Department of Intercollegiate Athletics

Wright State University

Personal Information

Name: ____

Sport: ____

Sex: __________

Date of Birth: ________________________

Social Security: ________________________

Permanent Address: ______________________________________
Street

____
City State Zip Code

School Address: ______________________________________
Street

____
City State Zip Code

Home Phone: ________________________

School Phone: ________________________

Cell Phone: ________________________

Emergency Contact: ________________________________

Relationship: ________________________________

Phone Number: ________________________________

Alternate Number: ________________________________

Department of Intercollegiate Athletics

Wright State University

Parent Information

Father/Guardian: ____

Date of Birth: _________________________________

Social Security: _______________________________

Address: ____
Street

____
City State Zip Code Country

Phone Number: _______________________________

Mother/Guardian: ____

Date of Birth: _________________________________

Social Security: _______________________________

Address: ____
Street

____
City State Zip Code Country

Phone Number: _______________________________

Wright State University **STUDENT MEDICAL HISTORY** Dept. of Intercollegiate Athletics

Instructions: We require you to complete this medical history form and return it to the Athletic Training Department prior to participation.

Please Print:

Last Name *First* *M.I.* *Telephone Number*

Local address/Street *City* *State* *Zip*

Month/Day/Year of Birth *City* *State* *Zip*

In an emergency, notify: Name/Relationship *City* *State* *Zip*

Personal Physician *City* *State* *Zip*

Hospital Preference (If a local Student-Athlete)

Insurance Company Name: ____

Group Name: ____________________________ **Group Number:** _________________

Name of Insured: ____________________ **SSN:** __________ **Relationship:** __________

Personal Health History

Please check if you have had any of the following. Give date of illness, operation or injury and date of last treatment.

Alcohol Abuse	Ear Trouble	Meningitis
Amnesia	Eating disorder	Menstrual problems
Appendicitis	Encephalitis	Migraine headaches
Asthma	Exercise Induced Asthma	Mumps
Birth Defects	Eye Trouble	Nervous/Mental Condition
Blood Clots	Fainting	Pneumonia
Bronchitis	Frequent headaches	Recurrent headaches
Cancer	Gall Bladder trouble	Rheumatic fever
Car or Air Sickness	Hearing defect/loss	Rubella
Chest Pain	Heart problem	Scarlet fever
Chicken Pox	Hemorrhoids	Seizure disorder
Chronic Cough	Hepatitis	Sexually transmitted disease
Concussion	Hernia	Sickle cell anemia
Convulsions	High Blood pressure	Sinus trouble
Diabetes	Hypoglycemia	Stomach/intestinal problems
Diphtheria	Kidney disease	Tuberculosis
Depression	Malaria	Ulcers
Drug abuse	Measles	

Head and Neck History: Check and write brief description	*yes*	*no*
Have you ever been unconscious? (If yes, check which one) a. Knocked out ______ b. Blacked out after accident ______		
Have you ever had a concussion? (If yes): How many times? ______ How long to make a complete recovery? _________ Date of last concussion? ________		
Have you ever fractured a bone (includes stress fractures)? Which bones?		
Have you ever had a musculoskeletal surgery? Where?		
Have you ever had a pin, plate, or screw placed in joint? Where?		

General Musculoskeletal	*yes*	*no*
Have you ever fractured a bone (includes stress fractures)? Which bones?		
Have you ever had a musculoskeletal surgery? Where?		
Have you ever had a pin, plate, or screw placed in joint? Where?		
Have you had a sprain or strain to a muscle or ligament within the last 2 years?		

Allergies (are you allergic to?)

Anti-Inflammatory	Hay Fever	Tetanus Antitoxin/serum
Aspirin	Insect Bites/Stings	Any food
Codeine	Penicillin	Any other drug
Cortisone	Sulfa	Other

Heat (have you ever experienced any of the following, list when and how long it took to recover)

Frequent dehydration/Heat syncope (fainting)	Heat Cramps
Heat Stroke	Heat Exhaustion

List any medications taken regularly: ____

____

____

Family History: (Have any of your relatives ever had any of the following?)

	Age	*State of health*	*Age of Death*	*Cause of Death*		*yes*	*Relationship*	*Explain*
Father					Tuberculosis			
Mother					Diabetes			
Brothers					High Blood Press			
					Heart Disease			
					Arthritis			
Sisters					Hay Fever			
					Asthma			
					Cancer			

Immunization Record: (List the date last completed)

Tetanus/Diphtheria		Measles, Mumps and Rubella	
Influenza		Hepatitis B Vaccine (Have you completed the series?)	

Foreign Travel Vaccines, Other ***Tuberculin Skin Test***

Immunization	**Date**	**Date**	**Results**
		Chest	***X-ray (if skin test positive)***
		Date	***Results***

List any other physical or mental concerns not already noted above: ____

____

____

____

Signature and Consent (if student is under 18, both parent/guardian and student must sign)

I certify that the medical facts stated above are true to the best of my knowledge.
I agree to pay any charge for service not covered by university fees or by insurance.
I hereby consent to the release of medical information to the appropriate university representatives.

____ ____

Signature of student **Date** **Signature of parent or guardian** **Date**

REQUIRED IMMUNIZATIONS

TETANUS-DIPHTHERIA
(Booster with TD in the last 10 years meets requirements)

Td Booster ______ / ______
Month Year

M.M.R. (Measles, Mumps, Rubella)

_______ / _______
Month Year
Dose 1 given at age 12-15 months or later

_______ / _______
Month Year
Dose 2 given at age 4-6 years or later and at least one month after first dose

TUBERCULOSIS SCREENING
(Required within last 12 months, regardless of prior BCG) (* If positive PPD see below)

Date Given	Date Given	Date Given
___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
M D Y	M D Y	M D Y

If positive PPD, Chest X-ray is required: Results: Normal: Abnormal:

Treated with anti-tuberculosis drug? Yes ______ No ______ How long?

RECOMMENDED IMMUNIZATIONS

HEPATITIS B (Three doses of vaccine or positive Hep B Surface Antibody)

#1	#2	#3	Hepatitis B Surface Antibody	
___ / ___	___ / ___	___ / ___	________	________
M Y	M Y	M Y	Positive	Negative

MENINGOCOCCAL
MENINGITIS A, C, Y, W-135
(Highly recommended by the ACHA, ACIP: One Dose-preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease.)

Quadrivalent
polysaccharide
vaccine
___ / ___
M Y

Do you have assistive devises? Yes ______ No ______
Please list: ____

Do you smoke? Yes ______ No ______

Have you ever had a serious illness, injury or operation not listed above? Yes ______ No ______
If "yes" please explain:____

____

____

Signature and Consent (if student is under 18, both parent/guardian and student must sign)

I certify that the medical facts stated above are true to the best of my knowledge. I hereby consent to the performance of diagnostic procedures, including x-ray and laboratory tests, pelvic examinations and the administration of treatments or medications that any physician or dentist associated with or consulted by Student Health Services deems necessary, and I agree to pay any charges for service not covered by university fees or by insurance.

I hereby consent to the release of medical information to the appropriate university representatives.

______________________________________ ______________________________________
Signature of student **Date** **Signature of parent or guardian** **Date**

TO: Wright State University Student-Athletes and Their Parents

FROM: Wright State Athletic Department

SUBJECT: Insurance Information

Wright State University provides accidental medical coverage for student-athletes for athletically-related injuries. However, coverage is subject to specific policy terms and conditions and includes certain restrictions and exclusions of which you should be aware. See attached form for further information or you may contact Adam Horseman at (937) 775-2776. Please note that Wright State University assumes no responsibility whatsoever for any uninsured medical expenses and we strongly recommend that the student-athlete have coverage through a primary health insurer to avoid possible, significant out-of-pocket expenses in the event of an injury.

Please also note that the NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a $75,000 deductible and is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's web-site at www.ncaa.org.

Listed below is a detailed summary of the provisions for our accidental insurance policy:

1. The athletes should first submit charges for medical treatment due to an athletic injury to any Group Insurance Company or plan that provides coverage of the athlete. Such a group insurance carrier is often the group health insurance plan at the place of employment of the athlete's parents.

2. The group insurance plan will pay benefits based on its contract of coverage. It is important to note that claims filed under a group medical insurance plan will not directly increase the premiums the parents of the athlete pay for the plan.

3. Any balance due for treatment of an athlete after payment by the group insurance plan will be considered for a benefit payment by our athletic insurance coverage**, provided the bills and explanation of benefits are received within a reasonable amount of time from the date of injury**.

4. If another insurance or medical plan does not cover the athlete, all expenses incurred **due to an athletic injury** are considered for a benefit.

5. The first $75,000 of covered expenses incurred within one year of an athletic injury is eligible for 100% benefit payment under the University's basic athletics insurance coverage.

6. Should medical expenses exceed $75,000 within two years from the date of a covered injury, additional benefits may be paid for the remainder of the athlete's life under the NCAA Lifetime Catastrophic Insurance Program.

7. **Our athletic accident insurance coverage does not cover personal illnesses.** We recommend that athletes purchase the university's student health insurance plan if they are not otherwise covered. The cost of the student insurance plan is currently $216 per quarter or $852 for the year. Benefits are payable for hospital charges, surgery charges, and for other covered medical expenses. A Certified Family Nurse Practitioner and Physician are available for primary health care in Student Health Services located on the first floor of the F. A. White Health Center for a fee. Should you have any questions regarding this coverage, please call Joyce Smith at (937) 775-2553. THE STUDENT HEALTH INSURANCE COVERAGE DOES NOT COVER ATHLETIC INJURIES OR TRAUMAS.

8. No benefits will be paid under this insurance plan for services, surgeries and/or physical therapy performed by other than the Wright State University designated team physicians group and therapy center unless prior approval for treatment is obtained through the athletic training office.

9. NO BENEFITS WILL BE PAID UNDER OUR INSURANCE PLAN FOR EXPENSES INCURRED AS A RESULT OF A PRE-EXISTING CONDITION OR AN AGGRAVATION OF A PRE-EXISTING CONDITION.

10. All injuries/illnesses (whether they are emergencies or not) must be reported to the athletic training room. All necessary care will be arranged through the athletic training room. Failure to follow this procedure will result in forfeiture of your athletic accident insurance benefits.

11. It is important for those athletes covered through Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's) to realize that they must be treated by HMO or PPO physicians approved by the HMO or PPO before the university's coverage will pay any benefit. We will be glad to work with you in contacting your HMO or PPO for their approval to forestall any problems during the competitive season.

12. Enclosed is a form to be completed and returned to the Athletics Department with a *copy of your insurance* card providing is with the necessary information to process insurance claims for our athletes. **ALL INCOMPLETE FORMS WILL BE RETURNED, AND PARTICIPATION WILL BE PROHIBITED.**

13. All physicals must be arranged through the Athletic Training Room.

14. Any athlete missing the scheduled appointments for a physical examination must pay for the cost of a physical from a private physician. That physician must use the Wright State University Athletic Training Room Physical Forms.

    Claims for medical expenses due to athletic injuries will be filed through the athletic training department in room 140 Nutter Center. It is then sent to the third party administrator for payment. If you should have any questions or concerns, please feel free to contact the athletic training room at (937) 775-2776.

Wright State University
Emergency Contact and Insurance Information

Student-Athlete: ____
Date of Birth: ___________________________ Sport: ___________________________________
SSN: __________________________________ Academic Year: ___________________________

EMERGENCY CONTACT

Parent/Guardian Name: ____

Address: ____
____

Home: _________________ Work: __________________ Cell: ___________________

Policy Holder Name: ____
Relationship to Athlete: ____

Address: ____
____

Phone: _____________________

Insurance Company Name: ____
Insurance Address: ____
____

Group#: ____________________________ Policy#: ____________________________

Effective Date of Policy: ____________________________

Primary Physician: ____________________________ Office Number: ____________________________

Policy Deductible: ____________________________ Co-pay: ____________________________

HMO or PPO: ____________________________

I have read the above letters and I agree to the terms set forth. I also agree to update any and all information as it changes.

____ ____
Student-Athlete Parent/Guardian

***Please include a copy of your insurance card (front and back)**

Student Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
Horizon League

I, _____________________________________, hereby authorize Wright State University and its physicians,
Name of Student Athlete

athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for the participation in intercollegiate athletics to the Horizon League and its employees or agents.

I understand that my protected health information will be used by the Horizon League for the purposes of:

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under the HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that Wright State University 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 the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/ consent in order to be eligible for participation in NCAA or conference athletics.

I also understand that the Horizon League is not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the Horizon League's use or disclosure of my injury/illness information.

This authorization/consent expires 380 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 director at Wright State University. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

____

Printed Name of Student Athlete Signature Date

Wright State University
Release of Information

I understand that the team physicians are representatives of Wright State University Orthopedics and Sports Medicine and that he/she may therefore disclose any and all medical information contained in this questionnaire or my medical files to the athletic training staff at Wright State University. It may also be necessary to discuss the above mentioned files with additional consulting physicians pertaining to related injuries or illnesses.

It is also understood that various physicians not associated with Wright State University Orthopedics and Sports Medicine may also act in the capacity as team physician for various ailments which may include but are not limited to optical, dental, and dermatological conditions. I authorize these attending physicians to disclose medical files to the athletic training staff at Wright State University and consulting physicians.

I further authorize Wright State University Athletic Training Room, to release information regarding injuries and illnesses that occur during my athletic career at Wright State University with attending physicians and coaches if necessary for return to play considerations. This may include but is not limited to personal and health related information.

I further authorize the release of information to the Student Health Center as necessary for the payment of bills related to athletic injuries.

____________________________________ ____________________________________

Athlete Signature Parent Signature (if minor)

Wright State University
Department of Athletics
Athlete Assistance Program (A.A.P.)

INTRODUCTION

The Wright State University Athletics Program is highly visible and its studentathletes are regarded within the community as being emissaries of the university. They are also role models for other students, the university and throughout the larger community. Because they have chosen a student activity that is so closely tied to the public's view of the university and in many instances accepted financial aid based upon athletic participation, studentathletes and those who work closely with them have special responsibilities and obligations not normally requested of other members of the university community.

Wright State University studentathletes are required to participate in a substance abuse screening program as part of their continued involvement in the university's athletics program. The purpose of the drug screening program is to identify and provide the necessary assistance to those who use illegal drugs, use drugs illegally, or whose use of drugs. In addition, the university hopes its program will help discourage experimentation and social or recreational use of illegal drugs within the university and throughout the community.

By making its position clear, the university hopes to convey a strong message to its students and the community that drug abuse in any form is not acceptable and will not be tolerated. The purpose of the program is educational and its intent is to encourage healthy patterns of behavior while rendering assistance to those who may be experiencing problems.

CONSENT TO BE EXAMINED AND/OR TESTED FOR DRUG ABUSE

Each studentathlete will be required to consent in writing to be examined and/or tested for the use of drugs and allow the results of such a test(s) to be released to the appropriate athletic department personnel. Refusal to sign the consent form will result in the studentathlete being disallowed from participation in Wright State University athletics. All financial aid based on such participation will be withdrawn immediately. This consent serves as a binding contract between the athlete and Wright State University, and is separate and distinct from any NCAA policy. This policy is subject to change without prior notice at any time.

DRUG TESTING PROGRAM

Any student athlete, during the period of his or her eligibility to participate in intercollegiate athletics, may not use any substance(s) identified as an NCAA Banned Drug(s) (see www.drugfreesport.com/education). The current list is subject to change by the NCAA Executive Committee. The student athlete shall be held accountable for testing positive for any banned drug(s) on the current list.

It is very important that student athletes report to their team physician any use of prescription or "over the counter" drug or medication they may be using. All Student athletes will be responsible for reporting this information. Failure to report such information may inadvertently result in a student testing positive for a banned substance.

1. UNNANOUNCED RANDOM TESTING

A student athlete, individual members of a team or an entire team may be subject to unannounced testing during

testing during the academic year and summer sessions. The selection of who will be tested may be made by either the screening committee (Athletic Director, Director of Athletic Training and Substance Abuse Coordinator) or by the Athletic Director and/or designee independently.

The Director of Athletic Training will be responsible for contacting the student athlete(s) who is chosen for drug testing. Notification will be made either in person or by telephone communication.

2. TESTING IN RESPONSE TO REASONABLE CAUSE

A student athlete, individual members of a team or an entire team may be subject to testing at any time when there is reasonable cause to suspect an individual(s) is or has been engaged in the use of banned substances. Reasonable cause exists if a person unfamiliar with the student athlete or the athletics program would conclude, based on the available information, that there is a basis for the suspicion that the student athlete is using a banned substance. Examples of such may include, but is not limited to:

(1) observed possession or use of banned substances;
(2) arrest or conviction for a criminal offense related to the possession, use, or trafficking of banned substances;
(3) a drug-related violation as defined by the WSU Office of Student Judicial Services;
(4) abnormal weight change; or change of behavior or conduct such as an
(5) unexcused absence from training, competition or academics, or other
(6) behavior reasonably interpreted as possibly being attributed to the use of a banned substance(s)

If, after reviewing all of the information available, the Athletic Director finds reasonable cause exists that the student(s) may have violated the policy the student(s) will be required to meet with the Athletic Director or designee to discuss the situation and any subsequent action(s) the Athletic Director may take. If, after meeting with the student athlete, the Director or designee believes that more likely than not a violation has occurred, immediate drug testing of the student athlete(s) will be required. All drug tests will be conducted by a company of the Athletic Department's choosing and at the department's expense.

PROCESS

In the event that a positive drug test(s) is determined, the Athletic Director or designee will contact the student athlete for the purpose of convening a meeting to discuss the positive drug test and inform the student that he or she will be referred to the Office of Student Judicial Services for disciplinary action. All students who are referred to the Office of Student Judicial Affairs and are found responsible for violating the drug or alcohol policy will be sanctioned in accordance with the University policies and procedures found in the Code of Student Conduct.

All sanctions may be assessed individually or in combination with other sanctions. Sanctions may also be increased or decreased based upon the severity of the incident, the impact upon the community, and/or the student's disciplinary history. The guidelines listed below may be used by the Conduct Officer when determining sanctions related to drug and/or alcohol violations.

Wright State University
Department of Athletics
Athlete Assistance Program (A.A.P.)--Page Three

Drug and/or Alcohol Violations Sanctioning Guidelines

First Offense
Written Warning, Alcohol.Edu and/or Marijuana 101 class, $50.00 fine, Parental Notification, Suspension from 20% of team contests, regular drug testing.

Second Offense
Referral for Substance Abuse Assessment, $100.00 fine, Parental Notification, University disciplinary probation for no less than three academic quarters, Suspension from 50% of team contests, regular drug testing.

Third Offense
Completion of outpatient substance abuse program, $150.00 fine, Parental Notification, possible suspension from school and Permanent removal from the athletic program

The Office of Student Judicial Services will provide the Athletic Director with a written resolution of the incident. The Athletic Director, and or designee reserves the right to issue additional sanctions to a student athlete in accordance with the policies and procedures contained within the Student Athlete Code of Conduct and/or to discuss with the parents/guardians any disciplinary action taken.

Written documentation of this process will be maintained by the Office of Student Judicial Services and may be released in accordance with the Family Education Rights and Privacy Act (FERPA). For more information about FERPA, see http://www.wright.edu/students/judicial/records.html#C

APPEAL PROCESS

The student athlete has the right to appeal any disciplinary sanctions assessed by a Conduct Officer through the WSU Office of Judicial Affairs in accordance with the guidelines provided for in the Code of Student Conduct. Any additional sanctions assessed by the Director of Athletics that result in loss of playing time or removal from a team may be appealed to the Vice President for Student Affairs and Enrollment Services or designee.

CONCLUSION

This program is intended to address potentially serious problems in a helpful and educational manner. It is designed to place studentathletes in communication with professionals who can help prevent potential substance abuse issues from growing and interfering with the educational process.

3-13-06

Wright State University
Department of Athletics
Consent to Testing of Urine Samples and
Authorization for Release of Information

I hereby acknowledge that I received a copy of the “Wright State University Intercollegiate Athletic Department Athletic Assistance Program”. I further acknowledge that I have read said program and that I understand the provisions of the program.

In consideration for the opportunity to participate in intercollegiate athletics at Wright State University, I understand and accept the terms of this Consent and Authorization.

I do hereby give my consent to have samples of my urine collected and tested for the presence of certain drugs or substances in accordance with the provisions of the “Athlete Assistance Program”.

I understand my urine samples will be sent to the appropriate laboratory for actual testing and I furthermore give said laboratory my permission to release the results of such tests to the Wright State University Director of Athletics or designee.

Signature: ____ Date: _____/_____/_____

Parent/Guardian Signature (if student-athlete is under the age of 18):

____ Date: _____/_____/_____

Name (please print): ____

SSN: _____________________________________

Campus Phone: _____________________________

Campus Address (include Zip Code): ____

____

Prescription drugs taken regularly: ____

____

____

Wright State University

Flexibility Testing

Name:_________________________________ Sport:________________________________

	Right	Left
1. Plantar Flexion (120)	_____	_____
2. Dorsiflexion (105)	_____	_____
3. Hip Abduction (45)	_____	_____
4. Knee Flexion (140)	_____	_____
5. Hip Flexion (90-120)	_____	_____
6 Hip Extension (10-15)	_____	_____
7. Shoulder IR (90)	_____	_____
8. Shoulder ER (90)	_____	_____
9. Shoulder Flexion (130-180)	_____	_____
10. Soulder Extension (50-60)	_____	_____
11. Shoulder Abduction (170-180)	_____	_____
12. Horizontal Adduction (130)	_____	_____
13. Elbow Flexion (145-150)	_____	_____
14. Pronation (80-90)	_____	_____
15. Supination (90)	_____	_____
16. Wrist Flexion(80-90)	_____	_____
17. Wrist Extension(70-90)	_____	_____
18.Neck Side Flexion (20-40)	_____	_____
19. Neck Flexion (80-90)	______	
20. Neck Extension (60-70)	______	

Areas of Concern:

Wright State University
Physical Examination

Name_______________________________ **Date**_____________

Sport__________ **Year:** Freshman Sophmore Junior Senior 5th Year

	Normal	Comments
1. Height & Weight	______________	____
2. Urine Analysis	______________	____
3. Blood Pressure	______________	____
4. Pulse	______________	____
5. Eyes	______________	____
6. Skin	______________	____
7. Head	______________	____
8. Ears	______________	____
9. Nose	______________	____
10. Throat & Mouth	______________	____
11. Neck	______________	____
12. Lymph Nodes	______________	____
13. Lungs	______________	____
14. Heart	______________	____
15. Abdomen	______________	____
16. Genitalia	______________	____
17. Extremities	______________	____
18. Neurological	______________	____
19. Musculoskeletal	______________	____

Regular Medications:____

Accepted:___ **Rejected:**___ **Hold for Further Testing:**_____

Physician Signature:____

Physician's Printed Name: ____

Physician Office Phone: ____