

LINFIELD COLLEGE

Department of Health, Human Performance, and Athletics

May 1, 2011

Dear Student-Athlete,

Welcome back to the Linfield College Intercollegiate Athletics program! We are looking forward to seeing you again 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 the continuance of 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. A physical examination is only required the year you enter the intercollegiate program at Linfield College. We will provide a free annual health appraisal the subsequent years that you participate.

Since this is not your first year in the athletics program at Linfield College, you will be given a health appraisal. **You do not need to get a physical examination from your physician.** However, if a medical condition is detected during the appraisal, you will be referred to a physician for further evaluation. The medical evaluation by a physician will be your financial responsibility.

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 6 and 7 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.**

Your coach will let you know when you are required to report for your annual health appraisal **in May**.

Be sure to bring the following completed information with you:

- General Information
- Emergency Contact Information
- Immunization Records Update
- Sickle Cell Trait Report
- Annual Health Appraisal
- 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

Linfield College

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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)

IMMUNIZATIONS RECORDS UPDATE:

Please list any immunizations or boosters you have had in the last year.

SICKLE CELL TRAIT SCREENING REPORT:

Based on recommendation from the NCAA and the National Athletic Trainers Association, Linfield College advises student-athletes to ensure that they provide accurate information concerning Sickle Cell Trait, which is typically screened in infants. All student-athletes are required to be tested for Sickle Cell Trait. No student-athlete will be precluded from participation due to result. **Failure to provide the date and result of a Sickle Cell Trait will result in the student-athlete not being medically cleared to participate.**

Test Result: POSITIVE NEGATIVE

Date of Test: _____

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: () _____

LINFIELD COLLEGE ATHLETICS ANNUAL HEALTH APPRAISAL

Name _____ Date of Birth _____

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

Medical History Update	Y	N	Comments
Do you have any ongoing or chronic illness/injuries?			
Are you currently taking any prescription or non-prescription (OTC) medications or using an inhaler? Please list			
Did you have any illnesses during the 2010-11 academic year?			
Were you hospitalized during the 2010-11 academic year?			
Did you have any injuries during the 2010-11 academic year?			
Did you have a head injury or concussion during the 2010-11 academic year?			

Females Only	Comments
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 ones that have occurred in the last year.

Athlete's signature: _____ Date: _____

- Follow up with ATC
- Follow up with PT
- Refer to Student Health Center
- Refer to Team Physician
- Refer to _____

Evaluations and recommendations: _____

ATC signature: _____ Date: _____

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 2011-12 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

