Warner University Sports Medicine
ATHLETIC PARTICIPATION MEDICAL CLEARANCE PACKET

Dear Student-Athletes and Parents,

Welcome to Warner University Athletics. We hope that you are looking forward to competing for Warner University in the upcoming year. The purpose of this letter is to inform you of some very important information for the school year.

All student-athletes are required, by law, to possess primary health insurance coverage prior to participating in any athletic event (workouts, conditioning, practices, games, etc.) sponsored by Warner University. The insurance policy must cover injuries that occur during an athletic event.

Warner University has purchased an "excess" policy to assist student-athletes with medical bills that are a direct result of an injury suffered during a school sponsored athletic event. It is important that you understand that this insurance policy will only become active after the student athlete's primary insurance has fulfilled its responsibility. At that point, the excess policy will pick up the balance at 100% of usual and customary charges within the terms of the policy. The excess policy will not pay for co-pays or deductibles as they are the responsibility of the primary policy holder (parent/guardian/student-athlete).

All injuries that occur from a direct result of an intercollegiate athletic event must be reported to the Athletic Training staff immediately. This allows the staff to perform an evaluation and referral, if necessary, to the appropriate physician. The Athletic Training staff is responsible to report all injuries with the school's insurance company. Costs pertaining to an injury that are not reported in a timely manner may be the responsibility of the student-athlete and/or the student-athlete's parent/guardian. Any financial obligation from medical treatments received *without* an Athletic Trainer's authorization will be the responsibility of the student-athlete.

All student-athletes must have the following forms filled out completely and turned into the Athletic Training Department before he/she will be cleared to participate in any Warner University athletic event:

- Athletic Participation Medical Clearance Packet (this form)
- Personal Information/Emergency Contact form
- Health Insurance Information/Authorization form
- **Copy (front and back) of primary health insurance card**
- HIPAA Release form
- Pre-Participation Physical Evaluation – History form (completed by student-athlete and parent if student-athlete is a minor)
- Pre-Participation Physical Evaluation – Physical form (completed by MD or DO office ONLY)
- Warner University Athletics Drug Testing form
- NAIA Drug Testing form
- Assumption of Risk form
- Athletic Pre-Participation Eligibility Statement
- Completion Checklist

Sincerely,

David Jantz, Med, ATC, LAT
Warner University
Head Athletic Trainer

Please sign and date below that you read and understand this letter.

Student-Athlete____ Date_____/_____/_______

Parent/Guardian)____ Date_____/_____/_______
(If student-athlete is under 18)

Warner University Sports Medicine
PERSONAL INFORMATION/EMERGENCY CONTACT FORM

PERSONAL INFORMATION

Athlete's Name____
First Last Middle Initial

Social Security #______-______-______

Year (check) _____Freshman _____Sophomore _____Junior _____Senior

Date of Birth______/______/_________ Sex (check) _____Male _____Female

Sport(s)____

____

Permanent Address____
Street

____
City State Zip

Local Address (Check one)

☐ Same as permanent address

☐ Campus housing

Dorm Name and Room #____

☐ Different from permanent address

____
Street

____
City State Zip

Cell phone #____

Preferred email (if different from school email)________________________________

EMERGENCY CONTACT INFORMATION

Name____

Relationship____

Cell phone #____

Address____
Street

____
City State Zip

Warner University Sports Medicine
HEALTH INSURANCE INFORMATION/AUTHORIZATION

Athlete's Name________________________________ SS#_________________________________

Sex (circle)   Male   Female   Date of Birth____/____/______ Sport_____________________

Home Address____
Street City State/Zip

Insurance Policy Holder's Name____
First Last Middle Initial

Insurance Policy Holder's Date of Birth____/____/_____ SS#_____________________________

Insurance Policy Holder's Phone #_____________________________

Insurance Policy Holder's Address____
Street

____
City State Zip

Insurance Company____

Insurance Company Claims Address____
Street

____
City State Zip

Insurance Company Member Services Phone#_______________________________________

Policy #___________________________________ Group #_________________________________

Plan ________________________________ Type (circle)   HMO   PPO   Other____________

Primary Care Physician__________________________ Phone #___________________________
Name

»»»»»» Copy front AND back of insurance card and attach to this form ««««««

- I/We hereby authorize Warner University, hospitals, and physicians connected with or provided services to furnish information to insurance carriers concerning any illness, injury and treatment and I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I/We agree to supply any and all information requested by my primary insurance, Warner University and their excess insurance company in a timely manner.
- I/We hereby authorize Warner University and their excess insurance company to secure and inspect copies of case history records, lab reports, diagnoses, X-rays and any other data pertaining to the injury/illness the aforementioned athlete is receiving care for or previous confinements or disabilities relevant to the care of the injury/illness.
- I/We agree to notify Warner University Athletic Training staff immediately upon any change in the above health insurance information. If I/We fail to do so, I/We fully understand that I/We may be responsible for any and all changes incurred.
- I/We hereby authorize Warner University's Athletic Trainers and/or coaches, to hospitalize and secure treatment for the aforementioned athlete for any athletic injury/illness and/or medical emergencies.
- A photocopy of this authorization shall be deemed as effective and valid as the original.

Policy Holder's Signature____ **Date**____/____/_____

Student-Athlete's Signature_______________________________________ **Date**____/____/_____

Warner University Sports Medicine
HIPAA RELEASE FORM

HIPAA stands for Health Insurance Portability and Accountability Act and was created to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, certified athletic trainers (ATC's) will not be able to speak to anyone in regard to an injury or condition unless a release is signed.

By signing below I, ___________________________________ **(print student-athlete's name)**, am allowing FULL disclosure of my personal health information in regard to any athletic injury I may sustain while participating in intercollegiate athletics at Warner University.

Any athletic injury may be disclosed to the following individuals/companies:

- Warner University Certified Athletic Trainers
- Warner University Coaches
- Warner University Administration/Student Services
- Warner University's insurance company
- Student-athlete's personal primary insurance company
- Student-athletes personal physician(s) and their office staff
- Student-athlete's parent/guardian

A photo-static copy of this consent form shall be deemed as effective and valid as the original. This release form shall remain effective unless revoked by me in writing.

Student-Athlete's Signature___________________________________ **Date**_____/_____/_______

Parent/Guardian Signature___________________________________ **Date**_____/_____/_______
(If student-athlete is under 18)

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ________ Age ________ Grade ________ School ________________ Sport(s) ________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name ____ Date of birth ________________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

**Please wait until July to complete your physical
** Physicals must be done by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA) or a Nurse Practitioner (NP/APRN)

EXAMINATION		
Height Weight ❑ Male ❑ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ❑ Y ❑ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. [b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

❑ Not cleared

- ❑ Pending further evaluation
- ❑ For any sports
- ❑ For certain sports

Reason ____

Recommendations ____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ____ Date ______________

Address ____ Phone ______________________

Signature of physician ____, MD or DO

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Warner University Sports Medicine
ATHLETICS DRUG TESTING POLICY

Warner University is committed to the best-interests of its student-athletes. A part of this commitment is a desire to ensure that athletes compete fairly and avoid making decisions that could lead to unnecessary physical, emotional, or spiritual harm to themselves. This is the reason for the drug testing policy.

All student-athletes participating as an active member in a Warner University athletic program are subject to random drug testing. The test will be administered by Warner University's Sports Medicine staff and must be completed within 24 hours of notification. Failure to report for testing will be considered a positive result. A result that is "non-negative" will be shipped to a lab for verification. Once the test is completed and the lab results returned, they will be forwarded to Warner University Administration. The student-athlete will then be notified of the results. A positive result is defined as a finding of a drug that is not prescribed by a physician. Positive results will be reported to the following personnel: the student-athlete, the Head Coach, the Athletic Director and the Dean of Students.

By accepting admission to Warner University, a student-athlete agrees to the terms of this drug testing policy and consents to any tests conducted pursuant to this policy. If a student-athlete withdraws that consent by refusing to take a random drug test, such refusal could result in an immediate termination of athletic participation.

THE UNDEERSIGNED STUDENT-ATHLETE ACKNOWLEDGES AS FOLLOWS:

I have received a copy and understand this drug testing policy.

As a condition of participation in an athletic program, I give my consent to any random drug testing done in pursuant to this policy.

Print Name____

Student-Athlete Signature__________________________________ **Date**_____/_____/_______

Parent/Guardian Signature_________________________________ **Date**_____/_____/_______
(If student-athlete is 18 or under)

NAIA Official Student Consent Form

A. Requirement to Sign Drug-Testing Consent Form

1. Name of Institution: ____

2. Name of student-athlete: ______________________________________ Sport(s): ________________

3. You must sign this form to participate in any NAIA National Championship competition. This includes but is not limited to Opening Rounds and Final Sites. If you have any questions, you should discuss them with your director of athletics.

B. Consent to Testing

1. You agree to allow the NAIA to test you in relation to any participation by you in any NAIA national championship or invitational competition. Examples of drugs in each class can be found at www.naia.org/wellness. Note: There is no complete list of banned substances. Check the NAIA Drug Free Sport AXIS for questions about supplements, medications and banned drugs.

C. Consequences for a Positive Drug Test

1. By signing this form, you affirm that you are aware of the NAIA drug-testing program, which provides:

2. A student-athlete who tests positive for use of a banned substance as defined by the NAIA banned-drug classes list, shall be sanctioned as outlined below:
   a. A student-athlete's first offense for testing positive for the use of any banned drug shall be immediately suspended from further competition in any sport; and
   b. The period of suspension will be for a minimum of 365 days from the date of the specimen collection that lead to the positive test result; and
   c. The student-athlete shall be charged one season of competition in all sports because of the positive test result.
   d. A student-athlete testing positive a second time for the use of any banned drug shall lose all remaining NAIA regular season and post-season eligibility in all sports.
   e. Individual placings and honors earned at the national championship at which the positive test occurred shall be vacated.
   f. Team championships will be determined by the National Drug Testing and Education Committee.

D. Signatures

1. By signing below, I consent:
   a. To be tested by the NAIA in accordance with NAIA drug-testing policy, which provides among other things that I will be notified of selection to be tested;
   b. I must appear for NAIA testing or be sanctioned for a positive drug test; and my urine sample collection will be observed by a person of my same gender;
   c. To accept the consequences of a positive drug test;
   d. To allow my drug-test sample to be used by the NAIA drug-testing laboratories for research purposes to improve drug-testing detection; and
   e. To allow disclosure of my drug-testing results only for purposes related to eligibility for participation in NAIA competition.

I understand that if I sign this statement falsely or erroneously, I violate NAIA legislation on ethical conduct and will jeopardize my eligibility.

______________________ ____
Date Signature of student-athlete

______________________ ____
Date Signature of parent (if student-athlete is a minor)

______________________________________ ________________ ________
Name (please print) Date of birth Age

____
Home address (street, city, state and zip code)

____
Sport(s)

Warner University Sports Medicine
ATHLETIC ASSUMPTION OF RISK

WARNER UNIVERSITY ATHLETICS' STATEMENT OF WARNING, AGREEMENT TO OBEY INSTRUCTIONS, RELEASE, ASSUMPTION OF RISK AND AGREEMENT TO HOLD HARMLESS

ALL ATHLETES *MUST* READ THE FOLLOWING STATEMENT AND SIGN:

- I am aware playing or practicing to play/participate in any sport can be a dangerous activity involving MANY RISKS OF INJURY.
- I understand that the dangers and risks of playing or practicing to play/participate in the above sport include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury or impairment to other aspects of my body, general health and well-being.
- I understand the dangers and risks of playing or practicing to play/participate in the any sport may not only result in serious injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life.

Due to the dangers of participating in a sport, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and to agree to obey such instructions.

In consideration of Warner University permitting me to try out for the Warner University Athletic Department's ____________________**(indicate sport team)** team and to engage in all activities related to the team, including but not limited to – trying out, practicing, or playing/participating in that sport, I hereby assume all risks associated with participating and agree to hold Warner University, the Florida Board of Education, and the State of Florida, as well as its' employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the Warner University ____________________**(indicate sport team)**.

The terms of this document shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Student-Athlete Signature__________________________________ **Date**____/____/______

Parent/Guardian Signature__________________________________ **Date**____/____/______
(If student-athlete is under 18)

Warner University Sports Medicine
ATHLETIC PRE-PARTICIPATION ELIGIBILITY STATEMENT

Athlete's Name____ **DOB**_____/_____/_______

STUDENT AGREEMENT (regarding conditions for participation):

I state that I have completed all parts of the Pre-Participation Physical Evaluation – History form which requires me to list all previous injuries or additional conditions known to me which may affect my performance or participation in conditioning, training, or treatment and I certify that it is correct and complete.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student-athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of the University and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules at the University and the laws of my community, state, and country.
- I agree to notify University authorities of any injury resulting from my athletic participation and activities while a student-athlete.

By signing below, I affirm that I have read, completed, signed where required, and understand all of the Athletic Participation Medical Clearance forms.

Signature____ **Date**_____/_____/_______

Parent/Guardian Signature___________________________________ **Date**_____/_____/_______
(If student-athlete is 18 or under)

Warner University Sports Medicine
COMPLETION CHECKLIST

ATHLETIC PARTICIPATION MEDICAL CLEARANCE PACKET COMPLETION CHECKLIST:

☐ Read and signed Athletic Participation Medical Clearance Letter to parents and student-athletes

☐ Completed the Personal Information/Emergency Contact form

☐ Completed Health Insurance Information/Authorization form

☐ Included a copy (front and back) of primary health insurance card

OR ☐ I have sent a picture and/or scanned a copy of my primary health insurance card to David Jantz, Head Athletic Trainer, at david.jantz@warner.edu

OR ☐ I do not have primary health insurance

☐ Read and signed the HIPAA Release form

☐ Completed the Pre-Participation Physical Evaluation – History form

☐ Included the Pre-Participation Physical Evaluation – Physical form (completed by MD or DO office only)

☐ Read and signed the Warner University Drug testing form

☐ Read and signed the NAIA Drug testing form

☐ Read and signed the Assumption of Risk form

☐ Read and signed the Pre-Participation eligibility Statement

☐ Read and signed the Completion Checklist (this form)

I, ____**(Print Name)**, have completed the above paperwork, I have read, understood and signed all forms and have my parent/legal guardian's signature if under the age of 18. I confirm that all information is accurate and up-to-date. If any information (contact information, address, phone number, insurance coverage, etc.) changes during the school year, I am responsible for turning the information into the Athletic Training Department personally. I also understand that any misrepresentation of the above information can result in disqualification or revocation of scholarship funds and releases Warner University from any financial obligations even if I am injured during a school sponsored athletic event.

Student-Athlete Signature____________________________________ **Date**_____/_____/_______

Parent/Guardian Signature____________________________________ **Date**_____/_____/_______
(If student-athlete is under 18)