

## **Student-Athletes and Parents,**

The following information is extremely important for athletic preparation and eligibility at Whitworth University. The primary concern of the athletic training staff and team physicians is to provide high quality medical care for student-athletes at Whitworth University. Please read these instructions, complete the appropriate forms, and mail all documents needed to the address below. If you have questions, please contact Jon Bosh, Assistant Athletic Trainer, or Melinda Larson, Head Athletic Trainer.

In addition to Whitworth's efforts to provide high quality medical care, the NCAA has several educational documents for student-athletes and families that can be accessed via their website. The NCAA recommends confirming Sickle Cell Trait status in all student-athletes during the pre-season medical exam. [Click here](#) to learn more about sickle cell trait. Please make every effort to discover your Sickle Cell Trait status and confirm the test date on your medical history. The NCAA also provides helpful information regarding concussions. [Click here](#) to access those educational documents.

In the required packet, you will find the following medical forms and requests for associated documents

### **1) Health History**

Whitworth University's athletic department policy states that all student-athletes must pass a pre-participation physical examination prior to participation in intercollegiate athletics. This initial examination will be provided free of charge on campus at pre-determined dates prior to the start of your season. Coaches will be communicating the time and location of these exams. If you are not present at this exam you must contact Jon Bosh, Assistant Athletic Trainer, for alternate scheduling which may be at your own cost. If you are currently experiencing a medical problem or have had any major illness or significant injury in the last twelve months you must provide a written release for participation in varsity intercollegiate athletics from your treating physician. You will not be eligible for participation until this written release is received. If necessary, you may send this release separately.

### **2) Insurance Information**

Whitworth University and the NCAA require proof of enrollment in a primary insurance plan prior to participation in intercollegiate athletics. If you will not have primary insurance for the school year, please contact the Health Center about possible options. Whitworth University provides secondary insurance coverage for all student-athletes which is in effect during supervised participation in varsity athletics. Educational and Institutional Insurance Administrators, Inc. (EIIA) administers this excess athletic policy which is designed to pay the balance of covered expenses up to the maximum of the policy after the bills have been processed through the primary insurance. In other words, the EIIA policy is intended to pay any deductibles or co-pays the primary insurance does not pay. Any student-athlete who sustains an injury that occurred during supervised participation (when a coach is present at a NCAA sanctioned practice or competition) is covered under this secondary policy, up to the policy limits and under its restrictions. The primary insurance will be billed first and student-athletes are responsible for providing the remaining statement balance to the insurance coordinator at the Health Center for processing payment. Information on the EIIA policy can be found at the Whitworth Health Center's website.

**In order to provide the required proof of primary insurance you must bring your insurance card(s) – or copies - with you to the pre-participation physical exam. This is required prior to your participation.**

### **3) Student Consent for Release of Health Information**

In order to provide optimal health care the athletic training staff may refer student-athletes to other medical specialists. Please complete and sign the Student Consent for Release of Health information form. You may also decline this release of information; please indicate your choice on the form.

#### **4) Prescription Medication Documentation for ADHD and asthma medications**

##### **NCAA Policy on the use of prescription medication for ADHD and asthma:**

The NCAA medical exception policy requires that documentation be on file for student-athletes taking ADHD and asthma prescription medication (Ritalin, Adderall, Albuterol, etc). This documentation must include specific information on the assessment used to diagnose ADHD or asthma in order to ensure the condition is being managed appropriately.

**The student-athlete is responsible for providing this documentation from the prescribing physician that must contain the following information.**

- a. Description of the evaluation process which identifies the assessment tools and procedures.
- b. Statement of the Diagnosis, including when it was confirmed.
- c. History of treatment (previous/ongoing).
- d. Statement that a non-banned alternative medication has been **considered** if a stimulant is currently prescribed.
- e. Statement regarding follow-up and monitoring visits.

**Please provide this information from your treating physician along with the rest of the necessary forms or mail separately if needed .**

**All forms must be submitted by August 1st:**

**Mail to:                      Jon Bosh  
Whitworth University  
300 W Hawthorne  
Spokane WA 99251**

##### **Please be sure these forms are signed and returned:**

Entire packet

Written release from physician if recently injured

ADHD or asthma medical documentation (if necessary and may be mailed in separately)

If you have any questions or have difficulty accessing any forms please contact:

**Jon Bosh  
Assistant Athletic Trainer  
(509) 777-3728  
jbosh@whitworth.edu**

**Melinda Larson  
Head Athletic Trainer  
(509) 777-4389  
mlarson@whitworth.edu**



WHITWORTH UNIVERSITY  
MEDICAL HISTORY & PRE-PARTICIPATION EXAM FORM

Date:	Sport 1:	Sport 2:
Student-athlete's Name:		
Last	First	Middle
Student ID No:	Date of Birth:	Age: Grade: <input type="checkbox"/> M <input type="checkbox"/> F
Local Address or Dorm:		
Cell or Local Phone:		

<b>Fathers Name:</b>	<b>Mothers Name:</b>
Last                      First	Last                      First
Address:	Address:
e-Mail:	e-Mail:
Home Phone:	Home Phone:
Business Phone:	Business Phone:
Cell Phone:	Cell Phone:

Check here if Emergency Contact information is same as above

**Emergency Contact**

Last                      First	Relationship:
Address:	
Home Phone:	Business Phone:
Cell Phone	e-Mail:

**Marital Information (if applicable)**

Spouse's Name:		
Last	First	
Address:		e-Mail:
Home Phone:	Business Phone:	Cell Phone:

**NOTE:** This information will be kept **CONFIDENTIAL**

**A. FAMILY MEDICAL HISTORY:** Has any close blood relative ever had any of the following conditions? If yes please briefly explain who and when in the provided area.

1. Cardiovascular Disease		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Died suddenly before age 50 years		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. High Blood Pressure		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Sickle Cell Trait/Disease		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Marfan Syndrome		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Stroke		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**B. GENERAL MEDICAL HISTORY:**

Have you ever had or do you now have any of the conditions below? If yes, provide explanation and information, including applicable dates, regarding the condition.

Use this column to briefly explain yes answers

1. Do you have or have you ever been treated for diabetes? If yes please list the age at which your diabetes began as well as all medications you take for this condition		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Do you have or have you ever had an epileptic seizure? If so, when.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever suffered from or been diagnosed with <u>asthma</u> or exercise induced asthma? If yes, what medication are you taking to control it?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you have any <u>heart disease, disorder or murmur</u> ? If yes, describe and list any medication you are taking for it.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever been tested for a heart condition? If so, please list the test. (EKG, echocardiogram, stress test)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Do you have <u>sickle cell trait/anemia</u> ? Please provide the date of test: <input type="checkbox"/> or <input type="checkbox"/> check here if you don't know. Please make every effort to find test results.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. During the last 12 months have you had any type of problem with intolerance to exercise?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Have you ever passed out before, during or after exertional activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Have you ever had trouble with dehydration, heat intolerance, heat cramps, heat exhaustion or heat stroke?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Have you ever had an injury to an internal organ?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Have you ever lost full use of any organ, either temporarily or permanently? (Eyes, Ears, Kidneys, Lungs, etc)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. In the past 24 months have you been treated for the following:			
Mononucleosis		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pneumonia		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Infectious Virus		<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Do you have a vision defect in either one or both eyes?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Do you wear glasses during activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Do you wear contacts during activity?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Do you wear any dental appliances?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
17. Have you had a tetanus shot in the last 3 years?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
18. Have you ever received the Hepatitis B (HBV) Vaccination?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
19. Any other medical conditions?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**C. ALLERGIES:** Are you allergic to any of the following items.

Aspirin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Acetaminophen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bee stings	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Codeine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Erythromycin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Novocain or other anesthetics	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Iodine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sulfa Drugs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ibuprofen	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tetanus antitoxin or serums	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Latex	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										<input type="checkbox"/> YES	<input type="checkbox"/> NO

**D. GYNECOLOGICAL HISTORY: \*\*\*ONLY FEMALES ANSWER THIS SECTION\*\*\***

CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE YEAR(S) AT WHICH THE CONDITION OCCURRED.

	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Years		<input type="checkbox"/> YES	<input type="checkbox"/> NO	Years		<input type="checkbox"/> YES	<input type="checkbox"/> NO	Years
Absence of Menstruation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Menstrual Cramps	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Scanty Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Painful Menstruation	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Irregular Periods	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Excessive Flow	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are currently taking Birth Control Pills?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, what type are you taking?						

**E. EATING DISORDERS:** Have you ever had: **Use this column to explain yes answers**

1. Diagnosis of anorexia? If yes, when and where?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Diagnosis of bulimia? If yes, when and where?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. A problem with food bingeing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you sometimes or often induce vomiting after eating?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Taken laxatives to lose weight?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**F. CONCUSSIONS:**

Have you ever had a Concussion? If yes, please list the dates and how long the symptoms lasted for each.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been hospitalized for any of the concussions you sustained? If so, list the dates.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been knocked unconscious? If yes, please list the dates	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**G. CURRENT MEDICATIONS:**

Are you currently taking any prescription medications?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If yes, please list all and explain purpose.

**REMEMBER: Due to NCAA requirements, if you are taking medication for ADHD or asthma, the following documents must be submitted to the athletic training staff. See the introduction letter for more information.**

- Description of the evaluation process which identifies the assessment tools and procedures.
- Statement of the Diagnosis, including when it was confirmed.
- History of treatment (previous/ongoing).
- Statement that a non-banned alternative medication has been considered if a stimulant is currently prescribed.
- Statement regarding follow-up and monitoring visits.

Please provide this information from your treating physician along with the rest of the forms or mailed separately if needed.

**ORTHOPEDIC MEDICAL HISTORY: For yes answers check which side if applicable and list when the injury occurred and what the injury is/was. Please be brief in your explanation as space is limited.**

**H. SPINE:**

Use this column to briefly explain yes answers

Have you ever injured your lower back or suffered from chronic low back pain?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you ever diagnosed with a spinal defect of any type?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had back surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**I. NECK:**

Have you ever sustained a serious neck or cervical injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did you have numbness, burning, or sharp pain in your arms or legs?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had an injury producing weakness or numbness of your arms or legs or both?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Were you ever transported by ambulance for a neck injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had neck surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had a burner or stinger (stretched or pinched nerve)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**J. SHOULDERS:**

Have you ever suffered a significant shoulder injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Has your shoulder ever felt like it was unstable or slipping?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had a problem with your shoulder repeatedly coming out of place?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Do you have any problems with your shoulder with overhead activities?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had shoulder surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**K. ELBOW, WRIST, HAND, FINGER:**

Have you ever had an elbow injury or problem?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had a wrist injury or problem?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had a hand or finger injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Do you have a finger deformity as a result of an injury? If so, which finger?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had elbow, wrist, or hand/finger surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**L. HIP:**

Have you ever injured either hip?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had hip surgery?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**M. KNEES: If yes, please check which side. Use this column to explain yes answers**

Have you ever had a knee injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Did you have surgery for your knee injury(s)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
<b>If you have had a significant knee injury or knee surgery, answer the following questions:</b>					
Were you placed on a rehabilitation program?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Do you wear any type of preventative/protective brace when you practice or play?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Does your knee ever swell or collect fluid?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever suffered from patellar tendinitis or jumper's knee?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever been diagnosed with Osgood-Schlatter's disease?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**N. ANKLES:**

Have you ever sustained an ankle injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had surgery on your ankle(s)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**O. FEET AND TOES:**

Have you ever had a foot or toe injury?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R
Have you ever had a problem with bunions?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> L	<input type="checkbox"/> R

**P. MUSCLE INJURIES:**

Have you ever had a severe muscle pull or strain? <b>What muscle(s) and when?</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has this injury reoccurred? <b>If yes, list the muscle(s) involved and date(s):</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Q. OTHER SURGERY:**

If you have ever had any *other* surgeries not listed above; please list them below:

DATE	SURGICAL PROCEDURES	LOCATION	COMPLICATIONS?

**R. OTHER:**

If you have any additional conditions, problems, or comments that have not been addressed in the above questionnaire, please use the space below to inform us so that we may be able to better serve you with our best medical care.

By signing below, I certify that all statements and answers in the above medical history questionnaire are true and complete to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

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

Date: \_\_\_\_\_

If student-athlete is under the age of 18 a parent or guardians signature is required:

Parent or Guardian Name (Please Print): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**WHITWORTH UNIVERSITY ATHLETICS DEPARTMENT**  
**Student-Athlete Nutritional Supplement Disclosure and Review Form**

Last Name

First Name

As part of the commitment to maintaining the health and welfare of our student-athletes, the athletic training staff is providing this very important information about nutritional supplements. Currently, the Food and Drug Administration does not regulate nutritional supplements. It is important to understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by Whitworth and/or the NCAA. Terms such as “healthy” or “naturally occurring” do not necessarily mean safe to take or use. Before taking or using any supplement, student-athletes are responsible for taking appropriate steps to discover if it contains any banned substances. By making this disclosure, student-athletes are requesting that these products and their ingredients be reviewed by the athletic training staff for the purposes of determining whether they are medically safe to use and do not contain banned substances. If you have further questions please contact the athletic training staff or you can find more information at [www.drugfreesport.com](http://www.drugfreesport.com). To log into the resource exchange center, click on the NCAA logo, click Division III from the drop down and the password is ncaa3.

I **AM NOT** taking any nutritional supplements. I understand that failure to declare nutritional supplement usage may result in a loss of eligibility if the supplements taken contain any substances banned by Whitworth and/or the NCAA. Should I begin taking supplements after this form has been completed it is my responsibility to report any change in supplement usage to the athletic training staff.

----- **OR** -----

I **AM** taking or intend to take the following nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for a Whitworth and/or NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements.

Provide brand name and all listed ingredients:

**Whitworth University Student Athlete Authorization for  
Release of Protected Health Information**

Last Name                      First Name

I hereby authorize **Whitworth University** 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 and participation in intercollegiate athletics to the **Athletic Director, Associate/Assistant Athletic Directors, Athletic Training Staff and related health care providers (MD specialists, therapists etc), Coaches, Sports Information Director, local media, and the NCAA Injury Surveillance System** for the purposes of:

- **Decision making about and plan for my care and treatment**
- **Referral, consultation and coordination of with other health care providers for my care and treatment**
- **Determination of my eligibility for health insurance benefits or coverage**
- **Releasing information to the media when a condition or injury affects my ability to participate**
- **Performance of office or administrative functions that support the athletic training department's effort to provide me with effective health care**
- **Facilitation of any other reason permitted by law**
- **Data collection by the NCAA for research purposes**
- **Promotion of Whitworth University athletics**

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

This authorization 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 my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization.

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

Date: \_\_\_\_\_

If student-athlete is under the age of 18 a parent or guardians signature is required:

Parent or Guardian Name (Please Print): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Insurance Information Form

*To Be Used For Filing Medical Claims*

Name: Last <span style="margin-left: 100px;">First</span>	Birth Date:
Local Address:	
Cell or local Phone:	

Sport 1:

Sport 2:

1. Are you covered by insurance through, (please check all that apply):  Father  Mother  Self  Whitworth  Other
2. Which of the above is the source of your primary insurance?
3. Please provide the following:

Insurance Plan:

Insurance Type:

<b>Head of household</b>			
	Last Name	First Name	
Date of Birth:		Home Phone:	
Employer Name:			
Employer Phone:			
Insurance Co Name:			
Insurance Co Phone:			
Insurance Co. ID#:			
Is Student Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Other</b>			
<b>Parent/Spouse:</b>	Last Name	First Name	
Date of Birth:		Home Phone:	
Employer Name:			
Employer Phone:			
Insurance Co Name:			
Insurance Co Phone:			
Insurance Co. ID#:			
Is Student Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If there is a change in coverage or expiration of coverage, immediately notify Whitworth University and update the insurance information on file.

**REMEMBER: You must also bring your insurance card(s) – or copies - with you to the pre-participation physical exam. This is required prior to your participation even if you have brought it in previous years.**