Physical Examination Packet Instructions for Students and Student Athletes

- Please follow the instructions below carefully to ensure timely processing of your physical examination packet.

All Students:

1. Print, review, and complete pages 1-5 of the physical examination packet.

2. Take the completed pages 1-5 to your healthcare provider for examination and required signatures.

3. Once your healthcare provider has completed the documentation, upload all forms to Medicat (pages 1-5).

4. Complete page 6 electronically (fillable form with electronic signature required and will be reviewed by health services)

Student Athletes:

1. Print, review, and complete pages 1-5, 7 & 8 of the physical examination packet.

2. Take the completed pages 1-5, 7 & 8 to your healthcare provider for examination, required signatures and sickle cell testing.

3. Once your healthcare provider has completed the documentation, upload all forms to Medicat (pages 1-5, 7 & 8).

Additional requirement for student athletes with diagnosed ADHD and take medication:

- Print and complete pages 9-11.
- Documentation must be completed by healthcare provider who diagnosed your ADHD and prescribed medication.

4. Complete pages 12-33 electronically (fillable forms with electronic signature required)

To the student: Health Information you provide will not be used to influence your situation at the college; This information will be used, if necessary, solely as an aid to providing necessary health care while you are a student.

CEDAR CREST COLLEGE
Health Services
100 College Drive
Allentown, PA 18104-6196

This information is strictly for the use of Health Services and will not be released to anyone without your consent
.

REPORT OF MEDICAL HISTORY:

PLEASE COMPLETE FORM BEFORE GOING TO YOUR PROVIDER FOR EXAMINATION

All students must review and complete pages 1–6 of this packet.

Only student athletes are required to complete the remaining pages (pages 7-33).

LAST NAME (print) FIRST NAME MIDDLE GENDER STUDENT ID NUMBER

HOME ADDRESS CITY OR TOWN STATE ZIP CODE DATE OF BIRTH

HOME PHONE TELEPHONE NUMBER STUDENT CELL PHONE NUMBER

NAME, RELATIONSHIP AND ADDRESS OF EMERGENCY CONTACT EMERGENCY PHONE NUMBER (Other than home phone)

INSURANCE COMPANY TYPE NUMBER

FAMILY PHYSICIAN PHONE SPORT (If playing a sport at CCC)

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS					
SISTERS					

Have any of your relatives ever had any of the following?

	Y	N	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in the space below or an additional sheet.

HAVE YOU HAD?	Y	N
Allergy to Medications		
Cephalosporins		
Fluoroquinolones		
Macrolides		
Penicillin/Amoxicillin		
Sulfonamides		
Other Med allergies		
Food Allergies		
Seasonal Allergies		
Insect allergies		
Any other allergies (List)		
Do you have an Epi-Pen?		
Do you use an inhaler?		
Sleep Apnea		

	Y	N
Insomnia		
Frequent Anxiety/Worry		
Frequent Depression		
ADD / ADHD		
Recurrent Headaches		
Frequent Colds/Sinusitis		
Chronic Cough		
Asthma/Reactive Airway		
Tuberculosis		
Pain/Pressure in Chest		
Palpitation (Heart)		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Stomach Problem		
Gall Bladder Issues		

	Y	N
Recent Weight Loss		
Anorexia		
Bulimia		
Frequent Diarrhea		
Frequent Vomiting		
Jaundice (not newborn)		
Thyroid Disease		
Auto Immune Disease		
Diabetes		
Cancer		
Back or Spinal Problems		
Disease or injury of joints		
Have you had Chicken Pox?		
Eye, ear, nose, throat Problems		

	Y	N
Urinary Tract Infections		
Kidney Stones/Infections		
Weakness/Paralysis		
Epilepsy/ Seizure		
Dizziness/Fainting		
FEMALES ONLY		
Heavy Menstrual Flow		
Irregular Periods		
Severe Cramps		
Last Menstrual Period		

Please explain any of the "yes" answers from the table. ***PLEASE GIVE DETAILS***

Please list any Surgeries:

Please list any other Health Problems:

Please list any drugs or medications you take regularly _____

Do you wear glasses or contacts? Y _____ N _____

Do you have any permanent handicap or disability? Y _____ N _____ Please explain. _____

Are you under a physician's care at the present time? Y _____ N _____ Please explain. _____

Do you have loss or impaired function of any paired organ (kidney, ovary, eye) _____

	Y	N	EXPLAIN
Has your physical activity been restricted during the past five years? (Give reasons and durations)			
Have you had difficulty with school, studies, or teachers? (Give details)			
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)			
Have you had any illness or injury or been hospitalized other than already noted? (Give details)			
Do you have any questions in regard to your health, family history, or other matters, which you would like to discuss now with a member of the staff of the Health Service?			
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?)			

REMARKS OR ADDITIONAL INFORMATION - use additional sheet if necessary

I certify that the above statements are true to the best of my knowledge.

_____

STUDENT'S SIGNATURE **DATE**

_____

Provider's SIGNATURE **DATE**
(acknowledging review)

FOR EXAMINING PHYSICIAN /NURSE PRACTITIONER /PHYSICIAN'S ASSISTANT ONLY

TO THE EXAMINING PROVIDER: Please review the student's history and complete the physical examination form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. This information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Service and will not be released without student consent.

Name_____

Height _____ **Weight** _____ **BMI** _____ **Blood Pressure** _____ **Pulse** _____

Vision: Corrected _____ **Uncorrected** _____

Right 20 /_____ **Left 20 /**_____

Examination	Normal	Abnormal-please explain
1. Head		
2. Neck		
3. Eyes		
4. Ears, Nose, Throat		
5. Lymph		
6. Cardiovascular System		
7. Respiratory System		
8. Abdomen		
9. Musculoskeletal System		
10. Spine, Back		
11. Shoulders, Arms		
12. Elbows, Wrist, Hands		
13. Hips		
14. Thighs, Knees		
15. Ankles, Feet		
16. Genitourinary		
17. Neuropsychiatric		
18. Skin		

Is this student presently under a health care provider's care for any reason? Y_____N _____If yes, please explain and list any medications prescribed_____

IMMUNIZATIONS GIVEN TODAY_____

PROVIDER'S (PHYSICIAN, NP OR PA) STATEMENT:

Is the patient now under treatment for any medical or emotional condition? Yes_____ No_____

Is there any loss or seriously impaired function of any paired organ? Yes_____ No_____

Do you have any recommendations regarding the care of this student? Yes_____ No_____

Complete FOR Student Athletes Only:

☐ Full participation

☐ Limited participation. Explain_____

☐ No athletic participation. Explain: _____

☐ Clearance withheld until _____. Explain: _____

PROVIDER'S (PHYSICIAN,NPOR PA)SIGNATURE_____ **DATE** _____

ADDRESS _____

PHONE NUMBER _____

CEDAR CREST COLLEGE HEALTH

Cedar Crest College is committed to providing a safe environment for its students and has formulated its health policy based on guidelines presented by the American College Health Association.

Vaccine	Vaccine Schedule	Documentation Required
Measles, Mumps, Rubella	Two doses of MMR at least 28 days apart after 12 months of age	Provider-verified documentation of (MMR) vaccine dates or Positive serological test demonstrating immunity.
Tetanus, Diphtheria, Pertussis (Tdap – *Adacel* or *Boostrix*) TD booster if Tdap is over 10 years ago.	One dose of Tdap regardless of interval since last TD booster. TD booster within last 10 years if Tdap is over 10 years ago.	Provider –verified documentation of vaccine date.
Polio	Primary series should be completed with IPV or OPV.	Provider-verified documentation of primary series completed and booster date.
Varicella	Two doses of varicella vaccine at least 12 weeks apart if vaccinated between 1 and 12 years of age and at least 4 weeks apart if vaccinated at age 13 or older.	Provider-verified documentation of vaccine dates, history of disease or positive serological test demonstrating immunity.
Hepatitis B	Series of three doses.	Provider-verified documentation of vaccine dates or positive serological test demonstrating immunity.
Meningococcal Quadrivalent (MCV4) and Men B (*Bexsero* or *Trumenba*) **The Pennsylvania College and University Student Vaccination Act of 2002 requires all students to provide proof of immunization or sign a waiver declining the meningitis vaccine in order to be housed on campus.**	MCV4 -- At least one dose after 16th birthday. MenB – At least one dose.	Provider-verified documentation of vaccine date or signed waiver.
Tuberculosis Screening Test	A tuberculin test (PPD) is required on all students who meet the "high risk" criteria who **have not** had a previous positive PPD or BCG inoculation. A quantiferon gold blood test is required for all students with a previous positive PPD or BCG inoculation. Positive result of Quantiferon Gold results requires a chest x-ray.	Provider-verified documentation of PPD results. Copy of lab result. Copy of x-ray report.
The following vaccines are strongly recommended, but not required: **HPV Vaccine (*Gardasil* or *Gardasil9*)** **Hepatitis A** **Pneumococcal Polysaccharide Vaccine – Indicated for high-risk groups; includes smokers and individuals with asthma** **Flu Vaccine**	 Series of 3 vaccines Series of 2 vaccines One vaccination Given on an annual basis.	

Our Pre-Admission policy is designed to protect the health and well-being of the entire campus community.

CEDAR CREST COLLEGE **IMMUNIZATION RECORD**

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
Please record dates (month/day/year) below AND include a copy of vaccine records from your medical provider.

NAME _____
Last First Middle

D.O.B. _____/_____/_____
Month Day Year

REQUIRED IMMUNIZATIONS

THIS SECTION MUST BE COMPLETED AND FILLED OUT.
ANY BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED.

	1st Dose Date	2nd Dose Date	3rd Dose Date	4th Dose Date
1. **Hepatitis B** A three (3) dose series is required. A blood test report indicating immunity is acceptable. *Alternative 2 dose series* ☐ ***HEPLISAV-B***				
2. Polio				
3. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.				
4. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**				
5. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**, given at least 28 days apart. A blood test report indicating immunity is acceptable.				
IMMUNIZATONS AFTER AGE 16				
6. **Meningitis** (Serogroups A,C,Y, W135) at least one (1) dose **after age 16.** *MenQuadfi, Menactra, Menveo or Menomune*				
Both Meningitis and Meningitis B are required immunizations				
7. **Meningitis B** (Serogroup B) Two (2) doses are required. Please indicate which brand received. ☐ ***BEXSERO*** *- 2 dose series (6 months apart)* OR ☐ ***TRUMENBA*** *-2 doseseries (6 months apart)*				
Alternative Meningitis (Serogroups A, B, C, W, and Y) ☐ ***PENBRAYA*** *Second dose of **Trumenba** required after 6 months.* Alternative Meningitis (Serogroups A, B, C, W, and Y) ☐ ***PENMENVY*** *Second dose of **Bexsero** required after 6 months.*				

OTHER IMMUNIZATIONS RECEIVED (**highly recommended** *but not required*)

COVID-19 *( )Moderna ( )Pfizer ( )Johnson & Johnson ( )*_____				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza				
BCG Vaccine				

I certify that to the best of my knowledge the information provided on this form is true and complete.

Healthcare Provider's Signature _____ **Date:** _____

Telephone: _____

Fax: _____ [Office Stamp]

Tuberculosis (TB) Risk Assessment Form (All students must complete)

Tuberculosis (TB) screening questionnaires and testing are administered as part of institutional communicable-disease prevention procedures in accordance with the Pennsylvania Disease Prevention and Control Law (1955), 28 Pa. Code Chapter 27 (Communicable and Noncommunicable Diseases), and guidance from the Pennsylvania Department of Health. These requirements support public health surveillance, reduce the risk of disease transmission in campus and clinical environments, and ensure that students participating in academic, residential, or clinical programs meet health clearance standards. Health information collected through TB screening is maintained in accordance with applicable federal and state privacy laws, including HIPAA and FERPA where applicable.

Student Name: _____Date of Birth: _____Student ID:_____
Please answer YES or NO to the following:

1. Country of Birth ☐ Yes ☐ No
Were you born in a country outside of the United States, Canada, Australia, New Zealand, or Western Europe? If yes, country: _____
Did you receive BCG vaccine? ☐ Yes ☐ No

2. Extended Travel ☐ Yes ☐ No
Have you lived in or traveled for more than 1 month to a country with high TB prevalence? Country and dates: _____

3. TB Exposure ☐ Yes ☐ No
Have you had close contact with someone diagnosed with active tuberculosis?

4. High-Risk Settings ☐ Yes ☐ No
Have you lived or worked in: Healthcare settings, Homeless shelters, Correctional facilities, Long-term care facilities, Refugee camps?

5. Immunocompromised Status ☐ Yes ☐ No
Do you have any of the following: HIV infection, Organ transplant, Chronic steroid use, Biologic immunosuppressive therapy, Cancer treatment?

6. Previous TB Testing ☐ Yes ☐ No
Have you ever had a positive TB skin or blood test? If yes:
Date: _____
Chest X-ray completed? ☐ Yes ☐ No

Determination *(For Health Services Use Only)*

☐ No risk factors identified — No TB testing required
☐ Risk factors identified — TB testing required
☐ Prior positive — Documentation review required
Signature of Reviewing Clinician: _____Date:_____

CEDAR CREST COLLEGE
DEPARTMENT OF ATHLETICS

SICKLE CELL TRAIT TESTING INFORMATION ACKNOWLEDGEMENT

About Sickle Cell Trait:

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells
- Sickle cell trait is a common condition (> three million Americans)
- Although sickle cell trait is most predominant in African Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait has been associated with a condition known as exertional rhabdomyolysis, renal failure and death. Complicating factors include extreme exertion, increased heat, altitude and dehydration.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to a collapse from the rapid breakdown of muscle starved of blood.
- Please see the below website from more information regarding sickle cell trait including the NCAA fact sheet. SSI_NCAASickleCellTraitforSA.pdf (ncaaorg.s3.amazonaws.com)

Sickle Cell Trait Testing:

- The **NCAA** requires that all NCAA Division III student-athletes have knowledge of their sickle cell trait status.
- **NCAA Bylaw Update:**
  17.1.5.1 Sickle Cell Solubility Test. The examination or evaluation of student-athletes who are beginning their initial season of eligibility and students who are trying out for a team shall include a sickle cell solubility test (SST) unless documented results of a prior test are provided to the institution.
- Effective August 1st, 2022, all student-athletes (including those who Try-out) MUST be tested for Sickle Cell Trait
- Cedar Crest College requires that all student-athletes who are unable to confirm their sickle cell trait status undergo sickle cell trait testing prior to participation in any intercollegiate athlete activity, including strength and conditioning sessions, try-outs, practices, or competitions.
- Athletes who are positive for the trait will not be prohibited from participating in intercollegiate athletics.

CEDAR CREST COLLEGE
DEPARTMENT OF ATHLETICS
Sickle Cell Trait Testing Results Acknowledgement Form

Name (Print Name): _____

DOB: _____ Sport(s): _____

Health Care Provider: COMPLETE FOR ATHLETES ONLY

Sickle Cell Trait Status Physician Verification
NCAA requires confirmation of sickle cell trait status for all Division III athletes

I verify that the above-named individual has been tested for sickle cell trait.

Date of Sickle Cell Trait Testing _____

Results: ☐ Positive ☐ Negative

☐ **Copy of lab results given to student**
(Copy showing sickle cell Trait Test Results needed for NCAA requirements)

Provider's (Physician, NP or PA) Signature: _____

Address:_____ Phone Number:_____

Student-Athlete Signature _____Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

Information about NCAA Medical Exception Documentation Reporting Form to Support Diagnosis of ADHD and Treatment with Banned Stimulant Medication

Dear Student-Athlete,

The NCAA enacted a policy effective August 1, 2009 regarding documentation for ADHD treatment with NCAA banned stimulant medications. The most common medications used to treat ADHD are Ritalin and Adderall, which are banned under the NCAA class of stimulants. In order for a medical exception to be granted for use of these stimulant medications, the student-athlete must document that s/he has undergone standard assessment to identify ADHD. The student-athlete should either provide documentation of an earlier assessment, or undergo an assessment prior to using stimulant medications for ADHD. Please be aware that a student-athlete may find that the demands of college present learning challenges. They may be observing other students benefiting from the use of stimulant medications. As such, a student-athlete might ask his or her family doctor to prescribe a stimulant medication to help them. **If the student-athlete has not undergone a standard assessment to diagnose ADHD, they have not met the requirements for the NCAA medical exception.**

In order to comply with these guidelines, Muhlenberg College Athletics Department and Health Services are requesting your cooperation with submitting the necessary documentation regarding ADHD and stimulant use before your pre-participation physical exam. The reason for this request is as follows. If you are drug tested and test positive, this documentation must be forwarded by the Athletic Director to the NCAA immediately in order for you to continue to participate in your current sport during the medical exception process. Please refer to the "NCAA Drug-Testing Program" for complete information.

In compliance with these guidelines, please complete the "NCAA Medical Documentation Reporting Form to Support the Diagnosis of ADHD and Treatment with Banned Stimulant Medication" including an attached written summary by the treating physician of a comprehensive clinical evaluation for ADHD. **The Reporting Form and written report summary must be submitted to the Sports Medicine Office prior to your pre-participation exam.**

In addition, the student-athlete must submit **annually** to the Sports Medicine Office an updated letter from the prescribing physician with written documentation of date of most recent medical evaluation; diagnosis; student-athlete's blood pressure, pulse, and comments; written indication of current treatment (including medications and dosage); and follow-up orders.

It is the student-athlete's responsibility to ensure that this documentation is complete and returned to the Athletic Training Office.

These guidelines are specific for medical reporting for ADHD prescribed stimulants. You do not need to complete this form if you are not diagnosed or being treated for ADHD. If your ADHD treatment changes or if you are newly diagnosed with ADHD and taking prescribed medications at any time during your student-athlete career, it is your responsibility as a student-athlete to update the required medical documentation and submit it to the Sports Medicine Office.

Please be aware that if you are taking any other medications, in accordance with NCAA guidelines, you should report these medications to the Sports Medicine Staff and Health Services.

Please direct any questions to Cedar Crest College Athletic Trainers.

NCAA Medical Exception ADHD Documentation Reporting Form

This form must be completed for medical exception requests following a positive stimulant NCAA drug test and submitted to the NCAA-designated drug testing agency (See Section 8.0 of the NCAA Drug-Testing Manual).

Note: The NCAA must approve the use of anabolic agents, hormone and metabolic modulators, peptide hormones, growth factors, related substances and mimetics before the student-athlete is allowed to participate in competition while taking these medications.

To be completed by the College/University:

College/University Name: Cedar Crest College

College/University Representative Submitting Form:

Name: _____ Title: _____

Phone: _____ Email: _____

Student-Athlete Name: _____

Student-Athlete Date of Birth: _____

Medication for which approval is requested: _____

If this is a submission for continued use of a previously approved medical exception for the banned substance check here ☐

To be completed by the student-athlete's physician:

Current Treating Physician (print name): _____

Specialty: _____

Office address: _____

Physician signature: _____ Date: _____

Include the following medical documentation with this form for ADHD disorder and treatment with a banned stimulant:

Comprehensive clinical evaluation summary by physician, psychologist/neuropsychologist, psychiatrist or psychiatric nurse practitioner with training in diagnosis and/or treating ADHD, please note this is not an exhaustive list:

1. Written Summary:
   - Summarize the diagnostic evaluation, including the original clinical notes.

2. Diagnostic Standards:
   - Diagnosis must adhere to DSM5 criteria for ADHD and list the criteria used for diagnosis.

   Evaluation Details:
   - Conduct a thorough psychiatric history review.
   - Document individual and family history related to ADHD.
   - Evaluate and document any comorbid conditions specifically: mood disorders, anxiety disorders, history of substance use.

   Secondary Source Verification:
   - Obtain mandatory collateral information from at least one secondary source (e.g., parent, teacher, secondary healthcare provider, school records, etc.).

- Acceptable forms: written feedback, formal ADHD rating scales, parental testimonials, report cards or behavioral assessments from sources familiar with the student's behavior.

Medication History and Current Prescription:

- Medication Documentation:
  - Provide the name of each stimulant prescribed (e.g., Adderall, Ritalin, Vyvanse).
  - Include dosage and frequency (e.g., "10 mg Adderall, twice daily").
  - Outline any adjustments in dosage since the initial prescription.
- Non-Banned Alternatives:
  - List any non-stimulant medications or therapies previously tried (e.g., Strattera, Wellbutrin) or rationale for not trying.
  - Include evidence for the lack of effectiveness or contraindications for each alternative.
- Time Range of Treatment:
  - Document the start date of stimulant medication and any changes over the treatment period (e.g., "Vyvanse started in June 2022; dosage increased in September 2023").

Follow Up Orders:

- Monitoring Plan:
  - Include the timeline and type of follow-up visits (e.g., quarterly visits for the first year, biannual thereafter).
  - Provide details on any regular assessments to evaluate the efficacy of treatment and any potential side effects.
- Supporting Documentation:
  - Ensure that updated prescriptions and follow-up notes are maintained in the athlete's file.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.

Student Athlete Paperwork
Cedar Crest College Athletics Pre-Participation Physical Evaluation Form
First Year and Transfer Student Athletes

Name:_____ **Sport(s):** _____ **Date:** _____
Graduating Year: _____ **Cell Phone:** _____ **DOB:** _____ **Age:** _____ **Sex:**___ **Gender:**_____
Emergency Contact: _____ **Phone (H):** _____ **Phone (cell):** _____

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If yes, please identify: [ ] Asthma [ ] Diabetes [ ] Seizures [ ] other		
3. Have you ever spent the night in a hospital?		
4 .Have you ever had surgery? If yes, specify:		
HEART HEALTH QUESTIONS ABOUT YOU		
5. Have you ever passed out or nearly passed out DURING exercise?		
6. Have you ever passed out or nearly passed out AFTER exercise?		
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
8. Does your heart race or skip beats at rest or during exercise?		
9. Has a doctor ever told you that you have [ ] High Blood Pressure [ ] High Cholesterol [ ] other _____ [ ] Heart Murmur [ ] Heart Infection [ ] Kawasaki Disease [ ] Arrhythmias (extra heart beats)		
10. Has a doctor ever ordered a test for *your* heart? (for example, ECG. Echocardiogram). Have you ever seen a cardiologist for any reason? If yes, specify		
11 Do you get more tired or short of breath more quickly than your friends during exercise?		
12 Have you ever had an unexplained seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50? If yes, specify		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, long QT syndrome, short QT syndrome, arrhythmogenic right ventricular cardiomyopathy, WPW (wolf Parkinson white syndrome) Brugada syndrome, or catecholamine polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implantable defibrillator?		
16. Has anyone in your family died for no apparent reason?		
BONE AND JOINT QUESTIONS		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game? If yes, circle affected area below.		
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle affected area below.		
19. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, brace, cast, or crutches? If yes, circle below:		
BoneandJointInjuryLocations: **Neck Shoulder Upper Arm Elbow Forearm Hand/fingers Chest Upper back LowerBack Hip Thigh Knee Calf/Shin Ankle Foot/Toes**		
20. Have you ever had a stress fracture?		
21. Have you been told that you have or have you had an *x-ray* for atlantoaxial (neck) instability?		
22. Do you regularly use a brace or assistive device?		

MEDICAL QUESTIONS	Yes	No
23. Has a doctor ever told you that you have asthma or allergies?		
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
25.Have you everused an inhaler ortaken asthma medicine?		
26. Is there anyone in *your* family who has asthma?		
27. Were you born without or are you missing a kidney, eye, testicle, or any other organ?		
28. Have you had infectious mononucleosis (mono) within the last month?		
29. Do you have any rashes, pressure sores, or other skin problems?		
30. Have you had a herpes skin infection?		
31. Have you ever had a head injury or concussion?		
32. Have you ever had a hot or blow to the head that caused confusion, prolonged headache, or memory problem? If yes, specify (include dates):_____ _____		
33. Have you ever had a seizure?		
34. Do you have headaches with exercise?		
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
36. Have you ever been unable to move your arms or legs after being hit or falling?		
37. When exercising in the heat, do you have severe muscle cramps or become ill?		
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
39. Have you had any problems with your eyes or vision?		
40. Do you wear glasses or contact lenses?		
41. Do you wear protective eyewear, such as goggles or a face shield?		
42. Are you happy with your weight?		
43 Are you trying to gain or lose weight?		
44. Has anyone recommended you change your weight or eating habits?		
45. Do you limit or carefully control what you eat?		
46. Have you ever had an eating disorder?		
47. Do you have any concerns that you would like to discuss with a doctor?		

MEDICATIONS AND ALLERGIES

Please list all the prescription and over the counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

Do you have any allergies? [ ] Yes [ ] No
If yes, please identify specific allergy below:
[ ] Pollens _____ [ ] Food_____ [ ] Stinging Insects _____
[ ] Medications_____
_____

Additional Questions

Have you ever had a menstrual period? yes no
Howoldwere you when youhad yourfirstmenstrualperiod? Age
How many periods have you had in the last 12 months?
Date of Last Menstrual period.

EXPLAIN ALL "YES" ANSWERS On the following page

Student Athlete Paperwork
Cedar Crest College Athletics Pre-Participation Physical Evaluation Form
First Year and Transfer Student Athletes

Explanation to Answers on previous page

Question Number	**Explanation for "Yes"**

Additional Comments and Concerns (please write in space below):

Student Athlete Paperwork
Cedar Crest College Athletics Pre-Participation Evaluation Orthopedic Health History Form
First year and Transfer Student Athletes

Please complete the section below regarding any past injury history:

Body Part	Injury (including side)	Date of Injury	If you saw a doctor, please mark (X).	Imaging needed List: example: x-ray, MRI, CT, etc.	Treatment	Date cleared to return to activity
Head						
Neck						
Shoulder/Clavicle						
Arm						
Elbow						
Hand/Wrist/Finger						
Torso/Back						
Pelvis/Hip (Groin)						
Quad/Hamstring/Upper Leg						
Knee						
Shin/Lower leg						
Ankle						
Feet/Toes						
Eyes/Ears/Nose/Mouth						

Please complete the section below regarding any past surgical history:

Body Part	Injury (including side)	Date of Surgery	Date Cleared to return to activity
Head			
Neck			
Shoulder/Clavicle			
Arm/Elbow			
Hand/Wrist/Finger			
Torso/Back			
Pelvis/Hip (Groin)			
Quad/Hamstring/ Upper Leg			
Knee			
Shin/Lower leg			
Ankle			
Feet/Toes			
Eyes/Ears/Nose/Mouth			

Student Athlete Paperwork
Cedar Crest College Athletics Pre-Participation Evaluation Orthopedic Health History Form First year and Transfer Student Athletes

Concussion History:

Have you ever been diagnosed with a concussion? Yes ☐ No ☐

Have you ever been hospitalized due to a head injury? Yes ☐ No ☐

DATE	MECHANISM OF INJURY	Imaging needed CT scan/MRI/etc.	Treatment (OT or PT, return to play)	Date Cleared to return to play

Current Concerns:

Do you have any current injuries or issues heading into the season? Yes ☐ No ☐

If yes, please list concerns:_____

_____

Any other additional information:

_____

_____

IF YOU HAVE HAD SURGERY OR SIGNIFICANT INJURY
You will be contacted by athletic trainers for further information needed for clearance.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student-Athlete Signature: _____ Date: _____

Student-Athlete (Print Name): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian (Print Name): _____

Student Athlete Paperwork
Cedar Crest College Athletics Pre-Participation Evaluation Orthopedic Health History Form
First year and Transfer Student Athletes

The undersigned herewith:

1. Understands that the Athletic Participation Physical form information will be reviewed by the Health Services and Athletic Training staff and Team Physician, who will determine the athlete's ability to fully participate in athletics. The athlete **may not** participate until such time medical clearance is *granted.*

2. Understands that he/she must refrain from practice or play while ill or injured, whether or not receiving medical treatment and during medical treatment, until he/she is discharged from treatment or is given permission by the physician/athletic trainer to restart participation despite continuing treatment.

3. Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find medical reason to disqualify him/her at the time of said examination.

4. Certifies that the answers to the questions with the form are correct and true.

5. Allows Cedar Crest College Health Services to share all health information relevant to my athletic participation with the Cedar Crest College Athletic Training Staff for the duration of my enrollment at Cedar Crest College, and understand that subsequent disclosure of that information, i.e. to coaches, cannot be controlled by Health Services.

Student-Athlete Signature: _____ Date: _____

Student-Athlete (Print Name): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian (Print Name): _____

SUDDEN CARDIAC ARREST (SCA) AWARENESS INFORMATION & ACKNOWLEDGMENT

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) occurs when the heart suddenly and unexpectedly stops beating. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

NCAA Sports Heart Health Informational Sheet:

suddencardiacdeath.pdf (dt5602vnjxv0c.cloudfront.net)

How common is sudden cardiac arrest in the United States?

There are about 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athletes and the leading cause of death on school campuses.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as

Dizziness or lightheadedness	Fatigue (extreme or recent onset of tiredness
Fainting or passing out during or after exercising	Shortness of breath or difficulty breathing with exercise, that is not asthma related
Unusual Weakness	Chest pains/pressure or tightness during or after exercise
Racing, skipped beats or fluttering heartbeat (palpitations)	

These symptoms can be unclear and confusing in athletes. Symptoms can happen before, during, or after activity. Some may ignore the signs or think they are normal results of physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

What are the risks of practicing or playing after experiencing these symptoms?

There are significant risks associated with continuing to practice or participating in athletics after experiencing these symptoms. The symptoms might mean something is wrong and the athlete should be

checked before returning to play. When the heart stops due to cardiac arrest, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it; survival rates are below 10%.

PA Act 73 – Peyton's Law - Electrocardiogram testing for student athletes

The Act is intended to help keep student-athletes safe while practicing or participating in athletics by providing education about SCA and by requiring notification to parents and players that you can request, at your expense, an electrocardiogram (EKG or ECG) as part of the physical examination to help uncover hidden heart issues that can lead to SCA.

Why do heart conditions go undetected?

• Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;

• Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and

• Often, individuals don't report or recognize symptoms of a potential heart condition.

What is an electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

Why add an ECG/EKG to the physical examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease.

• ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.

• ECG/EKG screenings with abnormal findings should be evaluated by trained physicians.

• If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made and may prevent the student from participating in sports for a short period of time until the testing is completed, and more specific recommendations can be made.

• The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist (false positive findings occur less when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of young athletes).

• ECGs/EKGs result in fewer false positives than simply using the current history and physical exam.

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in asymptomatic patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

Reporting signs/symptoms of SCA

Any student-athlete who has signs or symptoms of SCA must report the signs or symptoms to the athletic trainer staff immediately for further evaluation and referral, if warranted.

I have reviewed this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues. I understand the warning signs and seriousness of sudden cardiac arrest (SCA) related to participation in athletic programs and the need for immediate evaluation for any suspected condition.

_____ I understand that a physician or athletic trainer should be consulted if an individual experiences fainting or
Initial seizure during or after exercise, emotional excitement, emotional distress or being startled.

_____ I understand that a physician or an athletic trainer should be consulted if chest pain is noticed or felt during
Initial exercise.

_____ I understand that a physician or an athletic trainer should be consulted if an individual experiences and unusual
Initial shortness of breath during exercise or unusual fatigue during exercise.

_____ I understand that a physician or an athletic trainer should be consulted if an individual experiences unexplained
Initial fainting or seizures.

_____ I understand that a physician or an athletic trainer should be consulted if an individual experiences a racing
Initial heartbeat; dizziness or lightheadedness during or after exercise.

Student-Athlete Signature _____Date _____

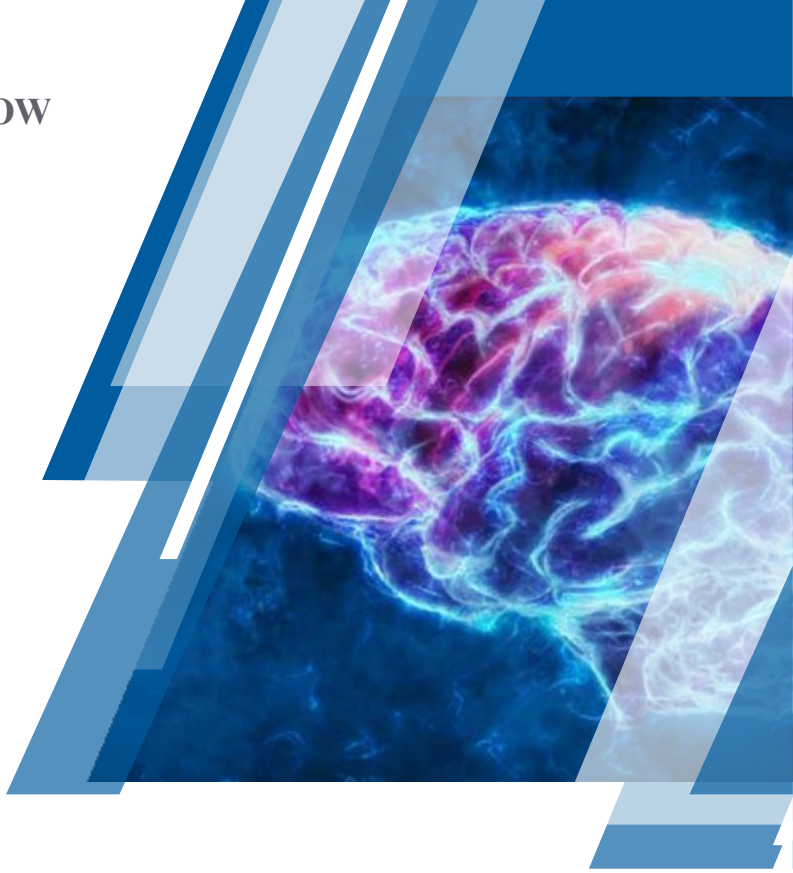
Student-Athlete(Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

WHAT STUDENT-ATHLETES NEED TO KNOW

Concussion Safety



What Is a Concussion?

The Consensus Statement on Concussion in Sport, which resulted from the sixth international conference, defines sport-related concussion as follows:

Sport-related concussion is a traumatic brain injury caused by a direct blow to the head, neck or body resulting in an impulsive force being transmitted to the brain that occurs in sports and exercise-related activities. This initiates a neurotransmitter and metabolic cascade, with possible axonal injury, blood flow change and inflammation affecting the brain. Symptoms and signs may present immediately, or evolve over minutes or hours, and commonly resolve within days, but may be prolonged.

Additional information on concussion diagnosis, management and prevention in collegiate athletes, including a complete definition of concussion, can be found here.

How Can I Keep Myself Safe?

1. **Know the symptoms.**

You may experience …

- Headache or head pressure.
- Nausea.
- Balance problems or dizziness.
- Double or blurry vision.
- Sensitivity to light or noise.
- Feeling sluggish, hazy or foggy.
- Confusion, concentration or memory problems.

2. **Speak up.**

- If you think you have a concussion, stop playing and talk to your coach, athletic trainer or team physician immediately.

3. **Take time to recover.**

- Follow your team physician and athletic trainer's directions during concussion recovery.
- When managed properly, most student-athletes recover fully from concussion. Exercise, under medical supervision, is a core component of concussion management.
- There may be negative consequences when concussion is left untreated.
- Once you've recovered from a concussion, talk with your physician about the risks and benefits of continuing to participate in your sport.

How Can I Be a Good Teammate?

1. **Know the signs.**

You may notice that a teammate …

- Appears dazed or stunned.
- Forgets an instruction.
- Is confused about an assignment or position.
- Is unsure of the game, score or opponent.
- Appears less coordinated, unsteady on feet or wobbly.
- Answers questions slowly.
- Loses consciousness.

2. **Encourage teammates to be safe.**

- If you think one of your teammates has a concussion, tell your coach, athletic trainer or team physician immediately.
- Help create a culture of safety by encouraging your teammates to report any concussion symptoms.

3. **Support your injured teammates.**

- If one of your teammates has a concussion, let them know you and the team support playing it safe and following medical advice during recovery.
- Being unable to practice or join team activities can be isolating. Make sure your teammates know they're not alone.

No two concussions are the same. Symptoms may appear several hours after the initial impact or even the next day. Symptoms may also evolve over several days. If you are unsure if you have a concussion, talk to your athletic trainer or team physician immediately.

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What Happens If I Get a Concussion and Keep Practicing or Competing?

- Due to brain vulnerability after a concussion, an athlete may be more likely to suffer another concussion while symptomatic from the first one.
- In rare cases, repeat head trauma can result in brain swelling, permanent brain damage or even death.
- Continuing to play after a concussion increases the chance of sustaining other injuries too, not just concussion.
- Athletes with concussion have reduced concentration and slowed reaction time. This means that you won't be performing at your best.
- Athletes who delay reporting concussion take longer to recover fully.

What is the Recovery Time for a Concussion?

- Each athlete is different, but emerging information indicates that most athletes fully recover from concussion.
- Some athletes experience persisting post-concussive symptoms, which are managed with exercise and targeted treatment.
- If your symptoms persist, you may also have another treatable condition unrelated to your concussion. If you are experiencing any ongoing symptoms, please seek medical care with the team physician.

What Do I Need to Know About Repeated Head Impacts?

- Research into the new concept of repeated head impacts is evolving rapidly.
- Most head impacts in sport occur at low levels well below the force needed to cause a sports-related concussion.
- The medical and scientific community continues to conduct research to determine if long-term exposure to head impacts may be deleterious to brain health.
- While many questions remain unanswered, the NCAA Concussion Checklist recommends that efforts should be made to reduce head impact exposure in both practice and game settings.

Chronic Traumatic Encephalopathy ("CTE")

- In recent years, there has been ongoing research into CTE, and more research is needed to answer important questions.
- According to the Centers for Disease Control website, research-to-date suggests that CTE is associated with long-term exposure to repeated head impacts at levels that would cause injury to the brain.
- According to the CDC, there is no strong scientific evidence that shows that getting one or more concussions (or other mild traumatic brain injuries) or occasional hits to the head leads to CTE.

More research is needed to better understand:

- The causes of CTE, including the role of repeated head impacts.
- Other potential risk factors for CTE, including the role of a person's sex, genetics, medical history, and environmental and lifestyle factors.
- How the CTE pathology develops, and what symptoms CTE pathology may cause.
- Why some people develop CTE and others do not.

You can find more information on the emerging CTE research at various sources including the **CDC**, **NINDS** and the **Consensus Statement on Concussion in Sport**.

If you are concerned or have questions, please talk to your medical doctor.

Did You Know?

- NCAA rules require that team physicians and athletic trainers manage your concussion and injury recovery independent of coaching staff, or other non-medical, influence.
- We're learning more about concussion every day. To find out more about the largest concussion study ever conducted, which is being led by the NCAA and U.S. Department of Defense, visit **ncaa.org/concussion**.

CONCUSSION TIMELINE

Baseline Testing

Balance, cognitive and neurological tests that help medical staff manage and diagnose a concussion.

Concussion

If you show signs of a concussion, NCAA rules require that you be removed from play and medically evaluated.

Recovery

Your school has a concussion management plan, and team physicians and athletic trainers are required to follow that plan during your recovery.

Return-to-Learn

Return-to-learn should be done in a step-by-step progression in which adjustments are made as needed to manage your symptoms.

Return-to-Sport

Final return-to-sport only happens after you have returned to your pre-concussion baseline and you've gone through a step-by-step progression of increasing activity.

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CEDAR CREST FALCONS

Student-Athlete Concussion Statement

_____ I understand that it is my responsibility to report all suspected injuries and illnesses to a
Initial member of the LVHN Sports Medicine staff (i.e. athletic trainer or team physician).

_____ I have read, understand and been given a copy of the NCAA Sport Science Institute's *Concussion*
Initial *Safety, What Student Athletes Need to Know.*

After reading the NCAA Sport Science Institute's *Concussion Safety, What Student Athletes Need to know or Heads Up Concussion Fact Sheet,* I am aware of the following information:

_____ A concussion is a brain injury and I am aware of the signs and symptoms of a concussion.
Initial I also acknowledge a concussion is difficult to see and the signs and symptoms may not show up for hours or days.

_____ A concussion can affect a person's ability to perform everyday activities and affect
Initial reaction time, balance, sleep and classroom performance.

_____ Following a concussion, the brain needs time to heal. An athlete is much more likely to
Initial have a repeat concussion if he/she returns to play before the symptoms resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, even death.
Initial

_____ The long-term effects of concussions are not fully understood and multiple concussions may
Initial lead to degenerative brain disease and cognitive/emotional difficulties later in life

_____ If I suspect a teammate has a concussion, I will be responsible for reporting these suspicions
Initial to my athletic trainer or team physician.

_____ LVHN medical staff will manage your concussion independent of the coaching staff or other non-
Initial medical influence

_____ If I have received a blow to the head or body that results in known or suspected concussive-like symptoms,
Initial I will inform my coach and athletic trainer or team physician that it may not be possible for me to return to play in a game or practice until I have received medical clearance from a qualified professional.

_____ I acknowledge that, if I am professionally diagnosed with a concussion, a member of the LVHN
Initial staff may need to communicate regarding the injury to ensure proper steps are taken to provide academic accommodations to allow for cognitive rest (if applicable).

Student-Athlete Signature _____Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

DEPARTMENT OF ATHLETICS
STATEMENT OF INFORMED RISKS

Date _____Student Athlete _____Sport(s) _____

Birthdate _____Age _____

Parent/Guardian Name _____

Home/Cell Phone (____) _____

Home Address: (Street) _____

(City) _____(State) _____(Zip) _____

I wish to participate in Cedar Crest College intercollegiate athletics being engaged in the sport(s) of

_____.

I hereby acknowledge that I am participating in these activities with the full realization that they may involve a significant risk of bodily injury. I understand that the injury may range in severity from minor to long term catastrophic up to and including death, or damage to property of me and others. I am aware that it is not possible to delineate specifically each and every individual injury risk. However, knowing the material risk and appreciating and reasonably anticipating that injuries and even death are a possibility, I hereby expressly assume all of the risks which could occur as a result of my participation. I agree that in exchange for and in consideration of the College permitting me to participate in this sport and all activities related to it including, but not limited to travel, I hereby assume all the risks associated with the sport and agree to release and hold harmless Cedar Crest College, its officers, agents, coaches and employees from any and all liability, actions, causes of actions, negligence, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the sport. Additionally, I understand that any previous injury or condition I have may predispose me to an increased risk of re-injury or increased risk of other injuries or conditions.

Furthermore, I understand that in the event of any new injury, there may be short term and/or long term health related risks involved with continued participation in athletics, even after proper treatment or rehabilitation. I am aware of these risks, and providing the college athletic/medical staff informs me of these risks if they are not self-evident, I wish to continue my participation in intercollegiate sport athletics.

I understand and accept the risk of possible tragic injury in athletics at Cedar Crest College and give permission for the Athletic Trainer and coaches to administer first aid.

I authorize the Cedar Crest College Health Center and the Department of Athletics to exchange any and all pertinent medical information which may affect my health and/or performance while participating in my sport. I certify that Health Insurance and/or additional coverage by a medical insurance company have been secured.

I do agree to use all safety equipment that is issued to me by my coach, equipment manager, or athletic trainer. I further agree not to alter or change my protective equipment without obtaining permission from the athletic trainer. This includes all braces, protective gear, mouthpieces, and uniforms.

The undersigned, herewith,

A. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.
B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletic sports, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

Student-Athlete Signature _____ Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____ Date _____

Parent/Guardian (Print Name) _____

CEDAR CREST COLLEGE ATHLETIC TRAINING
CONSENT FOR RELEASE OF MEDICAL INFORMATION

Student Athlete Name_____

Sport(s)_____

If you should refuse to sign, you should cross out the word "give" and insert the word "refuse". If the form is not signed, it will be interpreted as a refusal of permission.

"I give permission for the release of medical information on my daughter or myself between and/or to the Cedar Crest College athletic trainers, physicians, consulting physicians, health center staff, coaching staff of my sports(s) and other athletic or institutional personnel and with the Sports Information Department, and various media outlets, and professional team personnel (e.g. scouts, athletic trainers, etc.) concerning illness or injury, during my career at Cedar Crest College, relative to my past, present, or future participation in athletics."

This consent may be revoked at any time by sending such request in writing and dated to the athletic training department.

Student-Athlete Signature _____Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

ATHLETIC TRAINING
CONSENT FOR TREATMENT

Participation in the sport(s) of _____ requires an acceptance of risk of injury. Cedar Crest College has taken reasonable precautions to minimize risk of significant injury by providing competent coaching and instruction, properly maintained equipment and facilities, and proper conditioning and medical services.

The chance of sustaining a catastrophic sports injury is extremely remote yet understand that serious injuries can and do occur to anyone. Participation in your sport could result in death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of your body, general health and well being.

I understand and accept the risk of possible injury in athletics at Cedar Crest College in the sport(s) of _____ and give permission to the Certified Athletic Trainers and coaches to administer emergency care and first aid. I also understand that I must refrain from activity while ill or injured until I am given permission by the certified Athletic Trainer to restart participation. If I am attended to by a physician, I must get permission from the physician to restart participation.

Student-Athlete Signature _____ Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____ Date _____

Parent/Guardian (Print Name) _____

Student-Athlete Authorization/Consent for Disclosure of Protected Health Information

I, _____ hereby authorize _____
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers, host athletic trainers, Strength and conditioning coach, Coaches of the sport(s) I participate in, Academic Success Center, Counseling, College Nurse, Insurance Companies, Athletic Director, Parent(s)/Guardians/Spouse, NCAA Drug Testing Staff, NCAA Reporting/Injury Surveillance system, Cedar Crest College faculty 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 National Collegiate Athletic Association (NCAA) and its employees or agents.

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 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA 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 requested for this disclosure. I also understand that I am not required to sign this authorization/consent to be eligible for participation in NCAA athletics.

The reason for this disclosure is to advise my faculty, coaches, and athletic staff of the nature, diagnosis, prognosis, or other treatment concerning my medical condition and injuries/illnesses sustained while I am a student-athlete. I authorize the release of my private health and medical information to ensure fast, safe, and efficient care of my medical condition. I understand that this information may be pertinent to the decisions of participating that day during practice and competitions. I understand that the following are a non-exhaustive list of examples of types of information that may need to be discussed and/or disclosed: Injuries, Illnesses, Rehabilitation, X-rays, Progress Notes, Test Results, Past Medical history and other medical information pertaining to my participation as a student athlete. I understand that this information will not be disclosed to others outside those individuals listed above and that the College will keep my medical records confidential.

This authorization/consent expires 545 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 Athletics Director and Head Athletic Trainer at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Student-Athlete Signature _____ Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____ Date _____

Parent/Guardian (Print Name) _____

Cedar Crest College Injury and Illness Reporting Acknowledgement Form

I, _____, acknowledge that I must be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all my injuries and illnesses to the sports medicine staff of my institution (e.g., team physician, athletic training staff). I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that Cedar Crest College has provided me with specific educational materials on what a concussion is and given me an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, _____, have read the above and agree that the statements are accurate.
Name (please print)

Student-Athlete Signature _____Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

CEDAR CREST COLLEGE
DEPARTMENT OF ATHLETICS
EMERGENCY CONTACT INFORMATION

Personal Information:

Name _____ DOB:_____

Home Address: _____

City, State, ZIP: _____

Cell Phone: _____Email Address: _____

Emergency Contact Information (Parent/Guardian)

Primary Contact Name: _____ **Relationship:** _____

Phone Number: _____ **Email Address:** _____

Secondary Contact Name: _____ **Relationship:** _____

Phone Number: _____ **Email Address:** _____

Medical Information:

Known Allergies:_____

Current Medications: _____

Medical Conditions or Concerns: _____

Insurance Information:

Health Insurance Provider: _____

Policy Number: _____

Group Number: _____

Insurance Phone Number: _____

Consent:

I hereby authorize the designated emergency contacts to be informed about my medical condition in the event of an emergency. I affirm that the information provided above is accurate and up to date.

Student-Athlete Signature _____ Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____ Date _____

Parent/Guardian (Print Name) _____

Cedar Crest College
Department of Athletics
Insurance Coverage Acknowledgement

Health Insurance Requirement

All full-time students at Cedar Crest College are required to maintain active health insurance coverage. The College provides an excess (secondary) insurance policy for athletic injuries, which supplements the student's primary insurance.

1. **Reporting Injuries**: All injuries sustained during intercollegiate athletic activities must be reported to the Certified Athletic Trainer promptly. Delayed reporting may result in denial of insurance claims.
2. **Coordination of Care**: Medical or dental services related to athletic injuries must be arranged through the Certified Athletic Trainer. Unauthorized services may not be eligible for reimbursement.
3. **Referrals**: The Certified Athletic Trainer will provide written authorization and necessary documentation for referrals to appropriate healthcare providers. Failure to file this documentation with the Athletic Training Office may result in the student-athlete being responsible for expenses incurred.
4. **Initial Consultation**: In the event of an injury, the student athlete must first consult with the Certified Athletic Trainer before seeking external medical care, except in emergencies. Failure to follow this protocol may lead to the student-athlete assuming full financial responsibility.
5. **Changes in Insurance Coverage**: The student-athlete and/or parent/guardian must notify Cedar Crest College of any material changes or expiration in insurance coverage and update the information on file with both the Health Center and the Athletic Training Department. It is the student's responsibility to obtain necessary authorizations or pre-certifications for off-campus medical appointments.
6. **Scope of Secondary Insurance**:
    a. All full-time students must provide proof of primary health insurance coverage, which can be through a parent, spouse, or employer.
    b. The College's secondary insurance policy is an "excess coverage plan" that covers eligible expenses not paid by the student's primary insurance.

c. The Certified Athletic Trainer will coordinate all insurance matters. The student athlete is responsible for submitting all medical bills and insurance paperwork promptly. Claims must be filed within a specific timeframe from the date of initial treatment.

Acknowledgment

I, _____, have read and understand the health insurance requirement outlined above. I acknowledge that Cedar Crest College, its Athletic Department, and associated offices are not responsible for medical bills incurred due to athletic injuries if the stated guidelines are not followed. I understand that failure to adhere to these policies may result in personal financial responsibility for medical expenses.

Student-Athlete Signature _____Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____Date_____

Parent/Guardian (Print Name) _____

CEDAR CREST COLLEGE
DEPARTMENT OF ATHLETICS
ATHLETIC TRAINING POLICY & PROCEDURES

1. **Medical Clearance:**
   Any athlete who sees a doctor outside of the team physician for any reason must provide written medical clearance before returning to participation. The team physician must review and approve this clearance letter before the athlete is allowed to resume activity.

2. **Injury Reporting:**
   All injuries must be reported to the Athletic Trainer immediately.

   - If injured during an away game/match, notify your head coach, notify the host Athletic Trainer and report/notify to a staff Athletic Trainer before the next practice.

3. **Appointments:**
   All evaluations, rehab sessions, and paperwork must be scheduled through SportsWare—unless the injury is severe or an emergency. In such cases, contact your primary athletic trainer immediately to schedule a time to see them.

4. **Attendance & Punctuality:**
   Be on time for all treatments, rehab sessions, and doctor appointments. If you need to cancel, notify the Athletic Trainer you scheduled with, cancel the appointment in SportsWare, and reschedule.

5. **Respectful Conduct:**
   The Athletic Training staff is dedicated to providing top-level care. Please treat all staff with professionalism, courtesy, and respect.

6. **Training Room Conduct:**
   Athletes who fail to act respectfully may be asked to leave the training room.

7. **Access Policy:**
   No one is allowed in the training room without supervision or permission from a staff Athletic Trainer.

8. **Treatment Policy:**
   Athletes may not administer treatment to themselves or to others.

9. **Privacy & Phone Use:**
   To protect privacy, cell phones, video, and audio recordings are not allowed in the training room. If phone use is necessary during rehab, permission from the Athletic Trainer is required.

Student-Athlete Signature _____ Date _____

Student-Athlete (Print Name) _____

Parent/Guardian Signature (if under 18 years of age) _____ Date _____

Parent/Guardian (Print Name) _____