ATHLETIC PARTICIPATION MEDICAL PACKET

Dear Weatherford College Athlete,

A new year of Weatherford College Athletics is quickly approaching. I hope this letter finds you healthy and looking forward to the new athletic season.

Enclosed in this packet are forms that must be returned to the Department of Sports Medicine before you are eligible to participate in Weatherford College Athletics. These forms will be reviewed for completeness by the Head Athletic Trainer and/or Team Physician upon receipt.

1. **Medical History Questionnaire**
    - **a.** Ensure that all the questions are answered to the best of your knowledge.
    - **b.** Please attach any relevant medical information along with this form (including releases to participate)
2. **Medical Consent & Authorization to Release Medical Information**
    - **a.** Must be signed by athlete and parent/guardian (if under 18yrs).
    - **b.** It is important that there be consent to release health information between health care professionals regarding only those injuries/conditions that may directly affect the athlete's performance and safety in Weatherford College Athletics. However, you may choose to exclude other parties (such as the media etc.) from the consent form. If you and/or your parent/guardian (if under 18yrs) and/or your child choose to exclude certain parties, please include a signed letter with the consent form to the Head Athletic Trainer.
3. **General Information/Emergency Contacts & Insurance Information**
    - **a.** Must be completely filled out
    - **b.** Please attach a copy of the primary's insurance card (front and back), if applicable
    - **c.** Make sure you or your parent/guardian sign the form under "Insurance Information"
    - **d.** If you are not covered under any insurance policy, you will need to complete the "Affidavit of No Insurance."

All of the above-mentioned forms MUST be completed before you are authorized to participate in any organized team activity (games, practices, conditioning sessions, etc.).

If you have any questions or concerns, please feel free to contact me at (817) 598 - 8830. We look forward to a great year.

Sincerely,
Chris Nelson MS, ATC, LAT
Head Athletic Trainer
Weatherford College
cnelson@wc.edu

General Medical History

Please answer all of the following questions to the best of your knowledge. Please explain any conditions that have been marked "yes" in the space provided. Provide additional sheets or paperwork as needed.

FAMILY HISTORY

HAS ANY BLOOD RELATIVE EVER BEEN DIAGNOSED WITH THE FOLLOWING:

CANCER	YES	NO
TUBERCULOSIS	YES	NO
DIABETES	YES	NO
EPILEPSY	YES	NO
HAY FEVER OR SEASONAL ALLERGIES	YES	NO
ASTHMA	YES	NO
DEPRESSION	YES	NO
INSANITY	YES	NO
SUICIDE ATTEMPTS	YES	NO
STROKE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
MARFAN'S SYNDROME	YES	NO
ARRHYTHMIA (HEART MURMUR)	YES	NO
HEART CONDITIONS	YES	NO
(INCLUDING LONG QT SYNDROME OR HYPOTROPHIC CARIDOMYOPATHY)	YES	NO
DIED OF HEART CONDITION OR SUDDEN DEATH UNDER 50 YEARS OLD	YES	NO

EXPLAIN:____

____

ARE YOU CURRENTLY ON ANY MEDICATION? IF YES, PLEASE LIST WITH GENERAL PURPOSE:

____

____

HAVE YOU HAD SURGERY? IF YES, PLEASE SPECIFY:

____

____

HAVE YOU BEEN ADVISED TO HAVE ANY SURGERY, WHICH HAS NOT BEEN DONE? IF YES, PLEASE SPECIFY:

____

____

HAVE YOU RECENTLY BEEN HOSPITALIZED (LAST 2 YEARS)? IF YES, PLEASE SPECIFY:

____

____

General Medical History

General Medical

Have you ever experienced or been diagnosed with the following:

Sickle cell trait	Yes	No
Asthma	Yes	No
Diabetes	Yes	No
Headaches (general)	Yes	No
Migraines	Yes	No
Fainting	Yes	No
Neck Injuries	Yes	No
Dizziness	Yes	No
Nosebleeds	Yes	No
Seizures	Yes	No
Concussion	Yes	No

1. If yes, how many? ___________________
2. When? ______________________________

Explain:

____

____

Allergies

Are you allergic to:

Penicillin or sulfa	Yes	No
Aspirin	Yes	No
Mycins or other antibiotics	Yes	No
Tetanus antitoxin/serums	Yes	No
Insect stings	Yes	No
Quinine	Yes	No
Codeine	Yes	No
Foods	Yes	No
Adhesive tape	Yes	No
Other	Yes	No

____

I attest that the above mentioned information is complete and accurate. ***Failure to provide information regarding any pre-existing condition or injury may result in full liability, to the athlete, for costs related to treatment.***

______________________________	______________________________	______________
Printed Name of Athlete	Athlete Signature	Date
______________________________	______________________________	______________
Printed Name of Parent/Guardian *(If Athlete is under 18 yrs.)*	Parent/Guardian Signature	Date

Orthopedic History

Please provide details of any previous orthopedic injuries you have suffered. Include date, type of surgery, right or left (if applicable), any surgical procedures and/or special test (MRI, CT, Bone Scan, etc).

UPPER EXTREMITIES

HEAD (INCLUDING EARS, TEETH, NOSE AND EYES, FACE): ____________________________________

____

NECK:

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CHEST:

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SHOULDERS:

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ARMS:

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ELBOWS:

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FOREARMS:

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WRISTS:

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HANDS (INCLUDING FINGERS):

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Orthopedic History

LOWER EXTREMITIES

SPINE:

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HIPS:

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THIGHS:

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KNEES:

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LOWER LEGS (CALVES & SHINS):

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ANKLES:

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FEET (INCLUDING TOES):

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____

I attest that the above mentioned information, regarding injuries that are orthopedic in nature, is complete and accurate. ***Failure to provide information regarding any pre-existing condition or injury may result in full liability, to the athlete, for costs related to treatment.***

Printed Name of Athlete	Athlete Signature	Date
Printed Name of Parent/Guardian *(If Athlete is under 18 yrs.)*	Parent/Guardian Signature	Date

Medical Consent

I hereby grant permission for qualified Weatherford College Athletic Training Staff and/or Team Physicians to render my son/daughter, or myself, any medical treatment or care as deemed necessary. This includes preventative care, first aid, rehabilitation and emergency care. Also, I grant permission for my son/daughter, or myself, to be hospitalized if deemed reasonably necessary.

The Head Athletic Trainer and/or Weatherford College coaching staff will notify parents/guardians or the emergency contact if such an emergency situation occurs.

Printed Name of Athlete	Athlete Signature	Date
Printed Name of Parent/Guardian *(If Athlete is under 18 yrs.)*	Parent/Guardian Signature	Date

Authorization To Release Medical Information

I hereby authorize qualified Weatherford College Athletic Training Staff and/or Team Physicians to release medical information about my son/daughter (if under 18 yrs), or myself, to my parents and/or coaches, including information concerning illness or injuries relative to past, present or future participation in Weatherford College Athletics. I also authorize previous or current health care providers to release my medical information to qualified Weatherford College Athletic Training Staff.

Printed Name of Athlete	Athlete Signature	Date
Printed Name of Parent/Guardian *(If Athlete is under 18 yrs.)*	Parent/Guardian Signature	Date

General Information

STUDENT NAME ______________________________________ DATE OF BIRTH ___/___/___

SPORT(S) ____ SSN# ____________________

PERMANENT ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: _______________________________ CELL PHONE: ________________________

EMERGENCY CONTACTS

FATHER/GUARDIAN'S NAME: ____

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ______________ CELL PHONE: ______________ OTHER PHONE: ____________

MOTHER/GUARDIAN'S NAME: ____

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ______________ CELL PHONE: _______________ OTHER PHONE: ___________

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN): _________________________________

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ______________ CELL PHONE: ______________ OTHER PHONE: ____________

Insurance Information

*Weatherford College medical insurance provides medical coverage for any injury/illness that is directly related to the athlete participating in Weatherford College Athletics. This insurance is **"EXCESS"**, meaning that claims are only paid by Weatherford College **AFTER** the athlete's primary insurance has been billed. Please complete the following information, as applicable. Include an **enlarged copy (front and back)** of the Primary's insurance card and prescription card. If you have NO insurance coverage continue to the Affidavit of No Insurance.*

STUDENT'S NAME: ______________________________ STUDENT'S SSN: ___________________

□ **MY CHILD IS NOT COVERED BY INSURANCE** □ **MY CHILD IS COVERED BY INSURANCE BELOW**

PRIMARY INSURANCE COMPANY: _____________________ POLICY/GROUP #: _________________

PRIMARY INSURED NAME: ___________________________ PRIMARY SSN#: _________________

PRIMARY ADDRESS: ____

CITY/STATE/ZIP: ____

EMPLOYER: ____

HOME PHONE: ______________ CELL PHONE: _______________ WORK PHONE: _______________

PARENT SIGNATURE: _____________________________________ DATE: ___________________

SECONDARY INSURANCE COMPANY: _____________________ POLICY/GROUP #: ______________

SECONDARY INSURED NAME: ___________________________ SECONDARY SSN#: _____________

SECONDARY ADDRESS: ____

CITY/STATE/ZIP: ____

EMPLOYER: ____

HOME PHONE: ______________ CELL PHONE: _______________ WORK PHONE: _______________

PARENT SIGNATURE: _____________________________________ DATE: ___________________

Affidavit of NO Insurance

NAME: ____ SSN: ____________________

ADDRESS: ____

CITY/STATE/ZIP: ____

HOME PHONE: ____________ CELL PHONE: _____________ WORK PHONE: _____________

I, THE UNDERSIGNED, CERTIFY THAT:

1. I HAVE NO INSURANCE, OR ANY OTHER TYPE OF ACCIDENT OR HEALTH PLAN UNDER WHICH I AM COVERED.
2. ALL THE INFORMATION LISTED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.
3. **I UNDERSTAND THAT I MAY BE HELD RESPONSIBLE FOR CERTAIN COSTS INCURRED IN THE MEDICAL TREATMENT OF MY SON/DAUGHTER OR MYSELF DUE TO THE LACK OF PRIMARY INSURANCE.**

______________________________	______________________________	______________
Printed Name of Athlete	Athlete Signature	Date

______________________________	______________________________	______________
Printed Name of Parent/Guardian *(If Athlete is under 18 yrs.)*	Parent/Guardian Signature	Date