

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

RETURNING STUDENT-ATHLETES: You are only required to have a full physical exam your first year. Each subsequent year you will be screened by the athletic training staff for changes in your medical status. If needed, you will be referred to a physician for further examination and clearance to participate. If you have had any major illness or significant injury since your last health screening please also send a written release for participation in varsity collegiate athletics from your treating physician. If you were treated by the Whitworth University athletic training staff and team physicians, we will provide this release for you.

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.



**WHITWORTH UNIVERSITY
MEDICAL HISTORY UPDATE 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:		

Fathers Name:	Mothers Name:
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. MEDICAL ILLNESS: IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING:

Use this column to briefly explain yes answers

1. Chest pain while exercising		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Fainted or nearly fainted while exercising		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Unexplained shortness of breath or fatigue with exercise		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Suffered from heat illness		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Been knocked out or experienced a concussion. If yes, were you seen by a medical professional?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Diagnosis of mononucleosis, pneumonia or other infectious virus		<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Other illnesses, please list:			

B. GENERAL MEDICAL INFORMATION:

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 any and all medications you take for this condition.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever had Anemia?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Do you or have you ever had hypoglycemia (low blood sugar)?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Do you have sickle cell trait? (Please make every effort to find test results):	Date(month/year) <input type="checkbox"/> or <input type="checkbox"/> don't know	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Do you have a vision defect in either one or both eyes and if yes, please specify.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Do you wear glasses?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, do you wear them during athletic activity?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Do you wear contact lenses?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, do you wear them during athletic activity?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Do you have a hearing defect? If yes, please specify and list any hearing aids worn:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Do you wear any dental appliances?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, do you wear them during athletic activity?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Have you had either a gain or loss of ten pounds or more in the past 12 months? Specify:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Do you currently take any medication or drugs? If yes, what medications or drugs are you taking, and for what reason?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EIA)? If yes, what medication(s) are you taking to control EIA?		<input type="checkbox"/> YES	<input type="checkbox"/> NO

REMEMBER: Due to NCAA requirements, if you are taking medication for ADHD or asthma, the following information from your treating physician is needed. See the introduction 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. If you have sent the information in previously, then you will not need to do so again.

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*****
 IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?

	<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: IN THE PAST 12 MONTHS HAVE YOU HAD ANY OF THE FOLLOWING?
 Use this column to briefly explain yes answers

	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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. INJURIES: IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING?

	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1. Fracture, sprain, strain that has limited your athletic participation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Chronic injury (ex, tendonitis) that has limited your athletic participation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Visited a health care provider due to a condition that limited your athletic participation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Participated in physical therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Been treated by a chiropractor, massage therapist, or acupuncturist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

G. 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: _____

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. 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: _____

