never	Rarely	Occasionally	Frequently
Vitamins				
Diet Pills				
Sleeping Pills				
Laxatives				
Alcoholic Beverages				
Antihistamines				
Anti-Inflammatory				
Caffeine				
Tobacco				
Ergogenic Supplements				
Other				

MISCELLANEOUS – Have you ever...?	YES	NO		YES	NO
Worn hearing aids			Had any pins, staples or wires implanted in any part of your body?		
Stuttered or stammered					
Coughed up blood			Had any illness other than those already noted		
Bled excessively after injury					
Been advised to have any operations			Missed a game because of illness		
Been diagnosed with asthma			Used or currently use an inhaler to control asthma? *		
Been diagnosed with sickle cell anemia			Been told that you have sickle cell trait		

* If yes, please ensure your inhaler is with you at ALL TIMES; you may also provide the athletic trainer with the inhaler to hold in case it is needed.

Explain any "Yes" answers below:

**FOR FEMALE ATHLETES ONLY, MALES PROCEED TO NEXT PAGE
WOMEN'S HEALTH HISTORY**

	YES	NO
Are your periods regular?		
Age of Onset: _____		
Date of last period: _____		
Interval between periods: _____		
Duration of period: _____		
Is flow heavy?		
Heavy bleeding ever a problem?		
Do you have bleeding between periods?		
Do you experience any unusual discharge?		
Are cramps a frequent problem during your period?		
Any past pregnancies/births?		
Are you on birth control medication?*		
Do you use a birth control device?***		
Do you do breast self examination?#		
Have you ever had a gynecological exam?+		
Have you ever had an eating disorder?		
Have you ever experienced an absence of your period?		

Comments:

*If yes, what brand name:
**If yes, explain:
#If yes, date of last exam:
+If yes, date of last:

ORTHOPAEDIC HISTORY QUESTIONNAIRE

**PLEASE PLACE A CHECK IN EITHER THE YES OR NO BOX, IF YOU HAVE QUESTIONS OR UNCERTAINTIES, PLEASE ASK ANY MEDICAL PERSONNEL FOR ASSISTANCE
HAVE YOU EVER INJURED OR CONSULTED A DOCTOR ABOUT ANY INJURY TO THE . . .**

HEAD	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a head injury?				
2. Have you ever had a concussion? If so, how many and when?				
3. Do you ever get dizzy or experience headaches when you play?				
4. Any other conditions which required a physician visit?				
NECK	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a neck injury? If yes, please explain.				
CHEST WALL	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever experienced a chest wall injury (clavicle, ribs), if yes, please explain.				
LOWER BACK	YES	NO	DATE	COMMENTS & EXPLANATIONS
1. Have you ever injured your lower back? If yes, please explain.				
SHOULDERS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either shoulder? If yes, please explain.				
UPPER ARM/FOREARM	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either upper arm/forearm? If yes, please explain.				
ELBOWS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either elbow? If yes, please explain.				
WRISTS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either wrist? If yes, please explain.				
HANDS/FINGERS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you injured your hands or fingers? If yes, please explain.				
PELVIS/HIPS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your pelvis or hips? If yes, please explain.				

THIGHS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you injured either thigh? If yes, please explain.				
LOWER LEGS	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your lower legs? If yes, please explain.				
KNEES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either knee before? If yes, please explain.				
ANKLES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured either ankle? If yes, please explain.				
FEET/TOES	YES	NO	DATE	COMMENTS & EXPLANATION
1. Have you ever injured your feet or toes? If yes, please explain.				

	YES	NO
Have you had or do you have any other medical problems or injuries not listed on this form?		
Do you have any medical or health problems that you are currently receiving medical treatment for?		
Have you ever been advised by a doctor not to participate in athletics?		
Are there any additional health problems you would prefer to discuss privately with our team physician?		
If any of the four questions above were answered with YES, please explain below:		
List any special equipment you require or would like to have provided:		

The undersigned herewith,

- A. Understands that any medical expense incurred due to the above pre-existing conditions and not directly attributable to the athletic participation at Fayetteville State University is their personal responsibility.
- B. Understands that the athletic medical insurance is secondary coverage and does not cover them until he or she has been cleared by an athletic physical examination.
- C. Understands that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
- D. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.
- E. Certifies that the answers above are correct and true.

Athlete Signature _____

Date _____

MEDICAL EVALUATION: TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Height: _____	Weight: _____	Resting HR: _____
BP: ____/____ If further testing required: Date: _____ (____/____) Date: _____ (____/____)		
Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____		

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE:

- I certify that this patient is **CLEARED** to participate in intercollegiate athletics for Fayetteville State University.
- I certify that this patient is **CONDITIONALLY CLEARED** to participate in intercollegiate athletics for Fayetteville State University

pending: _____

- Patient is **NOT CLEARED** to participate in intercollegiate athletics for Fayetteville State University

Physician / Physician's Assistant / Nurse Practitioner Signature

_____ **Date** _____

OFFICE STAMP OR ADDRESS AND PHONE NUMBER:



IMPORTANT!!!! Please read all of the following, and ask the athletic trainer any questions you may have, then **CIRCLE THE POLICY TYPE** and sign and date the second page.

- You have signed and filled out forms acknowledging that athletics at Fayetteville State University come with a risk of injury which you accept.
- You have signed and filled out forms which state that you agree to be treated by Fayetteville State University's athletic trainers and/or team physicians.
- Some medical care may come with a substantial cost.

YOU MUST HAVE A PRIMARY HEALTH INSURANCE PROVIDER TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS AT FAYETTEVILLE STATE UNIVERSITY!

Fayetteville State University provides an optional primary health insurance policy.

If you turn down/waive this primary policy^{*(See Below)} **provided by the school YOU MUST HAVE YOUR OWN PRIVATE PRIMARY HEALTH INSURANCE.** You are responsible for any "co-pay" your own primary insurance may require for doctors' visits.

*STUDENT-ATHLETES RECEIVING ANY ATHLETIC-BASED AID (i.e. A full or partial sports scholarship) ARE NOT PERMITTED TO WAIVE THE SCHOOL'S PRIMARY INSURANCE

The *Athletic Department* at Fayetteville State University provides you with a *SECONDARY* health insurance policy at no cost. This secondary policy is different from the school's primary plan and is for intercollegiate student-athletes and injuries resulting from intercollegiate athletics only. Keep in mind that this policy is *secondary* to any other primary health insurance policy and will not pay until after a primary insurance or the claimant (you) has paid. The current policy has a \$3000 disappearing deductible, which means it will not pay leftover costs until after the primary insurance and/or the claimant have paid at least \$3000 in medical expenses. For example, if you require an \$8000 knee surgery, your primary insurance may pay \$4000 towards it. The secondary insurance will pay the remaining \$4000. **However, if your primary insurance pays less than \$3000, it is YOUR responsibility to pay the difference.** This is important to know because many insurances work on an "80-20 plan" which means the insurance company pays 80% and you pay 20%. If the primary insurance company's 80% is less than \$3000 total there **WILL BE SOME COST TO YOU** before the athletic department's secondary insurance begins payment. Also your own primary insurance may not cover accidents related to

intercollegiate athletic activity – you will have to pay the \$3000 deductible out-of-pocket before the school’s secondary insurance picks up the remainder of you medical bills.

For insurance to cover the costs of your medical bills, proper paperwork must be filed according to the particulars of your health insurance provider. It is ultimately YOUR RESPONSIBILITY to see that paperwork and claims are turned in and filed correctly. The athletic trainers and school medical staff are here to help and assist you however possible. If you receive any bills, paperwork, or forms needing replies from hospitals or insurance companies regarding an injury related to athletics, please **bring them to the training room as soon as possible** so that we may assist you in proper handling of these items.

Beyond all the insurance policies and procedures, remember that you have chosen to accept the risk associated with intercollegiate athletics at Fayetteville State University. Any injuries and financial costs associated with said injuries incurred as a result of your participation in intercollegiate sports at Fayetteville State University are ultimately your obligation. The school is here to help you, but you must do your part to keep us involved in the process.

I certify that I am covered by a primary health insurance policy from **(circle one below)**:

Fayetteville State University or My own primary insurance company
(Please attach copy of insurance card)

I have read all the information contained on the pages of this statement and I understand my responsibilities and obligations.

Print name of Student-Athlete

Signature of student-athlete or legal guardian if athlete is under 18

Date

PLEASE CUT OUT AND TAPE OR PASTE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD BELOW (IF APPLICABLE):

**DRUG AND ALCOHOL EDUCATION, SCREENING AND
COUNSELING PROGRAM FOR INTERCOLLEGIATE ATHLETES**

CONSENT FORM

I hereby acknowledge that the program for drug education and drug testing has been presented to me. I further acknowledge that I have had the opportunity to review the program in written form and to ask questions and fully understand the provisions of the program.

I consent to have samples of my urine collected at various times and screened for the presences of any of the banned substances listed in the policy.

I authorize the confidential release of test results to pertinent university officials and my parent(s) or guardian(s). This includes any information and records relating to the screening and testing of my urine.

I waive any privilege I may have in connection with such information and release university officials, including the Fayetteville State University Board of Trustees, officers, employees, and agents from any legal responsibility or liability for any actions related to the implementation of this program or the release of information and records as authorized by this form.

For the academic year: _____

Print Name of Student Athlete: _____

Signature of Student Athlete: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____
(If student athlete is under 18 years of age)

Witness: _____ Date: _____

**FAYETTEVILLE STATE UNIVERSITY
STUDENT-ATHLETE CONCUSSION STATEMENT**

I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

I have read and understand the *NCAA Concussion Fact Sheet*.

After reading the NCAA Concussion fact sheet, I am aware of the following information:

_____ A concussion is a brain injury, which I am responsible for reporting to my
Initial team physician or athletic trainer.

_____ A concussion can affect my ability to perform everyday activities, and affect
Initial reaction time, balance, sleep, and classroom performance.

_____ You cannot see a concussion, but you might notice some of the symptoms
Initial right away. Other symptoms can show up hours or days after the injury.

_____ If I suspect a teammate has a concussion, I am responsible for reporting the Initial
injury to my team physician or athletic trainer.

_____ I will not return to play in a game or practice if I have received a blow to
Initial the head or body that results in concussion-related symptoms.

_____ Following concussion the brain needs time to heal. You are much more likely Initial
to have a repeat concussion if you return to play before your symptoms
resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, and
Initial even death.

Signature

Date

Printed Name

PACKET REVIEWED BY **FSU ATHLETIC TRAINING STAFF** AND IS COMPLETE:

ATC SIGNED: _____

DATE: _____