To: All Parents and Student-Athletes of Chowan University

From: Sallie Wallace Head Athletic Trainer

Enclosed is a set of forms regarding medical coverage of each student-athlete participating in intercollegiate athletics at Chowan University.

1. Please read all of the information.

2. All spaces must be filled in honestly.

3. You ***MUST*** present proof of primary insurance and have a completed medical packet or you ***WILL NOT*** be allowed to participate in athletics.

4. The University holds a ***secondary*** insurance policy for all student-athletes. This policy has a $500.00 deductible that you are responsible for if a claim is filed. Your insurance pays first and what it does not cover the schools' policy picks up after the $500.00 deductible has been paid.

5. Mail ALL completed forms and physicals as soon as possible to:

   Athletic Trainer
   Chowan University
   200 Jones Dr.
   Murfreesboro, NC 27855

NOTE: Freshman and Transfer Students: You must provide 2 copies of your preseason physical when you check in. Physicals must be filled out on the supplied form and 2 copies with you when you check in.

If you have any questions, please contact us at 252-398-6291
Or-6458.

Chowan University
Athletic Injury and Illness Policy and Information

<u>Section 1:</u> Intercollegiate Athletic Medical Eligibility

A. All team candidates **must pass an annual physical exam** given by a licensed physician. Without this no equipment can be issued or will they be allowed to work with the team. The physical examination is effective for the duration of the academic year.
B. The team Physician or Certified Athletic Trainer may request a re-exam and change of the athlete's playing status at any time.
C. A history of prior injuries must be provided to the Athletic Trainer, and any of the following conditions MUST be reported.
    1. Injuries or illness to the head, neck, back, shoulders, elbows, hands, wrist, knees, ankles, feet, or internal structures.
    2. Fractures, broken bones, dislocations, strains, or sprains within the last four years.
    3. Any serious illness, mental or physical
        - Failure to report conditions listed above releases Chowan University from any liability in the event of another injury caused by an unreported condition.
        - Loss of one of the paired organs may disqualify a candidate from future participation in Chowan University Athletics.

<u>Section 2:</u> Medical Treatment

A. Athletes must report all injuries or illnesses to the Athletic Trainer as soon as possible.
B. The Athletic Trainer will assess symptoms, provide recommendations or treatment, make necessary referrals to a physician and decide availability for practice and games.
C. Athletes are encouraged **NOT** to seek medical attention without the knowledge of the Athletic Trainer or School nurse unless it is an emergency. In the event that the athlete seeks medical attention without notifying the Athletic Trainer, the athlete may not return to athletic activity until a written release is given to the athletic trainer from the attending physician. Also, your injury/illness would not be covered under the Chowan University Athletic Injury Policy unless it is an emergency. **Should an athlete be seen by the school nurse for the illness or injury a written notice must be obtained and presented to the Athletic Trainer as soon as possible.**
D. Training Room hours of operation and rules are posted in the Helms Center Athletic Training Room.
E. When the Athletic Trainer makes specific recommendations of an athlete and the athlete refuses to be seen, all secondary insurance coverage becomes forfeited after 90 days on that injury.

<u>Section 3:</u> Medical Payment Policy

YOU MUST HAVE PROOF OF PRIMARY INSURANCE COVERAGE AND FURNISH EVIDENCE OF THE SAME PRIOR TO REPORTING TO THE FIRST PRACTICE. The University maintains a secondary accident policy on its' athletes that picks up expenses over and above your primary insurance plan. You will be required to satisfy the deductible, per accident, under the Chowan University Athletic Injury Policy. The secondary insurance has a **DEDUCTIBLE of $500.00** that must be satisfied prior to any payment. If your Primary insurance does not cover this, you will be the responsible party.

To: Chowan Student-Athletes and their Parents/Guardians
From: The Chowan University Sports Medicine Department
RE: Helpful Information About Insurance Coverage

Each student athlete is required to have a physical examination prior to any participation in any intercollegiate sport. The final decision on physical qualifications or reason for rejection is the responsibility of the team physician or athletic director. The team physician or athletic director also makes the decision on when an athlete may return to competition after a previous injury.

INJURIES----MEDICAL BILLS----INSURANCE COVERAGE----CLAIM PROCEDURE

Accidents do occur and we attempt to provide our athletes with the very best possible care. Medical bills may be incurred when the athlete is treated for bodily injury due to an accident, whether it be locally, during a road trip, or by a medical vendor in his/her own home area.

ONE FIRM STATEMENT: The NCAA discourages any college or university from providing coverage or paying the bills incurred for expenses related to illnesses or conditions which are not sustained as the direct result of an accident in our intercollegiate sports program. (This includes pre-existing conditions and non-athletic injuries.)

INSURANCE COVERAGE: The athletic accident insurance at Chowan University provides coverage for your son/daughter for accidents while participating in the play or official team practice of intercollegiate sports, including sponsored and authorized team travel.

CLAIM PROCEDURE: All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the college or university has instructed the medical vendors otherwise. In some cases the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the bill incurred to be sent.

A. Submit the bills incurred to your family, employer group coverage or plan first. They will do one of two things:
   1. Honor the claim and pay all or a portion of the bills incurred.
   2. Not honor the claim and send you a letter of denial. An example might be that your son/daughter is no longer part of your group policy after attaining the age of twenty-three.

B. If there remains a balance after your family, employer group insurance or plan has contributed towards the claim, send the claim sheet from the insurance company and a copy of the itemized bills incurred to the college or university's athletic department.

   If you receive a letter of denial from your family, employer group insurance or plan administrator, then send the letter of denial and a copy of the bills incurred to the college or university's athletic department. If no coverage is available, a letter from your employer with verification will be necessary.

C. If the bills incurred and not paid by the family, employer group insurance or plan is large enough, the claim will be sent from the athletic department to our insurance carrier office, which is in Kalamazoo, Michigan for processing. If they need any additional information, please cooperate with them and they will process the claim in the least possible amount of time. It is in your best interest to have the claim settled promptly since all the bills incurred are in your name.

PLEASE NOTE: If the primary family coverage is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) you must follow the proper procedures required by your plan in order for the college's insurance to satisfactorily complete its portion of the claim. This is especially important if your plan requires pre authorization to have your son/daughter treated if out of your plan's service area. Please remember that the student athlete must have a primary insurance policy in order to participate. Chowan University Athletics carries a **secondary** policy on all athletes. The student athlete is responsible for the $500 deductible, per injury, in case of injury.

Parents should retain this letter for future references. Your cooperation in this important area will help make this program successful in minimizing delays and accomplishing the purpose for which it is intended.

Chowan University
Student-Athlete Insurance Information

Student Athlete:_____ SSN:_____-_____-_____
Date of Birth:_____ Sport:_____
Permanent Address:_____
City: _____ State:_____ Zip:_____
Email:_____@_____ Phone: (____)_____

Parent's Information

Father's Name:_____	Mother's Name:_____
Father's SSN:_____	Mother's SSN: _____
Father's Address:_____	Mother's Address:_____
_____	_____
_____	_____
Phone: (___)_____	Phone: (___)_____
Employer:_____	Employer:_____
Employer Address:_____	Employer Address:_____
_____	_____
_____	_____
(W) Phone: (___)_____	(W) Phone: (___)_____
Is the student-athlete covered under father's insurance? ___yes ____no	Is the student-athlete covered under mother's insurance? _____yes _____no

Insurance Information: (*if student does not have secondary insurance, please leave that section blank)*

Primary:_____	Secondary:_____
Address:_____	Address:_____
_____	_____
_____	_____
Phone: _____	Phone: _____
Policy #: _____	Policy #:_____
Group #: _____	Group #:_____
Please check one:	Please check one:
HMO? _____ PPO? _____	HMO? _____ PPO? _____

<u>Parent/Guardian</u> and <u>Student-Athlete</u> please initial each of the following statements:

_____ *I have received and read the insurance information packet.*
_____ *I give authorization to claim a file under the above insurance policy(s).*
_____ *I give authorization to obtain any medical information needed to Chowan University.*

Parent/Guardian Signature:_____ Date:_____
Student-Athlete Signature:_____ Date:_____

Attach a copy of front of Insurance card here.

Attach a copy of rear of Insurance Card here.

CHOWAN UNIVERSITY ACCEPTANCE OF RISK

I,_____, am aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of intercollegiate athletics in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible condition and will follow the advice of the team physician(s), treatment, rehabilitation, and maintenance of athletic injury.

_____
Signature

ACKNOWLEDGEMENT STATEMENT

Insurance policy number_____, I acknowledge receiving the "Athletic Injury Insurance Letter". I understand the extent of the University's responsibility to an athlete who becomes injured as a result of participation in the intercollegiate athletic program at Chowan University. I also understand that there is assumed risk involved in intercollegiate athletics. I attest that my son/daughter has insurance coverage for injuries that occur while he/she is participating in intercollegiate athletics and that this coverage has limits of at least $75,000. I also agree to notify Chowan University if there is a change or expiration of coverage. I hereby authorize the Chowan University Department of Athletics and/or its medical vendors to make direct claim for bills incurred to the above named student-athlete.

_____ _____
Date Signature of Parent/Guardian

INFORMED CONSENT

Athlete's Name:_____ Date:_____

CHOWAN UNIVERSITY employs a Nationally Certified Athletic Trainer who is qualified to assess, treat, and rehabilitate most injuries you may incur while participating in our intercollegiate athletic programs. The Certified Athletic Trainers qualifications include:

1. Certification by National Athletic Trainer's Association Board of Certification
2. Licensed by the State of North Carolina Board of Athletic Trainer Examiners
3. Certified in CPR and First Aid

(Please circle appropriate response)
I DO - I DO NOT give my permission for the Athletic Training Staff to assess, treat, rehabilitate, and refer me as appropriate during the upcoming year.

_____
Signature

** Failure to give permission will result in the athlete being responsible for any and all injuries that may occur during the sports season. This results in the denial of first aid treatment, taping and wrapping, rehabilitation, and consultation. The athlete will be responsible for finding an outside source for all medical coverage.

Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

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

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 National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my protected health information will be used only by the NCAA's Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA, NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

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 in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent 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 athletics director 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.

_____ _____ _____
Printed Name of Student-Athlete Signature Date

Chowan University Athletic Department

Student Athlete Nutritional Supplement Disclosure and Review Form

I, _____ am taking or intend to take the following nutritional supplements.
(print name)
I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements.

I acknowledge and 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 do not contain substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NCAA endorses a product or approves its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's Head Athletic Trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's Head Athletic Trainer.

Brand Name	**Listed Ingredients**

_____ _____

Student Athlete Date Athletic Trainer Date

*** Please use the back of this sheet to list any additional supplements you are taking. Supplements include pills, powders, vitamins, energy products, protein and supplemental drinks.**

CHOWAN UNIVERSITY

STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF INFORMATION TO MEDIA

I, _____, HEREBY AUTHORIZE AND REQUEST the
Student- Athlete Print Name

Chowan University Board of Trustees, the Chowan University Athletics and Sports Medicine Departments, and their duly authorized officers, employees and agents (including coaches, athletic trainers, physicians, and physical therapists) to furnish TO SPORTS INFORMATION AND/OR JOURNALISTS AND/OR OTHER MEDIA OUTLETS any and all information concerning or having a bearing on my participation in athletics at Chowan University. This authorization shall include, but is not limited to, any and all information within their knowledge, or contained in any records under their supervision or control concerning my physical condition, illnesses, injuries, and any treatment, hospitalization, surgery, examinations, diagnostic testing, and otherwise, and to make such reports concerning myself to such persons or organizations as they may request.

This authorization DOES NOT apply to the release of any records pertaining to psychiatric, psychological or psychotherapeutic services.

I understand that a record will be kept of all individuals requesting information under this Authorization and the date of the request. This information is normally confidential and except as provided in this Authorization will not be otherwise released by the parties in charge of the information.

This Authorization remains valid for *[check one]:*

- ☐ **one (1) year** following the date I sign below; or
- ☐ to this date _____.

I understand that I may revoke this authorization by providing a written revocation of authorization to the Athletic Director that specifically mentions release of information to MEDIA, including journalists, reporters, sports information, or any other media outlet representatives. I understand that a revocation is not effective to the extent that the Chowan University has relied on this authorization to use or disclose any information about me.

I hereby fully release and discharge the Chowan University Board of Trustees and all its successors, assigns, trustees, officers, agents, and employees from any and all claims, demands, and causes of action whatsoever in connection with or in any way related to or arising out of the disclosure of information under the terms of this Authorization.

_____ _____
Student-Athlete Signature Date

_____ _____
Witness Signature Witness Print Name

REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

Last Name (Print) First Name Middle Name *Social Security Number

Local Address City State Zip Code Area Code/Phone Number

Date of Birth (mo/day/yr) _____ Gender Male _____ Female _____ Marital Status M__ S__ O__

Class you are entering (circle): FR SO JR SR

Sport(s):_____

Local Phone:

Cell Phone:

Email Address:

Name of person to contact in case of an emergency Relationship

Address

Area Code/Phone Number(home/Work/Cell)

The following health history is confidential, does not affect your admission status, and except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

A. FAMILY MEDICAL HISTORY: Has any blood relative ever had?

Cancer	**YES**	**NO**	Stroke	**YES**	**NO**	Alcoholism/Drug Abuse	**YES**	**NO**
Diabetes	**YES**	**NO**	Epilepsy/Seizures	**YES**	**NO**	Die suddenly before age 50 years	**YES**	**NO**
Heart Trouble	**YES**	**NO**	Mental Illness/Depression	**YES**	**NO**	Sickle Cell Trait/Disease	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Suicide	**YES**	**NO**	Bleeding Disorder/Blood Disease	**YES**	**NO**
Other, please explain:								

B. MEDICAL ILLNESS HISTORY: *NOTE: This information will be kept CONFIDENTIAL!!!

1. Have you ever had or do you now have any of the conditions below? If so, check yes. If not, check no.
2. If yes, put your age the condition occurred at in the appropriate box.

CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO	CHECK EACH ITEM	AGE	YES	NO
Car, Air, Motion, or Sea Sickness				Contact with Hepatitis B (HBV)				Palpitation or Pounding Heart			
Ear, Nose, or Throat Trouble				Contact with AIDS or HIV				Intestinal Trouble			
Asthma				Veneral Disease(STD's)				Stomach Trouble			
Bronchitis				Jaundice				Frequent Indigestion			
Chronic Cough				Mononucleosis				Cancer			
Tuberculosis				Chronic Frequent Colds				Tumor/ Growth/ Cyst			
Swimmer's Ear				Kidney Trouble				Skin Trouble			
Inner Ear Infection				Kidney Stones				Rheumatism			
Fever Blisters				Bloody Urine				Pain/Pressure in Chest			
Mumps				High Blood Pressure				Shortness of Breath			
Rheumatic Fever				Heart Trouble				Psychiatric Problems			
Hearing Loss				Painful Urination				Severe Head Injury			
Eye Problems				Frequent Urination				Excessive Worry			
Chicken Pox				Severe Abdominal Pain				Depression			
Hay Fever				Anoxeria/Bulimia				Hernia			
Arthritis				Hemorrhoids				Insomnia			
Goiter/Thyroid Disease				Peptic Ulcer				Concussion			
Diphtheria				Gall Bladder Trouble				Convulsions/ Fits			
Sinusitis				Appendicitis				Dizziness			
Sickle Cell Anemia				Gallstones				Paralysis			
3-Day Measles				Liver Trouble				Amnesia			
Malaria				Athletes Foot				Migraine Headaches			
Diabetes				Jock Itch				Frequent Headaches			
Pneumonia				Ringworm				Nausea/Vomiting			

Obesity				Lyme Disease				Heartburn			
Urinary Tract Infection				Herpes Virus				Gout			

C. GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items?

Aspirin	**YES**	**NO**	Penicillin	YES	**NO**	Tetanus antitoxin or serums	**YES**	**NO**	Bee stings	**YES**	**NO**
Codeine	**YES**	**NO**	Erythromycin	**YES**	**NO**	Novocaine or other anesthetics	**YES**	**NO**	Fire ant bits	**YES**	**NO**
Sulfa Drugs	**YES**	**NO**	Ibuprofen	**YES**	**NO**	Hay Fever – dust/mold/pollen/grass	**YES**	**NO**	Wasps stings	**YES**	**NO**
Iodine	**YES**	**NO**	Acetaminophen	**YES**	**NO**	Oral Anti-inflamitories	**YES**	**NO**	Latex	**YES**	**NO**

1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here: **YES** **NO**

2. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here: YES **NO**

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

CHECK YES OR NO FOR THE FOLLOWING & IF THE ANSWER IS YES, WRITE IN THE AGE AT WHICH THE CONDITION OCCURRED.

	Number	Date	Age		Yes	No	Age		Yes	No	Age
Number of Pregnancies				Last Pap Smear				Absence of Menstruation			
Number of Births				Endometriosis				Painful Menstruation			
Abnormal Pap Smears				Irregular Periods				Menstrual Cramps			

Are currently taking Birth Control Pills? **YES** **NO** If yes, what type are you taking?

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

E. GENERAL MEDICAL INFORMATION: (CIRCLE THE CORRECT ANSWER)

1. Do you have a Heart Disease? If yes, please list any medications taken for this condition:	YES	NO	Heart Disorder? If yes, please list any medications taken for this condition:	YES	NO	Heart Murmur? If yes, please list any medications taken for this condition:	YES	NO			
2. Have you ever had one of the following tests performed for a heart condition?	Electrocardiogram (EKG)	YES	NO	Echocardiogram	YES	NO	Treadmill Stress Test	YES	NO		
3. During the past year (twelve months) have you had any type of problem with tolerance to exercise? If yes, please give a brief explanation.								YES	NO		
4. Do you have Hypertension (High Blood Pressure)?	YES	NO	Do you have Hypotension (Low Blood Pressure)?					YES	NO		
5. Please list any and all medications you take for High or Low Blood Pressure including the names, dosages, and how often you take them:											
6. Have you Passed Out or had Fainting Spells?	YES	NO	Did this occur with exertional activities?					**YES**	**NO**		
7. Have you ever had a Concussion? If yes, please list the number of times and severity of each below:								**YES**	**NO**		
8. Have you ever been hospitalized for any of the concussions you sustained?								**YES**	**NO**		
9. Have you ever been knocked unconscious? If yes, please list the number of times and which ones you were hospitalized for?								**YES**	**NO**		
10. Have you ever had a Skull Fracture?	YES	NO	Double Vision?	YES	NO	Blurred Vision?		**YES**	**NO**		
11. Are you a Diabetic or ever been treated for Diabetes? If yes, please list the age at which your diabetes began as well as any and								**YES**	**NO**		

all medications you take for this condition:									
12. Do you or have you ever had Anemia?	YES	NO	Sickle- cell anemia or trait?	YES	NO	Hypoglycemia (Low Blood Sugar)?		YES	NO
13. Do you have a vision defect in either one or both eyes and if yes, please specify below:								YES	NO
14. Do you wear glasses?	YES	NO	Do you wear contact lenses?					YES	NO
15. If yes, do you wear them during practice?	YES	NO	If yes, do you wear them during games?					YES	NO
16. Have you ever had glaucoma?	YES	NO	Have you ever had retinal detachment?					YES	NO
17. Do you have a hearing defect? If yes, please specify below and list any hearing aids worn:								YES	NO
18. Do you wear any dental appliances?	YES	NO	If so, do you wear them during practice?					YES	NO
19. If yes, circle the appropriate appliance: Corrective Braces. Permanent Bridge, Permanent Crown or Jacket, Removable Partial or Full Plate									
20. Do you have any severe tooth trouble, gum trouble, or dead teeth? If yes, please list details below:								YES	NO
21. In the past 3 years have you had a Tetanus shot?	YES	NO	Toxoid shot?	YES	NO	Booster shot?		YES	NO
22. Have you ever received the Hepatitis B (HBV) Vaccination?	YES	NO	If yes, have you received all three shots?					YES	NO
23. In the past 12 months have you been treated for >>>	Mononucleosis ?	YES	NO	Pneumonia?	YES	NO	Infectious Virus?	YES	NO
24. Do you currently take any medicines or drugs? If yes, what medications or drugs are you taking, and for what reason?								YES	NO
25. Have you ever had trouble with dehydration? (Excess loss of salt & water)	YES	NO	Heat Intolerance?					YES	NO
26. Have you ever had Heat Cramps?	YES	NO	Heat Exhaustion?	YES	NO	Heat Stroke?		YES	NO
27. Have you ever suffered from or been diagnosed with Exercise Induced Asthma (EAI)? If yes, what medication(s) are you taking to control EIA?								YES	NO
28. Have you ever had an internal injury? If yes, describe the nature of the injury and the body part(s) or organ(s) involved?								YES	NO
29. Have you ever lost the full use of the following organs, either temporarily or permanently? (Hearing, Sight, Kidneys, Lungs, Testicles(male), Ovaries(female), other) If yes, please list the organ(s) and details regarding the loss, including the dates and treating physicians for each:								YES	NO
30. Have you ever had surgery to repair or remove any organ? If yes, please list the organ(s) and details regarding the repair and/or removal including the dates and treating physicians for each:								YES	NO
31. Are you an Epileptic or ever have had an Epileptic seizure? if yes, please list any and all medications you take for this condition:								YES	NO
32. Do you have a Hernia? If yes, where?								YES	NO
33. Have you had either a gain or loss of greater than ten (10) pounds in the past 12 months?								YES	NO
34. Do you currently have any body piercing(s)?	YES	NO	If so, where?				Do you have a tattoo?	YES	NO

F. NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:

Check the appropriate space according to your use of the following products:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Stimulants (Benzedrine, Amphetamines, etc.)				
Chewing Tobacco, Snuff, or Smokeless Tobacco				
Cigarettes, Cigars, or Pipe				
Vitamins				
Sleeping Pills				
Diet Pills				
Alcoholic Beverages				
Anabolic Steroids (growth stimulants)				
Androstenedione				
Amino Acids				
Creatine phosphate				
Antihistamines				
Ephedrine				
Any other diet, nutritional or performance enhancing drug				

G. EATING DISORDERS:

1. Have you ever had a problem with food bingeing? If yes, when?	YES	NO
2. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	YES	NO
3. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	YES	NO
4. Do you sometimes or often induce vomiting after eating?	YES	NO
5. Have you or do you take laxatives to prevent being overweight?	YES	NO

ORTHOPAEDIC MEDICAL HISTORY:

H. FRACTURES:

1. Have you ever broken (fractured) a bone? If yes, please fill in the appropriate boxes below:	YES	NO

BODY PART	*DATES*	BODY PART	RIGHT	LEFT	DATES
SKULL		COLLAR BONE			
NOSE		UPPER ARM			
FACE		FOREARM			
JAW		WRIST			
NECK		HAND			
SPINE		THIGH			
PELVIS		LOWER LEG			
RIBS		FOOT			

FINGERS	R_____	1_____, 2_____, 3_____, 4_____, 5_____	L_____	1_____, 2_____, 3_____, 4_____, 5_____
TOES	R_____	1_____, 2_____, 3_____, 4_____, 5_____	L_____	1_____, 2_____, 3_____, 4_____, 5_____

2. Did the fracture require surgery or create any residual defect? If yes, please describe the defect or type of surgery, date, physician, and location of the hospital.	YES	NO
3. Have you ever had a calcium deposit form in your thigh or anywhere else following a bad bruise? If yes, where is the calcium deposit located?	YES	NO
4. Have you ever had a bone spur develop and if so, where?	YES	NO

I. DISLOCATIONS:

1. Have you ever dislocated a joint? If yes, please fill out the appropriate boxes on the chart below:	YES	NO

	RIGHT	LEFT	# OF TIMES	DATES		RIGHT	LEFT	# OF TIMES	DATES
SHOULDER					ELBOW				
A-C JOINT					WRIST				
KNEE CAP					HIP				
KNEE					FINGERS				
NECK					TOES				
ANKLE									

2. Have you ever had surgery for a dislocation? If yes, describe surgery type, date, physician, and location of hospital below

J. MUSCLE INJURIES:

1. Have you ever had a severe muscle pull or strain?	YES	NO
2. Has this injury reoccurred? If yes, list the muscle(s) involved and date(s):	YES	NO

K. NECK:

1.	Have you ever sustained a serious neck or cervical injury?				**YES**	**NO**
2.	Did you have numbness, burning, or sharp pain in your arms or legs?				**YES**	**NO**
3.	Have you ever had an injury producing weakness or numbness of your arms or legs or both?				**YES**	**NO**
4.	Were you ever transported by ambulance for a neck injury?	**YES**	**NO**	If yes, did you have neck or spinal X-Rays taken?	**YES**	**NO**
5.	Have you ever had neck surgery? If yes, describe surgery type, date, physician, and location of hospital below:				**YES**	**NO**
6.	Have you ever had a burner or stinger (stretched or pinched nerve)?				**YES**	**NO**
7.	Do you currently have any weakness due to a neck or spinal injury? If yes, give the location(s) of the weakness.				**YES**	**NO**

L. SPINE:

1.	Have you ever injured your back? If yes, how many times? Please provide details regarding each injury including dates, treatment, rehabilitation, etc.	**YES**	**NO**
2.	Were you ever diagnosed with a spinal defect of any type? If yes, provide details of defect?	**YES**	**NO**
3.	Have you ever had back surgery? If yes, describe surgery type, date, physician, and location of hospital below.	**YES**	**NO**

M. SHOULDERS:

1.	Have you ever had a significant shoulder joint injury?	L	R	**YES**	**NO**
2.	Have you ever had an A-C sprain or separation?	L	R	**YES**	**NO**
3.	Has your shoulder ever felt like it was unstable or slipping?	L	R	**YES**	**NO**
4.	Have you ever had a problem with your shoulder repeatedly coming out of place?	L	R	**YES**	**NO**
5.	Do you have any problems with your shoulder when trying to throw?	L	R	**YES**	**NO**
6.	Do you have any problems with your shoulder with overhead activities?	L	R	**YES**	**NO**
7.	Have you ever had shoulder surgery? If yes, describe surgery type, date, physician, and the location of hospital below.	L	R	**YES**	**NO**

N. ELBOW, WRIST, HAND, FINGER:

1.	Have you ever had an elbow injury or problem?	L	R	**YES**	**NO**
2.	Have you ever had a wrist injury or problem?	L	R	**YES**	**NO**
3.	Have you ever had a problem with hand or finger injury?	L	R	**YES**	**NO**
4.	Do you have a finger deformity as a result of this injury? If so, which finger?	L	R	**YES**	**NO**
5.	Have you ever had elbow, wrist, or hand/finger surgery? If yes, describe surgery type, date, physician, and the location of hospital below.			**YES**	**NO**

O. KNEES:

1.	Have you ever had a significant knee injury? If yes, please describe the injury(s) you have sustained?	L	R	**YES**	**NO**
	If you have had a significant knee injury or knee surgery, answer the following questions: A. Were you placed on a rehabilitation program?			**YES**	**NO**
	B. Do you wear any type of preventative/protective brace when you practice or play?			**YES**	**NO**
2.	Does your knee ever swell or collect fluid?	L	R	**YES**	**NO**
3.	Did you have surgery for your knee injury(s)?	L	R	**YES**	**NO**
	If yes, please describe the surgery type, date, physician, and the location of the hospital where surgery was performed				
4.	Have you had surgery on either knee more than once?	L	R	**YES**	**NO**
5.	Have you ever suffered from patellar tendinitis or jumper's knee?	L	R	**YES**	**NO**

6. Have you ever been diagnosed with Osgood-Schlatter's disease?	L	R	**YES**	**NO**

P. ANKLES:

1. Have you ever sustained a severe ankle sprain?	L	R	**YES**	**NO**
2. Have you ever sustained a "high ankle sprain" or syndesmosis sprain?	L	R	**YES**	**NO**
3. Have you ever had surgery on your ankle(s)? If yes, describe the surgery type, date, physician, and location of the hospital below.	L	R	**YES**	**NO**

Q. FEET AND TOES:

1. Have you ever had a problem with bunions?	L	R	**YES**	**NO**
2. Have you ever had a problem with turf toe or sprained great toe?	L	R	**YES**	**NO**
3. Have you ever had a problem with ingrown toenails?	L	R	**YES**	**NO**

R. OTHER:

If you have any additional conditions, problems, or comments that have not been addressed thoroughly 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.

_____

_____

IMPORTANT INFORMATION . . . PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT IS UNDER AGE 18)

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges)

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Business Office if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Business Office and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the University is unaffected by the existence of insurance coverage. (Not applicable to community colleges)

_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian, if student under age 18 Date

PHYSICAL EXAMINATION

(Please print in black ink)

*To be completed and **signed** by physician or clinic*

A physical examination is required by **Chowan University.** This form must be completed in black ink and signed by a physician or clinic.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	*Social Security Number
Permanent Address	City	State	Zip Code	Area Code/Phone Number

Height _____ Weight _____ TPR _____/_____/_____ BP _____/_____

IF REQUIRED:
Vision:
Corrected Right 20/_____ Left 20/_____
Uncorrected Right 20/_____ Left 20/_____
Color Vision _____

Hearing:
(gross) Right _____ Left _____
15 ft. Right _____ Left _____

IF REQUIRED:
Urinalysis: Sugar: _____ Albumin _____
Micro _____
Hgb or Hct (if indicated)_____

STS (may be required by some departments)
Date _____ Results _____
Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attached additional sheets if necessary)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No_____
Explain _____

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Date**

Office Address **City** **State** **Zip Code**

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

Helmet Warning Statement

Below is a reprint of the Warning Statement, which is attached to all football helmets. Please read the statement carefully, and then sign where indicated to signify that you have read the statement and understand what it implies. If you do not understand the statement, contact the athletic trainer and he/she will provide further explanation.

Do not strike an opponent with any part of this helmet or facemask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death.

Severe brain or neck injury may also occur accidentally while playing football.

NO HELMET CAN PREVENT SUCH INJURIES.
YOU USE THIS HELMET AT YOUR OWN RISK.

Player's Name: (Print)_____

Player's Signature:_____

Date:_____

Parent, spouse or legal guardian signature if under the age of 18:

_____