

SPRINGFIELD COLLEGE ATHLETIC TRAINING SERVICES
STUDENT-ATHLETE PRE PARTICIPATION FORM

Ñ Included in this form are the Athletic Training Services functional medical history, consent to treat, consent to participate, authorization to release, emergency contact information and important athletic health care policies and procedures. This form must be completed prior to athletic participation. If any portion is returned incomplete, the athlete will be asked to finish completing this form.

Athlete: _____ Grad yr: ____ Sport: _____ Date: _____
 D.O.B. ____/____/____ SC ID# _____
 Cell Phone #: _____ Campus Box #: _____ Dorm: _____ Rm# _____
 Home Address: _____ Home Phone #(____) _____
 City, State, zip _____

Parent/Guardian:
 1) _____ Home Ph #(____) _____ Work Ph #(____) _____
 2) _____ Home Ph #(____) _____ Work Ph #(____) _____
 Emergency Contact in addition to Parent/Guardian: _____
 Home Ph# (____) _____ Work Ph #(____) _____

RELEASE, IMDEMNIFICATION AND CONSENT TO PARTICIPATE

I wish to participate in the sport(s) _____, _____ during the _____ academic year, I understand that this sport is an inherently dangerous activity and that there are genuine and serious risks to anyone who engages in this activity. I understand that the risks of this activity and of transportation to and from this activity include, without limitation, a full range of injuries, including catastrophic injury resulting in permanent paralysis, brain injury or death.

I knowingly assume responsibility for any and all such risks and all such injuries. In furtherance thereof, and as a condition of my voluntary participation in this sport, I and my parents (if signing below), accept the risks of my participation in the sport and in any transportation connected therewith. I and my parents (if signing below) do hereby release, waive, forever discharge, quit and covenant to hold harmless, indemnify and not to sue Springfield College, its governing board, officers, agents, employees, volunteers and any students acting as employees or volunteers (hereinafter all called the "Releases"), against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs and expenses of any nature that I may have or that may hereafter accrue to me or my parents (if signing below) or to any of my dependents or beneficiaries arising out of or related to any loss, damage or injury, including but not limited to personal injury, pain, physical and emotional suffering and death, that may be sustained by me or by any property belonging to me or by my parent (if signing below) or to any of my dependents or beneficiaries, whether caused by the negligence or carelessness of the Releases, or otherwise, either before or after I reach the age of majority, as a result of my participating in the above sport and/or in any transportation undertaken in connection therewith. (Continued on following page)

This Release shall be construed in accordance with the laws of the Commonwealth of Massachusetts. The signatures below indicates that the person signing has read the entire document, understood it, is authorized to sign it and agrees to it completely.

Signature (athlete) Date Signature (witness) Date

Parent/Guardian must execute form if the athlete is under the age of eighteen (18) years.

Signature (Parent/Guardian) Date

FUNCTIONAL MEDICAL HISTORY

The Medical History form is to assist the Springfield College Athletic Trainers in providing quality athletic health care to the athletes at Springfield College. Please write neatly and complete the form in ink only. Please answer truthfully and completely. The information you provide is confidential. During the pre-participation examination a Springfield College Athletic Training staff member will ask the athlete to explain each response to obtain more detailed information if needed.

**Please check the appropriate response for each question.
If athlete is under the age of 18, the parent/guardian must complete form.**

#	<u>Individual Medical History</u>	<u>Response</u>	<u>Comments: dates, brief explanations as needed</u>
1	Epilepsy or seizures?	rYes rNo	
2	Hepatitis?	rYes rNo	
3	Mononucleosis ("Mono")	rYes rNo	
4	Pneumonia?	rYes rNo	
5	Childhood Illness?	rYes rNo	If yes, what:
6	Heart Murmur or Heart Problems?	rYes rNo	
7	Allergies?	rYes rNo	If yes, what:
8	Asthma?	rYes rNo	Inhaler type?
9	Sickle Cell Anemia	rYes rNo	
10	Diabetes?	rYes rNo	Insulin dependent?
11	Respiratory Problems?	rYes rNo	
12	Breathing Difficulty?	rYes rNo	
13	Frequent Headaches?	rYes rNo	
14	Concussion (s)?	rYes rNo	Date of most recent: Total # in past year:
15	Loss of Paired body organ?	rYes rNo	If yes please identify:
16	Abdominal Problems?	rYes rNo	
17	Reproductive Problems?	rYes rNo	
18	Heat Illness?	rYes rNo	
19	Recent Surgeries?	rYes rNo	Date of surgery: Body Part:
20	Contact lenses/glasses?	rYes rNo	Wear during sports participation: Yes or No
21	Pain, numbness down arm following blow to head or shoulder?(burner/stinger)	rYes rNo	Date of most recent: Total #: Total # in past year:
	<u>Orthopedic History</u> Have you ever had an:	<u>Response</u>	<u>Comments:</u> If answered yes, give dates and explanation

22	Injury to shoulder(s)?	rYes rNo	
23	Injury to elbow(s)?	rYes rNo	
24	Injury to wrist/hand(s)?	rYes rNo	
25	Injury to neck, back, or spine?	rYes rNo	
26	Injury to ankle(s)?	rYes rNo	
27	Injury to chest/ribs?	rYes rNo	
28	Injury to hip(s)/pelvis?	rYes rNo	
29	Injury to knee(s)?	rYes rNo	
30	Injury to eye(s)?	rYes rNo	
31	Shin Splints?	rYes rNo	
32	Stress fractures?	rYes rNo	
33	Do you wear orthotics?	rYes rNo	
34	Fractured a bone or dislocated a joint?	rYes rNo	
35	Ever had a sprain or strain that caused you to miss activity	rYes rNo	
36	Ever have an injury to bone or joint that needed an x-ray or MRI	rYes rNo	
37	Ever have an injury that needed rehabilitation, injection, surgery	rYes rNo	
38	Diagnosed with a heart condition?	rYes rNo	
39	Significant Weight loss?	rYes rNo	Amount lost: Length of time:
40	Significant weight gain?	rYes rNo	Amount gained: Length of time:
41	Wear any special equipment?	rYes rNo	What type:
42	Wear any type of brace?	rYes rNo	
43	Any pins, plates or screws from previous surgery	rYes rNo	
44	An unhealed injury?	rYes rNo	What is the injury: Occurred:
45	Take any Medications regularly?	rYes rNo	
46	Allergic to any medications?	rYes rNo	If yes, medication name:
47	Eating Disorder?	rYes rNo	
	Gynecological History:	Response	

48	Monthly period regular?	rYes rNo	
49	Date of last gynecological exam		Date:

CONSENT TO TREAT

Springfield College employs Athletic Health Care providers, such as Physicians, Certified Athletic Trainers and Registered Nurses, who are qualified to evaluate, treat and rehabilitate certain injuries you may incur while participating in the intercollegiate athletic program. I give my permission for the Athletic Training staff to evaluate, treat, rehabilitate and refer me as appropriate.

Signature (Athlete) Date Signature (Witness) Date

Parent/Guardian must execute form if the athlete is under the age of eighteen (18) years.

Signature (Parent/Guardian) Date

STATEMENT OF CONFIDENTIALITY AND AUTHORIZATION TO RELEASE

A complete history and medical record is maintained on each athlete that participates in the intercollegiate athletic program at Springfield College. All medical information is kept confidential and access is restricted to Athletic Training staff members that are responsible for your health care. Medical information, other than general injury information and participation status to coaches, will not be released without a written authorization of release. The authorization to release form must be signed by the athlete, indicating what specific information is to be released, and who is to receive the information.

MEDICAL CLEARANCE

Pre participation Medical Clearance: All intercollegiate athletes must be medically cleared prior to the start of each sport he/she chooses to participate in. This process includes completing required forms from the Health Center and the Athletic Training Department. A physical examination by a physician (first year students) verifying that the athlete is able to participate without restrictions and all immunizations must be up to date. All intercollegiate athletes must complete the athletic training pre-participation examination to be eligible to participate in athletics. These examinations are performed at the beginning of the Fall semester.

Post Injury Medical Clearance: Any athlete that sustains an injury and/or illness during his/her season that requires outside medical attention needs a written note of clearance from the treating physician. The athlete will not be eligible to participate until the written document is presented to the Athletic Training staff and/or Health Center staff. All athletes must complete five days of practice with their team before being eligible to participate in competition.

My signature below indicates that I have read this entire document and have answered the medical history questions truthfully, and to the best of my knowledge. My signature below also indicates that I consent to be examined during the pre-participation examinations which includes, blood pressure, pulse, height, weight, orthopedic examination, and function squat assessment.

Signature (Athlete) Date Signature (Witness) Date

Parent/Guardian must execute form if the athlete is under the age of eighteen (18) years.

Signature (Parent/Guardian) Date