

LINFIELD COLLEGE

Department of Health, Human Performance, and Athletics

May 1, 2011

Dear Student-Athlete,

Welcome to the Linfield College Intercollegiate Athletics program! We are looking forward to meeting you when you arrive on campus for the 2011-2012 academic year.

The team physicians and athletic training staff will be available to provide quality medical care for you during your athletic career at Linfield College. Your health care is our primary concern.

The NCAA requires that all student-athletes have a preparticipation medical evaluation when they enter an institution's intercollegiate athletics program. Since this is your first year in the athletics program at Linfield College, you will need to get a physical examination before you can participate in athletic team practice or competition. You will be financially responsible for the physical examination. The *Preparticipation Physical Examination* form is on page 5 of the INTERCOLLEGIATE ATHLETICS PHYSICAL EVALUATION packet. The physical examination must be dated **May 1, 2011** or later.

A physical examination is only required the year you enter the intercollegiate program at Linfield College. We will provide a free annual health appraisal of your medical status the subsequent years that you participate.

In addition to the preparticipation physical examination, you must have medical insurance that provides a minimum of \$15,000 coverage for athletic injuries. There are numerous insurance policies available. However, it is extremely important that you evaluate your insurance policy carefully to determine if it provides the type of coverage that you will need. We suggest that you have the most comprehensive coverage possible if you are participating in a high-risk sport, such as football, basketball, and soccer.

It is extremely important that your insurance information on pages 8 and 9 are complete. **You will not be allowed to participate until all sections of the *Insurance Information Form* and *Emergency Information* are completed, including a copy of your medical insurance card.**

Most student-athletes will need to return their physical evaluation packets by August 1, 2011. Your coach will let you know if you are required to mail your form OR bring it with you when you come to campus in the fall.

Be sure to bring the following completed information with you:

- General Information & Emergency Contact Information
- Immunization Records & Sickle Cell Trait Report
- Medical History Questionnaire
- Preparticipation Physical Examination
- Health Information Release Authorization
- Assumption of Risk
- Insurance Information Form
- Emergency Information
- Photocopy of Medical Insurance Card (front and back)

On behalf of the entire sports medicine team at Linfield College, I wish you a healthy and enjoyable athletic career. Please contact me if you have any questions or concerns.

Sincerely,

Tara M. Lepp, ATC
Head Certified Athletic Trainer

900 SE Baker, McMinnville, Oregon 97128-6894 * Telephone 503-883-2417 * Fax 503-883-2453

Linfield College

Department of Health, Human Performance and Athletics
McMinnville, Oregon 97128-6894
Phone: 503-883-2417
Fax: 503-883-2453

Unit Box No.: _____
Cell Phone: _____
Dorm/School address: _____
Sport(s): _____
Date: _____
Class (circle): F So Jr S

Campus Information

INTERCOLLEGIATE ATHLETICS PHYSICAL EVALUATION 2011-2012

GENERAL INFORMATION: (Please Print)

NAME _____ AGE: _____ DATE OF BIRTH: _____
last first middle month day yr

SEX: _____ STUDENT ID #: _____

CONTACT PERSON IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: () WORK PHONE: () CELL PHONE: ()

PARENT/or GUARDIAN NAMES (If different than above): _____ PHONE: ()

(If parents are separated or divorced, please provide information for both)

Cardiac History	Yes	No	Comments
Have you ever had prior occurrence of chest pain or discomfort during physical exercise?			
Have you ever been dizzy during or after exercise?			
Have you ever passed out during or after exercise?			
Have you ever experienced excessive, unexplained shortness of breath or fatigue with exercise?			
Have you ever had racing of your heart or skipped heartbeats?			
Do you have a prior history of heart murmur or increased blood pressure?			
Have you ever had chest pain during or after exercise?			
Do you have a family history of premature death in a close relative younger than age 50?			
Do you have a family history of cardiovascular disease in a close relative younger than age 50?			
Does anyone in your family suffer from any of the following: Hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, or Marfan's syndrome?			
Has a physician ever denied or restricted your participation in sports for any heart problem?			

If you receive a musculo-skeletal injury that requires surgery, would you prefer to be treated by our team orthopedic surgeons or your own surgeon? _____

LINFIELD ORTHOPEDIC SURGEONS:
PETER VAN PATTEN, MD O: 503-472-8162
GREG GRAMSTAD, MD O: 360-254-6161

YOUR ORTHOPEDIC SURGEON:
NAME: _____
OFFICE: () _____
FAX: () _____

Musculo-Skeletal Injury History	Y	N	Comments
Have you ever had an injury that required you to go to an emergency room or see a doctor?			
Have you ever had an injury that required you to stay in the hospital? required x-rays? caused you to miss 3 days of practice or a competition? required an operation?			
Have you ever had a head injury or concussion?			
Have you ever been knocked out, become unconscious or lost your memory?			
Have you ever had a seizure?			
Do you have frequent or severe headaches?			
Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
Have you ever had a stinger, burner, or pinched nerve?			
Neck injuries?			
Shoulder injuries?(surgery, dislocation, separation, fracture, tendinitis, bursitis)			
Knee injuries?(surgery, locking, giving way, tendinitis)			
Hip injuries?(bursitis, snapping hip)			
Quadriceps or hamstring strains?			
Ankle injuries?(surgery, sprains, fracture)			
Lower leg injuries?(shin splints, MTSS)			
Foot-arch-toe injuries?			
Arm-wrist-hand-finger injuries?			
Back injuries?			
Chest-rib injuries?			
Hernia?			
Broken nose or frequent nose bleeds?			
Ear, eye or facial injuries?			
Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eye wear?			
Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (knee brace, neck roll, foot orthotics, retainer or mouth piece)?			

Females Only	Y	N	Comments
How old were you when you had your first menstrual period?			
When was your most recent menstrual period?			
How much time do you usually have from the start of one period to the start of another?			
How many periods have you had in the last 12 months?			
What was the longest time between periods in the last 12 months?			
When was your last pelvic exam?			
Have you ever been diagnosed with anemia?			

To the best of my knowledge, the aforementioned illnesses and injuries are the only type that have occurred.

Athlete's signature: _____ Date: _____

Preparticipation Physical Examination

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____ / _____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL

Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

CLEARANCE

- Cleared
 Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

The NCAA prefers preparticipation physical examinations be performed by an MD or DO.
 Linfield College will also accept physical examinations performed by a PA or NP.

LINFIELD COLLEGE SPORTS MEDICINE DEPARTMENT
Health Information Release Authorization

I understand that the _____ Linfield College Treatment Center staff _____
(Referred to below as "LCTC staff") may need to use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that the LCTC staff may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how the LCTC staff will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of the LCTC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of the LCTC's Notice of Privacy Practices in effect will be available in the reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that the LCTC staff is not required by law to agree to such requests.

I understand that the terms of this authorization will expire on June 1, 2012.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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OR

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	

LINFIELD COLLEGE SPORTS MEDICINE DEPARTMENT

Acknowledgment & Assumption of Risk

I, _____ hereby acknowledge, affirm, and represent the following:

A. RETURN TO PARTICIPATION

I acknowledge and agree that a Linfield College team physician has the final authority on determining my ability to participate in intercollegiate athletics. _____ [initial]

B. FUTURE COMPLAINTS:

I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to a member of Linfield College’s sports medicine team, no matter how minor or insignificant I may deem them to be. _____ [initial]

C. MEDICATIONS:

I understand that The Linfield College Athletic Training program does not provide pharmaceuticals, including over-the-counter medications (e.g., Tylenol, Advil, Aleve). I will purchase any medications that I may require. _____ [initial]

D. EQUIPMENT:

If I need to use any Linfield College Athletic Training equipment (i.e. braces, sleeves, crutches), I will be required to check the equipment out/in at the Treatment Center. I understand that if I do not return the equipment when I am finished using it, my student account will be charged for its replacement. I also understand that the equipment must be returned in good condition and all CHARGES ARE FINAL. It is my responsibility to make sure that the item has been checked in properly and that I receive a copy of the “EQUIPMENT CHECK-OUT FORM” as proof of return. _____ [initial]

E. ACKNOWLEDGMENT & ASSUMPTION OF RISK

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious head, neck or spinal injuries which may result in complete or partial paralysis or brain damage, temporary or permanent cognitive disability, and/or degenerative brain disease, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Because of the aforementioned dangers of participating in any athletic activity, I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Sports Medicine Department. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

In consideration of Linfield College permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Linfield College, and their offices, agents, and employees from any and all liability, any medical expenses not covered by the College’s Intercollegiate Athletics’ medical insurance coverage, and any and all claims, causes of action or demand of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

I release, waive, discharge and covenant not to sue Linfield College, its officers, agents and employees all of which are hereinafter referred to as “releasees,” from any and all liability to me, my heirs, or next of kin for any and all claims, demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasees or otherwise.

I understand that there will be times when I will not have the immediate and full attention of a certified athletic trainer.

I have read and understand the content of the waiver and release and sign voluntarily. The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family. _____ [initial]

F. AUTHORIZATION:

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Linfield College. _____ [initial]

Signature

Date

Parent/Guardian Signature (if under 18 years old)

Date

2011-2012 Linfield College Athletic Training Insurance Information Form

GENERAL INFORMATION (Please print)

Name: _____ Age: _____ Sport(s): _____
Last First M.I.
Date of Birth (mo/day/yr): _____

_____ Please check here if you will purchase the school's insurance. (If yes, complete question 6)
If you will be covered by your own or your parents' health insurance, continue with #1 below.

1.	
Insurance Company: _____	
Address: _____ _____	Phone Number: _____
Principal Member: _____	Date of Birth: _____
Employer: _____	
Policy Number: _____	Group Number: _____

2. What type of insurance plan do you have?
_____ HMO (complete questions 3 and 6)
_____ PPO or Point of service plan (complete questions 4, 5, and 6)
_____ Other: please specify _____ (complete questions 4, 5, and 6)

3. **If an HMO plan**, please provide the name, address, and phone number of your primary care physician:
Name: _____
Address: _____ Phone number: _____

4. **If a PPO plan, Point of service plan or other**, are the following Linfield team physicians preferred providers (i.e., qualify for maximum reimbursement) within your insurance plan? (Information can be obtained by calling insurance provider's customer service number or visiting insurance provider's web site)

_____ Dr. Peter Van Patten (Orthopedics) _____ Dr. Greg Gramstad (Orthopedics)
_____ Dr. Elizabeth Ackerman (Orthopedics) _____ Dr. Scott Schieber (Family/General Practice)

5. **If none of the above are approved providers**, please supply a name and phone number of an approved physician in the greater McMinnville area you wish to see in the event of an athletic injury:
Name: _____
Address: _____ Phone number: _____

6. Other (Secondary) Insurance (if applicable) :

Insurance Company: _____	
Address: _____ _____	Phone Number: 1-800- _____
Principle Member: _____	
Policy Number: _____	Group Number: _____

I affirm that the above coverage is currently in effect and will continue to be in effect through the end of the academic year. If my insurance status should change for any reason, I will notify the college immediately.
My signature below verifies that my health insurance policy provides a minimum of \$15,000 coverage for athletic injuries.

Signature of student or parent Date

EMERGENCY INFORMATION 2011-2012

Athlete Name _____ Sport(s) _____
Last First MI

Birthdate _____

College Address _____ Cell Phone (____) _____

Allergies to medications (list) _____

Previous surgeries _____

Emergency Contact Person's Name _____

Work Phone (____) _____ Home or Cell Phone (____) _____

INSURANCE INFORMATION

IMPORTANT NOTICE: Please attach a copy of your insurance card (front and back), along with prescription card, if separate.

Medical Insurance Co. _____

Address _____

Primary or Secondary? (please circle one) Phone # (____) _____

Policy # _____ Group # _____

Principal Member _____ Birthdate _____

Employer _____

Work Phone (____) _____ Cell Phone (____) _____

Address _____

City _____ State _____ Zip Code _____

E-mail _____

MEDICAL CONSENT FORM

CONSENT TO ADMINISTER MEDICAL TREATMENT

I, the undersigned, hereby authorize Linfield College Sports Medicine Staff to act for me according to their best judgment for administering first aid and for securing professional medical service which they deem necessary.

(Full name of athlete) _____ a participant on the

_____ athletic team(s).

Date _____

Signature of Parent or Guardian of Athlete (if minor)

And/Or

Signature of Legally Independent Athlete