University of West Florida
Sports Medicine

Dear Argonaut,

On behalf of the UWF Sports Medicine Staff, I would like to welcome you to UWF and congratulate you on joining the UWF Athletic Department. I would like to take this time to inform you that prior to receiving your pre-participation physical at the beginning of the semester all medical forms must be completed and turned into the sports medicine facility at UWF. Each form must be completed and signed. Also you will be required to submit all medical notes, surgery notes, and imaging results, etc. We wish you luck during your career here at UWF and look forward to assisting you with your sportsmedicine needs. If you have any questions email me at jgamber@uwf.edu

Arnold Gamber

Pre-participation Check List

__Personal Information Form

__Medical History Packet

__Insurance Forms

__Medical Consent Forms

__Supplementation Form

__ADHD Forms (if Applicable)

__Nutrition Form

__All Medical Notes submitted to UWF Sports medicine

(Dr. notes, Surgery Notes, MRI/X-Ray reports, any other medical paperwork)

Please mail all forms to:
University of West Florida
ATTN: Athletic Training Room
11000 University Parkway
Pensacola, FL 32514

University of West Florida
Sports Medicine

Personal Information

Name of Athlete: _____ DOB: _____

Student ID#: _____ Sport: _____

Email Address:_____ Cell Phone:_____

Address while attending UWF:_____

City:_____ State:_____ Zip Code:_____

Home Address:_____ Home Phone:_____

Home City:_____ State:_____ Zip Code:_____

Parent Information

Father Name:_____ Cell Phone:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip Code:_____

Mother Name:_____ Cell Phone:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Information *(must be located in the United States)*

Name:_____ Home Phone:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

University of West Florida
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PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY:

(If you are under 18 years of age, a parent/legal guardian must also sign.)

The basis content of each is

A. Medical Consent	Allows UWF athletic trainers and physicians to treat any injury/illness you sustain while being an athlete at UWF.
B. Medical Care Statement	Informs you of provision for payment of medical care.
C. Shared Responsibility For Sport Safety	Informs you that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks.
D. Authorization for Release Of Information	Allow those listed to release any and all information concerning your injuries to those listed.

If you should choose to refuse to sign any of these, please write "Refused to Sign," on the signature line with the date. Please note, your refusal to sign any consent form(s) may affect your eligibility with UWF.

A. MEDICAL CONSENT

I hereby authorize the athletic trainers at the University of West Florida (UWF) who are under the direction and guidance of the UWF Athletic Training Department Medical Director, to render to_____ (Print Name) any preventative, first aid, rehabilitative, emergency treatment that they deem necessary for my health and well-being.

I also grant permission to the physicians and/or their consulting physicians utilized by the UWF Athletic Training Department to render to _____ (Print Name) and treatment, medical, or surgical care that they deem necessary for my health and well-being. Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital. I also hereby grant permission to the UWF Athletic Training Department to provide any necessary transportation related to any preventive, first aid, rehabilitative, or emergency treatment that they deem necessary for my health and well-being. I understand and agree that I will be primarily covered for any bodily injury related to such transportation by my or my family's automobile policy and I agree to submit any medical bills incurred to such insurance company for payment. If the policy has been issued with a deductible clause relative to the personal injury protection, I understand that I have assumed the deductible amount when the policy was purchased.

_____ _____
Print Name of Student-Athlete Date

_____
Signature of Student-Athlete

_____
Signature of Parent/Guardian if under age 18

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B. MEDICAL CARE STATEMENT

The University of West Florida Athletic Department (Athletics) and the University of West Florida (UWF) are committed to providing high quality medical care to its student-athletes. The UWF Athletic Department will provide necessary, reasonable and customary medical care for athletic related injuries/illnesses as permissible under the rules of the NCAA. The provisions to receive the benefits from the UWF Athletic Department are outlined in the following paragraphs.

The University of West Florida is responsible only for injuries or illnesses occurring as a direct result of participation in approved conditioning, practice, and contests. All injuries will be referred to physicians utilized by the UWF Athletic Training Department or those they designate. Any medical or dental expenses that occur outside of UWF approved athletics participation cannot and will not be covered by UWF.

UWF is responsible for only those student-athletes who are official members of the intercollegiate athletics programs. Medical expenses recorded after the student athlete has been released by the physician will no longer be the responsibility of the University.

HMOs:

If a student-athlete's primary insurance is an HMO, the UWF Athletic Training Department strongly encourages the student-athlete to change the primary care physician (PCP) to a UWF Team Physician or local physician. This will allow the student-athlete to have a network of physicians in the Pensacola area, as well as better access to care. A UWF certified athletic trainer can assist in this process.

Insurance Policy Changes:

The UWF Athletic Training Department must receive any changes to a health insurance policy as soon as they occur. If proper notification is not received, the UWF Athletics Department will not be responsible for any delays in payment, collections notices, credit reports, etc. that occur. **If a cancellation of a policy occurs without proper notification, any medical expense incurred during that period will be the responsibility of the student- athlete and/or his/her parent(s) or guardian(s).**

Physician Referrals / Consultations:

UWF has fostered positive relationships with many medical providers and facilities in the Pensacola area who have consistently provided high quality service to UWF student-athletes. A certified athletic trainer from the UWF Athletic Training Department will refer student-athletes to these providers, unless extenuating circumstances necessitate a different provider or facility.

All student-athletes must be seen and evaluated by a UWF certified athletic trainer before a referral to a physician will be made. A UWF certified athletic trainer must authorize and properly refer all student-athletes to see a physician or medical consultant. All diagnostic tests must be approved and authorized by UWF. ***If a student-athlete decides to see a physician/medical consultant, and/or undergo a diagnostic test WITHOUT prior authorization and referral from a member of the UWF Athletic Training Department, or if the student-athlete wishes to see a physician/medical consultant other than the one recommended by the UWF Athletic Training Department, the student-athlete and/or the student athlete's parent(s) or guardian(s) will be financially responsible for any and all medical bills incurred.***

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Policies and Procedures for Referral for Medical Care and for Payment of Medical Expenses

Members of the University of West Florida intercollegiate athletics teams may be covered for athletic injuries by the University's insurance policy under the following conditions:

1. The student-athlete must be an official member of a UWF intercollegiate athletic team.
2. The injury must have occurred while the student-athlete was engaging in athletic department supervised conditioning, practice or contests. This policy does not cover injuries incurred during tryouts.
3. The student-athlete must have a written physician referral from the Athletic Training Department. UWF has fostered positive relationships with medical providers in the Pensacola area who have consistently provided high quality service to UWF student- athletes. Members of the UWF Athletic Training Department will refer student-athletes to these providers, unless extenuating circumstances necessitate a different provider. All student-athletes must be seen and evaluated by a certified athletic trainer before a referral to an approved physician will be made, except in cases of medical emergency.
   In such cases, student-athletes are required to notify the Athletic Training Department of their injury as soon as practical. Appropriate referrals are required for diagnostic testing and follow-up care.
4. The medical care must be rendered by the referral physician or designee.
5. The student-athlete must submit a claim for the medical attention to his or her personal insurance for primary coverage.

If these conditions are met, the University will submit a claim for the balance remaining to its insurance carrier for secondary coverage after explanation of benefit (EOB's) and secondary statements are received by the Athletic Training Department. It is the student- athlete's responsibility to obtain all necessary claims and EOB's. The UWF Athletic Training Department will assist the student-athlete with this process. The University will submit a claim for primary coverage for those student-athletes who do not have personal health insurance who otherwise meet these conditions. All policy provisions, coverages, and exclusions are listed in the master insurance policy. A copy of the master insurance policy is available through the Athletic Training Department.

Medical expenses recorded after the student-athlete has been released by the attending physician are not the responsibility of the University of West Florida.

Claims for second opinions may be submitted for secondary coverage to the University of West Florida insurance carrier as long as the Athletic Training Department provided a referral for the second opinion. Second opinions obtained from physicians not referred by the Athletic Training Department will not be submitted to the University's insurance carrier and are not the responsibility of the University.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT REGARDING THE PROVISION OF PAYMENT FOR MEDICAL CARE.

_____ _____
Print Name of Student-Athlete Date

_____
Signature of Student-Athlete

_____
Signature of Parent/Guardian if under age 18

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C. SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in athletics requires an acceptance of the possibility of risk of injury. Athletes rightfully assume that those who are responsible for such activities have taken reasonable precaution to minimize such risk and that their participating peers will not intentionally inflict injury upon them.

Periodic analysis of injury patterns or refinements in the rules and other safety decisions will be made by the UWF Athletic Training Staff and the NCAA. UWF will do its best to ensure compliance with all safety precautions in order to protect all participants.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating in athletics at the University of West Florida.

_____ _____

Print Name of Student-Athlete Date

_____

Signature of Student-Athlete

_____

Signature of Parent/Guardian if under age 18

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D. AUTHORIZATION / CONSENT FOR RELEASE OF INFORMATION

I, the signee, understand that my health information is protected by the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment) and may not be disclosed without my authorization.

I, the signee, hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing the University of West Florida Athletic Training Department to release information regarding my medical condition(s) (including, but not limited to: type and severity of injury, prognosis, diagnosis, athletic participation status and related personally identifiable information) to other health care providers, hospitals and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or university administrators, and my parents/guardians for the purpose of coordinating continuing medical care as necessary.

I, the signee, am voluntarily choosing to participate in intercollegiate athletics at the University of West Florida and understand that giving authorization/consent for the disclosure of this health information is a condition for my participation in intercollegiate athletics at UWF.

I, the signee, agree that once information is disclosed by UWF to a third party, UWF is no longer liable for any further disclosure of the health information by the third party.

I, the signee, understand that I may revoke this authorization/consent at any time by notifying the Head Athletic Trainer in writing, but if I do, I understand it will not have any effect on the actions the University of West Florida officials/representatives took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires one year from the date it is signed.

_____ _____
Print Name of Student-Athlete Date

_____
Signature of Student-Athlete

_____
Signature of Parent/Guardian if under age 18

University of West Florida
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Insurance Information

Student-Athlete Name:_____ Sport:_____
Student ID #:_____ Date of Birth:_____
Year in School: __Fr __Soph __Jr __Sr Athletic Scholarship?: __Yes __No

Parent/Guardian Information:

Name(s):_____ Address: _____
City: _____State: _____ Zip Code: _____
Home phone #: _____Email Address: _____
Work phone # (s): _____
Cell phone # (s): _____
May we call you at work? __Yes __ No On your cell phone? __Yes __No

__ My son/daughter is NOT covered by any insurance policy.
__ My son/daughter is covered under the insurance policy carried by:
__ Father __ Mother __ Self __ More than one policy* __ Other _____
**If the student-athlete is covered under more than one policy, please list the primary information on the front and secondary on the back.

******PLEASE INCLUDE COPIES (FRONT AND BACK) OF ALL INSURANCE CARDS******

Medical Insurance Information:

Policy Holder's Name: _____
SS#: _____ Date of Birth: _____Home phone #: _____
Address: _____City: _____ State: _____ Zip: _____
Employer: _____Work phone #: _____
Insurance Company: _____Effective Date: _____
Address: _____City: _____State: _____Zip: _____
Insurance phone #: _ _____Type of Insurance: _____ PPO__ HMO__ Other__
Policy #: _____Group #: _____

Other Insurance Information:

Pharmacy Plan: _____ Pharmacy phone #: _____
Is there a separate Pharmacy card (from medical health insurance card)? __ Yes __ No
Dental Plan: _____ Dental phone #: _____
Is there a separate Dental card (from medical health insurance card)? __ Yes __ No
Do you anticipate any changes in coverage in the upcoming year? __ Yes __ No
If yes, please explain: _____

I acknowledge receiving information explaining UWF's insurance policy. I understand the extent of the University's responsibility to scholarship or walk on student-athletes who become injured as a result of participation in an intercollegiate sports program. I authorize the release of any medical information necessary to process claims submitted to my insurance companies. I authorize my insurance company to send payment directly to the provider. If I receive a payment for medical services, I will submit payment to the providers listed on the explanation of benefits from my insurance company. I authorize UWF athletic Department to send insurance information to other medical providers when necessary.

_____ _____
Student-Athlete or Parent/Guardian Signature Date

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INSURANCE INFORMATION VERIFICATION STATEMENT

1. Filing a medical insurance information form is a CONDITION OF ELIGIBILITY for participation in varsity athletics at The University of West Florida. No student-athlete will be cleared to receive equipment, to practice, or to participate in intercollegiate athletics until the form has been filed by his or her parents/guardian. Married or legally independent students should file the form themselves.

   a. Filing the form is MANDATORY. Having insurance coverage, while highly recommended is NOT MANDATORY for scholarship athletes. Insurance is MANDATORY for all walk on athletes.

2. Every athlete should have a complete understanding of the risks taken when participating in varsity athletics. However, it should also be clear to every individual, injuries can and do occur outside of athletics.

   a. The Athletic Department can pay only those expenses incurred as a result of an athletic injury sustained during NCAA sanctioned and staff-supervised practice, conditioning or competition. This includes diagnostics, treatment, surgery, physical therapy, and follow-up by team physicians and other approved health care providers.

      A FEW examples of specifically **EXCLUDED** items:

      - Emergency room visits that are not adjunct to practice or competition.
      - Surgery for any conditions other than an athletic injury. For example, although it may be a medical necessity to have your tonsils removed, the Athletic Department cannot pay for the surgery or associated fees.
      - Any condition related to an accident (automobile or other) outside of the above-specified circumstances of athletic participation. This includes injuries sustained while participating in intramural activities or pick-up games, regardless of whether the activity is related to your specific sport.
      - Surgery or treatment for any type of congenital disorder or illness or any condition existing prior to the first physical as a student-athlete at The University West Florida (e.g. injury sustained in high school athletics).
      - Immunizations required by University of West Florida for enrollment.

   b. Every individual should understand he or she has a responsibility to have adequate medical insurance coverage prior to the occurrence of such an accident or illness. If such coverage is not available under the group or personal insurance of the parent/guardian OR if the student's married, legally independent or beyond the age limitation for parental group insurance, each individual is counseled at this time to purchase individual insurance coverage via The University of West Florida Student Health insurance plan or other carrier.

   c. Student-athletes are free to see a team physician in the training room at scheduled arranged times or at Student Health Service for any reason at any time during office hours. However, A REFERRAL OR RECOMMENDATION FOR TREATMENT BY A TEAM PHYSICIAN DOES NOT CONSTITUTE A COMMITMENT ON THE PART OF THE ATHLETIC DEPARTMENT TO ASSUME RESPONSIBILITY FOR THE CHARGES YOU MAY INCUR.

3. As with any other NCAA rules, you jeopardize your eligibility to participate by committing a violation. If you ever have any questions regarding medical bills or charges, it is important to direct them to a full-time staff athletic trainer or to the insurance coordinator.

I, the undersigned, have been advised regarding medical insurance policies for student-athletes at The University of West Florida. It has been recommended to me I should have some form of personal or group insurance coverage in the event I become ill or sustain an injury outside of my participation in intercollegiate athletics. I agree to abide by the above outlined policies and procedures and understand any recommendation or referral by University of West Florida Team Physicians does not commit The University of West Florida to assume responsibility for any charges I might incur while pursuing treatment for an illness or injury.

I also acknowledge the above statements regarding insurance were read by me and I understand them.

_____ _____

Signature of Student-Athlete Date

_____

Student-Athlete Name (Printed)

University of West Florida
Sports Medicine
Student-Athlete Supplement/Ergogenic Aid Notification Form

I, _____, acknowledge I am currently taking/have previously
Student-Athlete Print Name
taken (within the past 6 months) taken the following ergogenic aids, supplements, etc. (this includes any vitamins, minerals, herbal supplements, weight gain/weight loss supplements, energy boosters, etc., use the back if necessary).

Name of Supplement	Dosage	Main Ingredients	Comments (current use or past use)

I acknowledge and fully accept:

1. The University of West Florida Department of Athletics does not condone the use of supplements, ergogenic aids, creatine powder, amino acids, anabolic/androgenic steroids, etc.;
2. I will be held responsible for every substance that enters my body and risk losing my eligibility to participate in intercollegiate athletics if I test positive for a NCAA banned substance;
3. I understand that I am to list all supplements on the Chain of Custody Forms at the time of my drug test; and

I understand the University of West Florida Department of Athletics, its agents, servants, trustees, and employees disclaim any liability and will not be held liable for any detrimental and possibly permanent defects caused by past, present, and/or future use or ergogenic aids, nutritional supplements, and/or anabolic/androgenic steroids in any form by student-athletes. I fully accept any and all liability if I have used in the past, continue to use, or use at anytime in the future, supplements, ergogenic aids, anabolic/androgenic steroids, etc. in any form, and release the University of West Florida Department of Athletics and all personnel of any and all responsibility and liability.

I further acknowledge that I understand all of the aforementioned policies and statements, and fully accept the detrimental and possibly permanent defects caused by the use of supplements, ergogenic aids, and/or anabolic/androgenic steroids.

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Guardian (if student-athlete is under 18) Date

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Name _____ Gender ____ DOB _____ Sport_____

Please give name address, and phone number of your primary care provider or family doctor and current or last athletic trainer

Doctor Name_____ AT Name_____

Address _____ Address _____

_____ _____

Phone Number _____ Phone Number_____

Previous Collegiate Experience

Have you ever played intercollegiate athletics at another college, university or junior college? YES NO

If Yes; What School? _____

Have you ever not passed a physical at another school? YES NO

If Yes; Why? _____

Have you ever been tested for sickle cell trait? YES NO

If Yes; Was your test normal or abnormal?

_____

Past Medical History

1. Have you ever been hospitalized for ANY reason? YES NO
   If Yes; Specify date and reason for each episode:

_____

_____

2. Have you had ANY type of surgery? YES NO
   If Yes; Specify procedure name(s) and date(s) for each episode:

_____

_____

3. Has a doctor denied or restricted your participation in sports for any reason, i.e. have you ever been told you cannot take part in any sport? YES NO
   If Yes; Explain:

_____

_____

4. Are you missing any paired organs (eye, kidney, testicle, etc.)? YES NO
5. Do you have any artificial hardware, pins, screw or implants? YES NO
   If Yes; Specify location:

_____

6. Have you ever been told to have a surgery or test you did not elect to do? YES NO
   If Yes; Explain:

_____

_____

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Do you have, or have you had treatment for ANY of the following conditions:

Heat illness (cramps, heat exhaustion)	YES	NO	ADD/ADHD	YES	NO
Anxiety	YES	NO	High blood pressure	YES	NO
Allergies	YES	NO	Learning disability	YES	NO
Anemia	YES	NO	Leukemia/lymphoma	YES	NO
Asthma	YES	NO	Marfan Syndrome	YES	NO
Bladder problems	YES	NO	Menstrual disorder	YES	NO
Bleeding tendencies	YES	NO	Mononucleosis	YES	NO
Cancer	YES	NO	Palpitations/Irreg. heart beat	YES	NO
Depression	YES	NO	Pneumonia	YES	NO
Diabetes (Type 1 or Type 2)	YES	NO	Sickle cell trait or anemia	YES	NO
Exercise induced asthma	YES	NO	Skin infections/Staph/MRSA	YES	NO
Fainting/Passing out	YES	NO	Sleep apnea	YES	NO
Hearing Defect	YES	NO	Spleen injury	YES	NO
Heart disease	YES	NO			

Medications

1. Are you taking ANY prescription medication(s), (i.e. asthma meds, Adderall, birth control, etc)? YES NO
   If Yes; List name/dose/how often taken:

---

2. Have you ever been told to take medication that you no longer take? YES NO
   If Yes; Specify medication(s):

---

3. Do you take any over the counter medications regularly? YES NO
   If Yes; Specify medication(s):

---

4. Are you taking any supplements, i.e. creatine, vitamins, etc? YES NO
   If Yes; Specify:

---

5. Do you have any medication allergies? YES NO
   If Yes; List name of medication(s):

---

6. Do you have allergies to any substance, i.e. insects, stings, pollen, food, latex, etc? YES NO
   If Yes; Specify:

---

7. Have you ever taken anabolic steroids with or without a doctor's prescription? YES NO
8. Have you ever had a positive drug test? YES NO
   If Yes; What was it positive for?

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Personal/Social

1. Do you use tobacco in any form? YES NO
   If Yes; Specify type and frequency:

---

2. Do you drink alcoholic beverages? YES NO
   If Yes; Specify quantity of drinks and frequency:

Family History

1. Has anyone in your family died suddenly for no apparent reason? YES NO
   If So; Specify cause of death:

---

2. Has any family member or relative died of heart problems or of sudden death before age 50? YES NO
3. Does anyone in your family have high blood pressure? YES NO
4. Does anyone in your family have Marfan syndrome? YES NO
5. Does anyone in your family have Sickle Cell Disease or Sickle Cell Trait? YES NO

Head

1. Have you ever had a concussion or head injury diagnosed by a medical healthcare professional (even if it is not related to sports participation)? YES NO
   If Yes; How many?

Describe how it occurred:

Please provide dates for each concussion or head injury:

Were you hospitalized? YES NO
Was there any loss of consciousness? YES NO
Was there memory loss? YES NO
2. Do you have frequent or severe headaches? YES NO
3. Have you been told you have migraine headaches or taken medicine for migraine headaches? YES NO
   If Yes; Medications used; Doctor's name/address/phone:

---

4. Have you ever had baseline cognitive testing (i.e. IMPACT testing)? YES NO

Eyes

1. Have you ever had a problem with your eyes or vision (frequent infections, trauma or surgery, etc.)? YES NO
2. Have you ever had a detached retina? YES NO
3. Do you wear glasses? YES NO
   If Yes; Doctor's name/address/phone:

---

4. Do you wear contacts? YES NO
   If Yes; Please specify prescription strength; Hard/soft disposal, Doctor's name/address/phone:

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Ears

1. Do you have a history of frequent ear infections?	YES	NO
2. Have you had problems with hearing?	YES	NO

Nose

1. Do you have Hay fever or seasonal allergy symptoms or take medications for allergies?	YES	NO
2. Do you have frequent sinus infections?	YES	NO
3. Do you have frequent nosebleeds?	YES	NO
4. Do you snore or have you been told that you are a loud snorer?	YES	NO
5. Have you ever fractured your nose?	YES	NO

Mouth/Throat

1. Have you ever had any teeth or dental injuries?	YES	NO
2. Do you wear dentures, implants, retainers, etc.?	YES	NO

If Yes; Explain:

---

3. Have you ever been told you have "TMJ" syndrome (temporomandibular joint dysfunction)?	YES	NO

If Yes; What type of treatment did you receive?

---

4. Do you have frequent throat/tonsil infections or "strep throat"?	YES	NO
5. Have you had your tonsils removed?	YES	NO

Neck

1. Have you ever had a burner, stinger, or pinched nerve?	YES	NO
2. Have you ever had a neck injury that caused you to miss practice or games?	YES	NO
3. Have you ever had a neck injury that caused numbness, burning, tingling, or sharp pain in any arm or hand?	YES	NO
4. Have you ever worn a neck collar because of neck injury?	YES	NO
5. Have you ever had x-rays, CAT scan, or MRI for a neck injury?	YES	NO
6. Have you ever seen a doctor for any type of neck injury?	YES	NO

If Yes; Why? What tests were done? What were the results? Doctor's name/address/phone:

Chest/Respiratory

1. Do you have asthma?	YES	NO
2. Have you ever been treated with an inhaler or puffer?	YES	NO
3. Do you cough, wheeze, or have difficulty breathing during or after exercise?	YES	NO
4. Have you ever seen a doctor for any type of asthma or respiratory problems?	YES	NO

If Yes; Why? What tests were done? What were the results? Doctor's name/address/phone:

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Cardiac

1. Have you ever passed out during or after exercise?	YES	NO
2. Have you ever passed out for any reason?	YES	NO
3. Have you ever been dizzy during or after exercise?	YES	NO
4. Have you ever had chest pain during or after exercise?	YES	NO
5. Have you ever had racing of your heart or skipped heartbeats?	YES	NO
6. Have you ever been told you have a heart murmur?	YES	NO

If Yes; please explain.

_____

7. Has a doctor ever ordered a test for your heart (ECG, echocardiogram, stress test, etc.)?	YES	NO
8. Have you ever been diagnosed or treated for high blood pressure?	YES	NO

If Yes; Why? What tests were done? What were the results? Doctor's name/address/phone:

_____

Abdominal/GI

1. Have you ever had any kind of hernia (groin/inguinal, abdominal hernia, sports hernia)?	YES	NO

If Yes; Did you have surgery? Doctor's name/address/phone:

_____

2. Do you have frequent symptoms of heartburn or acid reflux?	YES	NO
3. Do you have frequent symptoms of diarrhea/constipation?	YES	NO
4. Have you had any type of liver disease or injury?	YES	NO
5. Have you ever been diagnosed with any type of hepatitis?	YES	NO
6. Have you ever had any type of kidney injury or disease?	YES	NO
7. Have you ever had kidney stones?	YES	NO

Skin

1. Do you have or have you been treated for skin problems?

a. Itching	YES	NO
b. Rashes	YES	NO
c. Acne	YES	NO
d. Warts	YES	NO
e. Fungus	YES	NO
f. Blisters	YES	NO
g. MRSA (Methicillin-resistant *Staphylococcus Aureus*)	YES	NO
h. Staph infections	YES	NO

Neuro

1. Have you ever had a seizure?	YES	NO
2. Have you ever been diagnosed with meningitis?	YES	NO

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Musculoskeletal/Orthopedic

1. Have you ever dislocated a joint? YES NO
   If Yes; please explain (What body part? How? When?):

2. Have you ever broken a bone? YES NO
   If Yes; please explain (What body part? How? When?):

3. Have you ever had a muscle pull or strain that required care from a healthcare professional? YES NO
   If Yes; please explain (What body part? How? When?):

Shoulder

1. Have you ever had a shoulder injury? YES NO

a. Type of injury? Right/Left?

b. How and when did the injury occur?

c. Were x-rays, CAT scan, MRI, or arthrogram done? YES NO
   If Yes; Date(s); Doctor's name/address/phone:

d. If surgery; Doctor's name/address/phone:

e. Describe any difficulty you have now:

2. Has one of your shoulders ever "come out of place"; subluxated or dislocated? YES NO

a. Right/Left

b. How and when did the injury occur?

c. Were x-rays, CAT scan, or MRI done? YES NO
   If Yes; Date(s); Doctor's name/address/phone:

d. If Surgery; Doctor's name/address/phone:

e. Describe any difficulty you have now:

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Elbow

1. Have you had an elbow injury? YES NO
a. Type of injury? Right/Left?

b. How and when did the injury occur?

c. Were x-rays, CAT scan, or MRI done? YES NO
If Yes; Date(s); Doctor's name/address/phone:

d. Were you put in a cast or immobilized? YES NO
e. If Surgery; Doctor's name/address/phone:

f. Describe any difficulty you have now:

Wrist

1. Have you had a wrist injury? YES NO
a. Type of injury? Right/Left?

b. How and when did the injury occur?

c. Were x-rays, CAT scan, or MRI done? YES NO
If Yes; Date(s); Doctor's name/address/phone:

d. Were you put in a cast or immobilized? YES NO
e. If Surgery; Doctor's name/address/phone:

f. Describe any difficulty you have now:

Back

1. Have you ever injured your back? YES NO
a. Type of injury? Right/Left?

b. Were x-rays, CAT scan, or MRI done? YES NO
If Yes; Date(s); Doctor's name/address/phone:

c. If Surgery; Doctor's name/address/phone:

d. Describe any difficulty you have now:

2. Have you ever been told you have a congenital spinal defect? YES NO
3. Have you ever been told you have spondylosis, spondylolysis, spondylolisthesis? YES NO
4. Have you ever had leg or buttock pain associated with back pain or a back injury? YES NO
5. Did you see a physician, chiropractor, or physical therapist for any above condition? YES NO
If Yes; Doctor's name/address/phone:

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Knee

1. Have you had a knee injury? YES NO
a. Type of injury? Right/Left?

_____

b. How and when did the injury occur?

_____

c. Were x-rays, CAT scan, or MRI done? YES NO
If Yes; Date(s); Doctor's name/address/phone:

_____

d. Were you put in a cast or immobilized? YES NO
e. If Surgery; Doctor's name/address/phone:

_____

f. Describe any difficulty you have now:

_____

Ankle

1. Have you had an ankle injury? YES NO
a. Type of injury? Right/Left?

_____

b. How and when did the injury occur?

_____

c. Were x-rays, CAT scan, or MRI done? YES NO
If Yes; Date(s); Doctor's name/address/phone:

_____

d. Were you put in a cast or immobilized? YES NO
e. If Surgery; Doctor's name/address/phone:

_____

f. Describe any difficulty you have now:

_____

2. Do you have recurrent ankle sprains? YES NO

Feet

1. Have you ever had shin splints? YES NO
2. Have you ever been told you have flat feet or high arches? YES NO
3. Have you ever had "turf toe"? YES NO
4. Have you ever used orthotics? YES NO
5. Did you see a physician or surgeon for any foot problem? YES NO
If Yes; Doctor's name/address/phone:

_____

Heat Injury History

1. Have you ever become ill from exercising in the heat? YES NO
2. Have you ever been restricted from participation due to heat illness? YES NO
3. Do you often cramp during or after exercise? YES NO
4. Have you ever had heat stroke or heat exhaustion? YES NO
5. Have you ever been hospitalized for any type of heat injury? YES NO
If Yes; please explain:

_____

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Emotional/Psych

1. Have you ever been told you have ADD or ADHD? YES NO
   If Yes; List any medication(s) you are on or were treated with; Doctor's name/address/phone:

_____

2. Have you ever been treated for anxiety or depression? YES NO
3. Have you ever been told you have an eating disorder? YES NO
4. Have you ever been under the care of a psychiatrist or psychologist? YES NO
   If Yes; Doctor's name/address/phone:

_____

Male Athlete

1. Have you ever had any type of testicular injury or surgery (trauma, cancer, varicocele, etc.)? YES NO

Female Athlete

1. At what age was your first menstrual period? _____
2. How much time do you usually have from the start of one period to the start of another? _____
3. How many periods have you had in the last 12 months? _____
4. Are your periods painful? YES NO
   a. If Yes, does it require the use of over the counter pain medications YES NO
   b. Does the pain limit your activities? YES NO
   c. Do you use a heating pad or thermal patch? YES NO
   d. Is the pain most severe at the onset of the period? YES NO
   e. If applicable, do you have pain with intercourse? YES NO
5. Have you had a breast mass or nipple discharge? YES NO
6. For athletes age 21 or older, have you had a pap smear in the last year? YES NO
7. Have you ever been seen by a Gynecologist? YES NO
8. Do you need or desire contraception (birth control)? YES NO

Miscellaneous

1. Have you ever been in a motor vehicle accident (MVA) and suffered injuries that needed medical attention? YES NO
   If Yes; Explain:

_____

2. Do you have any medical problem(s) not mentioned above? YES NO
   If Yes; Specify:

_____

3. Do you have any concerns you would like to discuss with a doctor? YES NO

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The undersigned, herewith,

A. Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given a written permit by the attending physician to resume participation.

B. Certifies that the answers to these questions are correct and true.

C. Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.

D. Fully realizes the University of West Florida Intercollegiate Athletic Department cannot be held responsible for any previous medical condition(s) that he/she might have.

Student-Athlete Signature _____

Date _____

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Attention Deficit Hyperactivity Disorder (ADHD) Guidelines

Below is a checklist for documentation from your prescribing healthcare provider (MD/DO/NP/PA) to the University of West Florida Sports Medicine staff regarding assessment of student-athletes taking prescribed stimulants for attention deficit hyperactivity disorder (ADHD), in support of an NCAA medical exception request for the use of a banned substance.

The following must be included in supporting documentation:

- ☐ Student-athlete name
- ☐ Student-athlete date of birth
- ☐ Date of clinical evaluation

Clinical evaluation components including:

- ☐ Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) (Attach supporting documentation)
- ☐ ADHD rating scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary (Attach supporting documentation)
- ☐ Blood pressure and pulse readings and comments
- ☐ Note that alternative non-banned medications have been considered, and comments
- ☐ Diagnosis
- ☐ Medication(s) and dosage
- ☐ Follow-up orders

Additional ADHD evaluation components if available:

- ☐ Report ADHD symptoms by other significant individual(s)
- ☐ Psychological testing results
- ☐ Physical exam date and results
- ☐ Laboratory/testing results
- ☐ Summary of previous ADHD diagnosis

Other comments:

- ☐ Please include any other pertinent information needed to describe your decision to prescribe ADHD medication

Documentation from prescribing healthcare provider must also include the following:

- ☐ Healthcare provider's name (Printed) (MD/DO/NP/PA)
- ☐ Office address and contact information
- ☐ Specialty
- ☐ Healthcare provider's signature and date

This information can be submitted in multiple formats including a letter with supporting documentation attached. Please bring it to Arnold Gamber, Head Athletic Trainer when you arrive on campus.

A copy of the updated prescription for the ADHD medication must be attached.