

Medical Clearance Packet 2010-2011

Every Arcadia University Student-Athlete must have a yearly pre-participation physical completed and current insurance coverage in order to participate in intercollegiate athletics.

Please note the pre-participation physical may not be completed any earlier than May 1, 2010. This must be completed by the student-athlete's family physician. The student-athlete should bring the completed packet with them on the first day of their season.

First year and transfer students must complete this packet in addition to student health services information. That can be accessed <http://www.arcadia.edu/student/default.aspx?id=1420>.

ADD/ADHD Documentation

Effective in August 2009 there will be a stricter application of the NCAA Medical Exemption policy and specifically for the use of banned stimulant medications to treat Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). This stricter application will provide more complete information to the medical panel of the Committee on Competitive Safeguards and Medical Aspects of Sport (CSMAS), which reviews requests for a medical exception to a positive drug test for these stimulant medications. This information is necessary to appropriately apply the exceptions policy, so that student-athletes are adequately monitored while using a stimulant medication that can negatively impact health and safety, and so that stimulants are not being used strictly for athletic performance enhancement. Any student-athlete who tests positive from the effective date will need to comply with the stricter application, even if that student-athlete had received an exception for use of stimulation medication prior to August 2009.

Criteria for letter from prescribing Physician to provide documentation to the Athletics Department/Sports Medicine staff regarding assessment of student-athletes taking prescribed stimulants for Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD), in support of an NCAA Medical Exception request for the use of a banned substance. The following must be included in supporting documentation:

- Student-athlete name.
- Student-athlete date of birth.
- Date of clinical evaluation.
- Clinical evaluation components including:
 - o Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) -- attach supporting documentation.
 - o ADHD/ADD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary -- attach supporting documentation.
 - o Blood pressure and pulse readings and comments.
 - o Note that alternative non-banned medications have been considered, and comments.
 - o Diagnosis.
 - o Medication(s) and dosage.
 - o Follow-up orders.

Additional ADHD/ADD evaluation components if available:

- Report ADHD/ADD symptoms by other significant individual(s).
- Psychological testing results.
- Physical exam date and results.
- Laboratory/testing results.
- Summary of previous ADHD/ADD diagnosis.
- Other comments.

Documentation from prescribing physician must also include the following
Physician name (Printed)

- Office address and contact information.
- Specialty.
- Physician signature and date.

Athlete WILL NOT be allowed to participate without the complete medical packet and proof of current insurance (front and back of insurance card)

Please direct any questions to Meghan Sarao, MS, ATC 215-572-2848 or saraom@arcadia.edu

ARCADIA UNIVERSITY ATHLETICS REPORT OF MEDICAL HISTORY

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB	SOCIAL SECURITY #
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HOME ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE
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PARENT / GUARDIAN	HOME PHONE	CELL PHONE
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Please answer all of the following questions	Yes	No
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?		
If you answered yes to any of the above questions, please elaborate below		

Have you ever had or do you now have any of the following conditions?									
	Yes	No		Yes	No		Yes	No	
A heart murmur			Sickle Cell Trait			Ever have injuries to the following?			
High blood pressure			Eye Injury			-Neck			
A heart infection			Impaired Vision			-Shoulder			
Chest Pain			Dental Problems			-Arm or Elbow			
Heart Racing or Skipping			Missing Teeth			-Wrist or fingers			
Marfan Syndrome			Do You Wear:			-Back			
Dizziness or Fainting			-Glasses or Contacts			-Groin			
Breathing Problems			Neurological Injuries			-Thigh			
Heat Exhaustion or Heat Stroke			-Concussion			-Knee			
Frequent Headaches			-Skull Fracture			-Lower Leg			
Mononucleosis			-Loss of Consciousness			-Ankle or Foot			
Anemia			-Amnesia			Allergies			
Chronic Cough			-Seizure Disorder			-Medications			
Lung Problems			-Stroke			-Insects			
Stomach / Intestinal Problems			Skin Conditions such as:			-Latex			
Spleen Injury			-MRSA			-Other Allergies			
Hernia			-Bacterial infection			Females only:			
Seizure Disorder			Eating Disorder such as:			-Changes in menstrual			
Urinary Problems			-Anorexia			-Are you currently pregnant?			
Ear Injury			-Bulimia			Are you missing one of these organs?			
Hearing Difficulty			Do you have any medical Conditions not listed above? Please list below			-Lung			
Nose Injury						-Kidney			
Frequent Nose Bleeds						-Testicle			

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 Syndrome			
Asthma / Allergies			
Tuberculosis			
Alcohol / Drug Problems			
Depression			
Sickle Cell Disease			

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		
	YES / NO	
Any history of a heart murmur?		
Sickle Cell Trait?		
ADD or ADHD		** if yes please provide documentation of testing

_____ **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**

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 sate it is signed.

Name of Student-Athlete

Signature of Student-Athlete

Date

Social Security Number of Student-Athlete

Date of Birth of Student-Athlete

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

Date

ARCADIA UNIVERSITY ATHLETIC TRAINING ROOM

INSURANCE VERIFICATION / EMERGENCY CONTACT FORM

Name _____ **Date of Birth** ____ / ____ / ____ **M / F**
Last First MI

Permanent/Home Address _____
City State Zip Code

Home Telephone (____) _____ **Cell** (____) _____

Male Parent/Guardian

Female Parent/Guardian

Name _____

Name _____

Employer _____

Employer _____

Employer Address _____

Employer Address _____

Employer's Telephone _____

Employer's Telephone _____

Cell Phone _____

Cell Phone _____

INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE _____

POLICY # _____ **GROUP #** _____

POLICYHOLDER NAME _____ **RELATIONSHIP** _____

<p>CURRENT MEDICAL CONDITIONS: _____</p> <p>CURRENT MEDICATIONS: _____</p> <p>KNOWN ALLERGIES: _____</p> <p>Emergency Contact: _____ Telephone: (____) _____</p> <p>Relationship: _____</p>

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

ARCADIA UNIVERSITY ATHLETICS DEPARTMENT

I, _____, as parent, guardian or legal representative, attest that
(Name, please print)

_____ has insurance coverage under a current, in force insurance
(Student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics.

If there is a material change in coverage or expiration of coverage, I agree to notify Arcadia University of this development and update the insurance information I have on file with Arcadia University.

I understand and agree that Arcadia University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Arcadia University if the student-athlete fails to remain insured during the intercollegiate school year.

(signature of parent/guardian)

(date)

(signature of student-athlete)

(date)

**THIS FORM MUST BE SIGNED AND RETURNED TO ARCADIA
UNIVERSITY ATHLETIC TRAINING ROOM WITH COMPLETE
MEDICAL CLEARANCE PACKET**

**YOU MUST INCLUDE A COPY (FRONT AND BACK)
OF YOUR CURRENT INSURANCE CARD**