

# ARCADIA UNIVERSITY ATHLETIC TRAINING FORMS

**TO ATHLETE AND PARENTS:** All of the following forms must be filled out completely. The *Arcadia University Athletic Clearance Form* must be completed and signed by a physician or other health professional (Nurse Practitioner or Physician Assistant). You should bring all six (6) pages with you on the first day of pre-season.

**First Years and Transfers:** These forms must be completed in addition to the **Health Record** forms sent to you on behalf of Student Health Services. Those forms are separate from athletic training forms and you should receive them in the mail but they can be also accessed at <http://www.arcadia.edu/student/default.aspx?id=1420>

**Returning Athletes:** In accordance with NCAA regulations you are required to obtain a new physical every school year. Even if you had a physical for the 2008-2009 school year you must obtain a new physical for the 2009-2010 school year.

**Health Insurance Cards:** All students must bring their current health insurance card or a copy of the front and back of your health insurance card. You will not be able to begin pre-season without current proof of health insurance.

**Athletes diagnosed with ADHD:** If you have been diagnosed with and are being treated for ADHD you are required by the NCAA to do the following: Obtain documentation that demonstrates you have undergone a clinical assessment to diagnose ADHD are being monitored routinely for use of the stimulant medication, and have a current prescription on file, in order to be approved for a medical exception to the banned drug policy. A sample evaluation format and more information can be accessed from the NCAA website (<http://www.ncaa.org/wps/ncaa?ContentID=481>)

No exceptions will be made for students that do not have proper documentation.  
**If you have any questions please call Dené McKee, ATC 215-572-2848**

**ARCADIA UNIVERSITY ATHLETICS  
REPORT OF MEDICAL HISTORY**

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>	<b>DOB</b>	<b>SOCIAL SECURITY #</b>
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<b>HOME ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>CELL PHONE</b>
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<b>PARENT / GUARDIAN</b>	<b>HOME PHONE</b>	<b>CELL PHONE</b>
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<b>Please answer all of the following questions</b>	<b>Yes</b>	<b>No</b>
Have you been hospitalized or had surgery in the past 12 months		
Has a doctor ever denied or restricted your participation in physical activity for any reason?		
Do you have an ongoing medical condition such as asthma or diabetes?		
Are you currently taking any prescription or non-prescription medications?		
Have you been knocked unconscious at anytime during the last 12 months?		
Do you smoke or use tobacco products?		
Do you drink alcohol?		

<b>Have you ever had or do you now have any of the following conditions?</b>								
	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
A heart murmur			Eye Injury			<b>Ever have injuries to the following?</b>		
High blood pressure			Impaired Vision			Neck		
A heart infection			Dental Problems			Shoulder		
Chest Pain			Missing Teeth			Arm or Elbow		
Heart Racing or Skipping			<b>Do You Wear:</b>			Wrist or fingers		
Marfan's Syndrome			Glasses or Contacts			Back		
Dizziness or Fainting			<b>Neurological Injuries</b>			Groin		
Breathing Problems			-Concussion			Thigh		
Heat Exhaustion or Heat Stroke			-Skull Fracture			Knee		
Frequent Headaches			- Loss of Consciousness			Lower Leg		
Mononucleosis			- Amnesia			Ankle or Foot		
Anemia			-Seizure Disorder			<b>Allergies</b>		
Chronic Cough			<b>Skin Conditions such as:</b>			- Medications		
Lung Problems			-MRSA			-Insects		
Stomach / Intestinal Problems			-bacterial infection			-Latex		
Spleen Injury			<b>Eating Disorder such as:</b>			-Other Allergies		
Hernia			-Anorexia			<b>Females only:</b>		

Seizure Disorder			-Bulimia			Changes in menstrual		
Urinary Problems			<b>Are you missing one of these organs?</b>			Are you currently pregnant?		
Ear Injury			-Lung			<b>Do you have any medical conditions not listed above? List below</b>		
Hearing Difficulty			-Kidney					
Nose Injury			-Testicle					
Frequent Nose Bleeds								

**FAMILY HISTORY**                      **Have any of your relatives had the following?**

Condition	Yes	No	Relationship
Sudden Death Before age 50?			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Cancer			
Marfan's Syndrome			
Asthma / Allergies			
Tuberculosis			
Alcohol / Drug Problems			
Depression			

Please comment on all "YES" answers here \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that the answers to the questions above are correct and true.

\_\_\_\_\_  
 Student-Athlete Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Health Care Providers Signature (Acknowledging Review)

\_\_\_\_\_  
 Date

## ARCADIA UNIVERSITY ATHLETIC CLEARANCE FORM

NCAA policies recommends that any student who intends to participate in intercollegiate athletic activities must have on file at the school a record of having passed a complete physical examination upon initial entrance into the school's intercollegiate athletic program. Arcadia University requires their athletes to complete a heart and lung screening and medical history form yearly. All athletes must have a completed health record on file in the Student Health Services Center ***prior to participation.***

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sport \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

	Normal	Abnormal / Comments
Head, Ears, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Metabolic/Endocrine		
Neurological		
Skin		
Psychiatric		
Musculoskeletal		

\_\_\_\_\_ **Has Satisfactorily** completed the examination to participate in athletics at Arcadia University.

\_\_\_\_\_ **Has Not** satisfactorily completed the examination and is not cleared to participate in athletics at Arcadia University. The following findings should be further evaluated prior to participation clearance:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of physician or nurse practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of physician or nurse practitioner

\_\_\_\_\_

**Address**

**Phone**

I the undersigned certify that the answers to the questions above are correct and true. I also understand that passing the physical exam does mean that I am physically qualified to engage in athletics, but that the examiner did not find a medical reason to disqualify me.

\_\_\_\_\_  
**Student-Athlete Signature**

\_\_\_\_\_  
**Date**

**Student Athlete Authorization /Consent  
for  
Disclosure of Protected Health Information  
to the  
National Collegiate Athletic Association**

I, \_\_\_\_\_ herby authorize \_\_\_\_\_  
Name of Athlete Name of my Institution

and its physicians, 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 participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my protected health information will be used only by the NCAA’s Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database the provides the NCAA, NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provided to the Association and other groups with an information resource upon which base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold 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 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 athletics.

I understand that while HIPPA regulations do not apply to the NCAA’s use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any in any publication or disclosure or research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent expires 380 days from the date my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution. I understand that a revocation takes effect on its request and does not affect any action taken prior to that date.

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**Printed Name of Student-Athlete**

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**Signature**

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**Date**

**Student-Athlete Authorization/Consent  
For  
Disclosure of Protected Health Information**

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Arcadia University to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, and related personally identifiable health information. This protected health information may be released to my parents/guardians, other health care providers, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and or/or service companies, academic counselors, athletic and or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I hereby authorize medical insurance coordinators, insurance carriers, and hospitals and/or medical clinics to release all necessary medical billing information. This information is only to be released for settlement of medical bills incurred while participating as a student-athlete at Arcadia University.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Arcadia University. I understand that my protected health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974(the Buckley Amendment/FERPA) and may not be disclosed without my authorization under HIPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying the Head Athletic Trainer in writing. If I do it will not have any effect on actions Arcadia University took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires (6) years from the date it is signed.

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**Name of Student-Athlete**

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**Signature of Student-Athlete**

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**Date**

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**Social Security Number of Student-Athlete**

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**Date of Birth of Student-Athlete**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age)**

\_\_\_\_\_  
**Date**

Revised 6/07

**ARCADIA UNIVERSITY ATHLETIC TRAINING ROOM  
INSURANCE VERIFICATION AND EMERGENCY CONTACT FORM**

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **M / F**  
Last First MI

**Permanent/Home Address** \_\_\_\_\_  
City State

**Home Telephone** (\_\_\_\_) \_\_\_\_\_ **Cell** (\_\_\_\_) \_\_\_\_\_

**Male Parent/Guardian**

Name \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_

Employer's Telephone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Female Parent/Guardian**

Name \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_

Employer's Telephone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**INSURANCE COMPANY** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**TELEPHONE** \_\_\_\_\_

**POLICY #** \_\_\_\_\_ **GROUP #** \_\_\_\_\_

**POLICYHOLDER NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**CURRENT MEDICAL CONDITIONS:** \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**KNOWN ALLERGIES:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Telephone:** (\_\_\_\_) \_\_\_\_\_

**Relationship:** \_\_\_\_\_