Dear Student-Athlete/Parent/Guardian,

Please review all the forms in this packet. Each of the form contains information important to the student-athlete. Forms are located on the front and back of each page. Please complete, sign and date each form. **Please return forms to MVC Athletic Training only!**

Please review the forms for completeness. Incomplete forms or information found to be incomplete are unacceptable. Student-Athletes will not be allowed to practice or compete until all the information is provided.

PLEASE HAVE THE FOLLOWING FORMS COMPLETED AND RETURNED BY
AUGUST 1, 2005

ALL STUDENT-ATHLETES:

A. Assumption of Risk
B. Buckley Amendment
C. Drug Testing Consent
D. Family Insurance Notification
E. General Physical Examination (completed by family MD, DO, PA, NA only)
F. Insurance Notification
G. Insurance Travel Form
H. Medical History Forms
I. Permission to Provide Medical Treatment
J. Permission to Share Medical Information
K. **Xerox Copy of Health Insurance Card (Front & Back)**

Mail or Fax Completed Forms to:

MVC Athletic Training
500 E. College
Marshall, Missouri 65340
Fax (660) 831.4038

Please address any of your questions to: MVC Athletic Training - 660.831.4195

Thank you for your cooperation!

2005-2006

MISSOURI VALLEY COLLEGE
DEPARTMENT OF ATHLETICS
MEDICAL HISTORY FORM

Name:_____ Today's Date:____/____/____
Last First Middle

SSN: _____-____-_____ Birthday: ____/____/_____ Age:_____ Sex: M F

Sport: _____ Year in College: Fr. So. Jr. Sr. 5yr Sr. Height: _____ Weight: _____

Father's Name: _____ Home Phone Number: ( )_____

Father's Work Phone Number: ( )_____

Mother's Name: _____ Home Phone Number: ( )_____

Mother's Work Phone Number: ( )_____

Permanent Address (Home): _____
Street City State Zip

School Address & Phone Number_____
Street City State Zip Phone

Allergies to Medications: _____

Medications are you are currently taking: _____
_____

Please answer **all** questions and fill in the blanks. If a particular question does not apply to you, answer NA. For your benefit, be as complete as possible. Please include all information pertinent to your medical history. This information will be kept in your confidential medical file.

Disease and Illness

Yes No 1. Have you ever been treated for infectious mononucleosis, viral pneumonia, or any other infectious diseases in the past two years? If yes, what condition and when? _____

Yes No 2. Have you ever experienced an epileptic seizure or been diagnosed with epilepsy? If yes, the date of your last seizure. _____

Yes No 3. Have you ever been treated for diabetes? If yes, are you currently on medication? _____

Yes No 4. Do you have asthma? Is it exercise induced? Yes No If yes, do you require an inhaler for activity? Yes No If yes what brand? _____

Yes No 5. Have you had hepatitis in the past three years? If yes, when? _____

Yes No 6. Have you been treated for or diagnosed with scarlet fever? If yes, when? _____

Yes No 7. Have you been treated for or diagnosed with rheumatic fever? when? _____

Yes No 8. Have you ever been treated for or diagnosed with a heart condition? What, if any treatment was received: _____Are you currently taking any medication for this condition? Yes No If yes, what type_____. Are you currently under any restrictions? _____

Yes No 9. Have you had any illnesses requiring bed rest for one week or more during the past year? If yes, when? _____

Yes No 10. Have you ever been diagnosed with a hernia? Date _____

Yes No 11. Have you ever been diagnosed with iron deficiency or suffered from hemophilia? If yes, when. _____

Yes No 12. Have you ever been diagnosed with sickle cell anemia trait or been treated for sickle cell anemia? If yes, when. _____

Yes No 13. Have you ever had unexplained dizzy spells, or blackout? When _____

Yes No 14. Are you missing any internal organs? (i.e. Kidney, Spleen, testicle etc.) List any or all that apply. _____

Head and Neck Injuries

Yes No 1. Have you ever had a concussion? Dates_____ Were you totally unconscious? Yes No How many concussions have you had to date? _____

Yes No 2. Do you have a history of headaches? Do they require prescription medication? Yes No If yes, what type of medication?_____

Yes No 3. Have you ever injured your neck? Describe the injury. _____ were you seen by a physician? Yes No Hospitalized? Yes No

Yes No 4. Have you ever had a "stinger" or a "burner" in the neck or shoulders? Left Right Both Date(s)_____

Yes No 5. Have you ever had an injury involving the vertebral discs in your neck? Date(s) _____

Eyes – Ears – Dental

Yes No 1. Do you wear glasses? If yes, do you wear them during athletics? Yes No

Yes No 2. Do you wear contacts? Hard Soft Do you wear them during athletics? Yes No

Yes No 3. When was your last eye examination? _____Were there any visual problems found? Yes No If yes, please describe_____

Yes No 4. Do you have a hearing impairment? Left Right

Yes No 5. Do you wear any dental appliances? Braces Permanent Bridge Crown Partial Caps False Teeth Full Plate (Please Circle all that apply)

Upper Extremities and Back

Yes No 1. Have you ever dislocated, separated, or had any other shoulder injuries? Left Right Please describe w/ dates: _____

Yes No 2. Have you ever had shoulder surgery? Please describe w/ dates:_____ Were you released to participate in athletics? Yes No If yes, by whom (please include phone number) _____

Yes No 3. Have you ever sprained, strained, fractured, dislocated or otherwise injured either elbow? Left Right Describe and give dates: _____

Yes No 4. Have you ever injured your wrist? Please describe and give dates: _____ _____

Yes No 5. Have you ever jammed, dislocated, or fractured any bones of your hands or fingers? Left Right Describe and give dates: _____

Yes No 6. Have you ever injured your back? Describe and give dates: _____ _____

Yes No 7. Were you treated for this back injury? Did you see a physician? Yes No Did you see a chiropractor? Yes No Dates: _____

Yes No 8. Do you experience pain in your back after exercise or lifting? How often does this pain occur? _____

Lower Extremities

Yes No 1. Have you ever injured either hip? Left Right Describe and give dates: _____

Yes No 2. Have you ever "pulled" either hamstring? Left Right How many times? ___

Yes No 3. Have you ever injured the meniscus or cartilage in either knee? Left Right Describe and give dates: _____

Yes No 4. Have you ever injured the ligaments in either knee? Left Right Describe and give dates: _____

Yes No 5. If you answered Yes to either #3 and/or #4, were you seen by a physician? Yes No Did they advise surgery? Yes No If yes, give dates of surgery (if applicable) _____ Were you released for athletic participation? Yes No Give Dates: _____

Yes No

Yes No 6. Have you had any other problems with your knees or surrounding structures? Describe and give dates: _____

Yes No 7. Have you ever had shin splints or stress fractures in the lower leg? If yes , do they occur often? Yes No _____

Yes No 8. Have you ever experienced an ankle sprain of either ankle? Left Right Date(s) _____ Did this restrict your athletic participation? Yes No

Yes No 9. Have you had any other type of injury to either ankle? Left Right Describe and give dates: _____

Yes No 11. Have you ever had an injury to either foot? Left Right Describe and give dates: _____

Heat Related Illnesses

Yes No 1. Have you ever passed out during or after exercise?

Yes No 2. Have you ever been dizzy during or after exercise?

Yes No 3. Have you had chest pain during or after exercise? If yes, when_____

Yes No 4. Do you tire more quickly than your friends during exercise?

Yes No 5. Have you ever had high blood pressure?

Yes No 6. Have you ever been told that you have a heart murmur? If yes, explain _____
_____

Yes No 7. Have you ever had a racing pulse, or your heart skipped beats? If yes, explain
_____

Yes No 8. Has any one in your family died of heart problems or a sudden death before age 50? If so who, and what age? _____

Yes No 9. Have you ever had heat or muscle cramps?

Yes No 10. Have you ever been dizzy or passed out in the heat? If yes, when? _____

Yes No 11. Have you ever experienced heat cramps, heat exhaustion, or heat stroke? please circle, describe and give dates including location of occurrence and if hospitalization was required. If yes explain. _____
_____
_____

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Yes No 1. Do you have any skin problems? If so explain _____.

Yes No 2. Do you have trouble breathing or do you cough during or after activity.

Yes No 3. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?

Yes No 4. Have you had any problems with your eyes or vision?

Yes No 5. Do you wear glasses or contacts or protective eyewear?

Yes No 6. When was your last tetanus shot? _____

Yes No 7. When was your last measles immunization? _____

Yes No 8. Have you had any other operations, other than those listed above, in the past three years? If yes, describe and give dates _____
_____
_____

Yes No 9. Have you had any additional illnesses or injuries during the past three years? Describe and give dates_____
_____
_____

Yes No 10. Have you ever been advised by a physician not to participate in any form of athletics, on a permanent basis? Please describe and give dates. _____
_____
_____

Yes No 11. Is there any health or medical related problem that you feel needs to be disclosed in order to provide the best medical care possible? Please describe:
_____
_____
_____

Please Print Name _____ Date _____

Signature _____ Date _____

Guardian Signature _____ Date _____

2005-2006

General
Female Student-Athletes

All Information is Confidential

Yes No 1. Does your menstrual cycle occur: (monthly, twice a month, other). Please circle, please specify any irregularities:_____

Yes No 2. Have you ever missed more than three consecutive menstrual periods at any time? _____

Yes No 3. Have you ever missed your menstrual period for six consecutive months? Number of months missed _____

Yes No 4. Are you currently using birth control pills?

Yes No 5. Have you ever had a breast examination? Date of last examination _____

Yes No 6. Have you ever had a PAP smear? Date of last examination _____

Yes No 7. Has a physician ever diagnosed you with anorexia nervosa or bulimia?

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Pre-participation Physical Evaluation (Dr. portion)

Patient's name: _____

1. BP_____ WT_____ HT_____ Vision (R)_____ (L) _____
2. Cardiovascular Exam _____Normal _____Abnormal Comments:
3. Musculoskeletal Exam Record-laxity, weakness, instability, decreased ROM- if abnormal
   - Knee _____Normal _____Abnormal
   - Ankle _____Normal _____Abnormal
   - Shoulder
   - Other orthopedic problems (ex. Neck, foot, scoliosis, etc.) _____Normal _____Abnormal
4. Option Exam – should be done if history is positive. Comments:
   - ENT _____normal _____Abnormal
   - Chest
   - Abdomen
   - Genitalia
   - Skin
5. Assessment: A. _____No Problem identified B. _____Other

Clearance:

A. Cleared
B. Cleared after completing evaluation/ rehabilitation for: _____
C. Not cleared for : ____ Collision
   ____ Contact
   ____ Non-contact ____Strenuous
   ____ Moderately Strenuous ____Non-strenuous

Due to: _____

Recommendation(s):_____
_____

I certify that I have examined the above student athlete and that such examination revealed (____conditions ____no conditions) that would prevent this student from participation in interscholastic sports.

Are you licensed to practice medicine in the United States? ____Yes ____No

Print Name _____
Signature _____ Phone Number ( )_____
Address _____ Date _____

If student-athlete is not qualified, list reasons for disqualification: _____

(If following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, or ovary, etc.)

2005-2006

Missouri Valley College
Insurance Notification

The purpose of this form is to inform you of the health insurance policy that went into effect at Missouri Valley College in the Fall of 1996. Please read this entire letter carefully, sign it, and date it at the bottom. It is important that this letter be signed and dated by the Parent/ Guardian/Participant of the student-athlete. You(r) son/daughter will not be eligible to participate in athletics at MVC until this document is completed and handed in. If you have any questions, please call:

Tom Fifer- Director of Athletics	660.831.4219
Matthew C. Rowlett- Head Athletic Trainer	660.831.4195

Health Insurance Coverage Agreement

As the parent/ legal guardian/participant of _____, I understand that Missouri Valley College does not carry health insurance for their student-athletes. Therefore, I realize that **ALL** medical bills incurred as a result of my son/daughter participating in athletics at MVC are my responsibility.

I realize that it is mandatory for my son/daughter to be adequately covered by health insurance while participating in athletics at MVC. This health insurance policy that I have chosen, covers my son/daughter for accidents that occur from sports participation (broken bones, torn ligaments, dislocation, etc….). If I cancel or have my medical insurance discontinued for any reason, either voluntarily or involuntarily, I realize that all medical bills that may accumulate are still my responsibility and not the responsibility of MVC or its employees.

It is the responsibility of the Parent/Guardian/Participant to determine if the insurance the student-athlete is currently covered under **is** adequate for athletic participation **and** will cover the student-athlete in the state of Missouri at Missouri Valley College. Should the insurance not cover athletics or in the state of Missouri all medical bills will be the responsibility of the parent/guardian/participant.

The student-athlete must be covered during all participation of any type of sport/team related activity throughout the school year. This includes all pre-season, in-season, post-season and off-season activities that take place during the school year and season of the sport. If the student-athlete is not covered during any of this time, they will not be allowed to participate. Any injury incurred will not be the responsibility of Missouri Valley College. It is the recommendation by the MVC Athletic Training staff that the student-athlete be covered for all 9-10 months while at school.

I have read the above agreement and understand its contents.

Print Student-Athlete's Name _____
Signature of Student-Athlete _____
Sport of Student-Athlete _____

Print Parent/ Legal Guardian's Name _____
*Signature of Parent/ Legal Guardian _____
*Date Signed _____

2005-2006

Missouri Valley College
Athletic Department
Health Insurance Information

Missouri Valley College does not carry health insurance for any of its athletes. As a result, it is MANDATORY that all athletes carry insurance while participating in athletics at MVC. NO ATHLETE WILL BE PERMITTED TO PARTICIPATE WITHOUT PROOF OF HEALTH INSURANCE COVERAGE!

If your son/daughter is not currently covered by a health insurance policy, there are short-term health insurance policies available from insurance companies that will cover the student athlete during the school year. You are free to choose ANY health insurance company to adequately cover your child.

REQUIRED: 1) Complete the following form, DO NOT leave any lines blank. Incomplete or incorrect information will result in your son/ daughter being ineligible to participate until all the information has been complete.

2) Attach a copy of the front and back of the health insurance card the student-athlete is covered under.

If you have any questions, please contact the Head Athletic Trainer. This information is vital in case of an emergency or injury and could delay the treatment if filled out incorrectly. Please take time to fill out these and all forms completely and correctly.

1. Son/ Daughter's Name _____
2. Policy Holder's Name _____
3. Policy Holder's Social Security Number _____
4. Name of Health Insurance _____
5. Address of Health Insurance Co._____
   _____
6. Phone Number of Health Insurance Co. _____
7. Policy or ID# _____
8. Group or Certification # _____
9. Is this insurance company an: (Please Circle One) HMO PPO
10. If an HMO, please list Primary Care Physician's name and phone number_____
    _____
11. Emergency Contact Name and Number _____
    _____

Missouri Valley College
Insurance Travel Form

Student-Athlete Name: _____

Sport (s): _____

Age: _____ Birthdate: _____

SS #: _____

Local (School) Address: _____ Phone: _____

City: _____ Zip Code: _____ State: ___

Home Address: _____ Phone: _____

City: _____ Zip Code: _____ State: ___

Emergency Contacts:

Emergency Contact #1:

Name: _____

Phone: _____ Relationship: _____

Emergency Contact #2:

Name: _____

Phone: _____ Relationship: _____

Personal Information:

Allergies: _____

Medications: _____

Circle is any apply: Heart Murmur Diabetes Epilepsy

Contacts Retainers

Other Conditions: _____

Insurance Information:

Insurance Company: _____

Address: _____

Phone Number: _____ Circle: HMO/PPO/Other: _____

Policy Holder's Name: _____

Policy or Member ID #: _____ Group #: _____

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Missouri Valley College
Permission to Provide Medical Treatment

I, _____, hereby give my permission to undergo medical treatment for any injury or illness that may be sustained or acquired by me while engaged in intercollegiate athletics at Missouri Valley College or at any College or University in which Missouri Valley College will compete against, by Medical Personnel that is a representative at the College or University. I understand that the medical personnel will perform only those procedures that are within their training, credentials, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event that more serious medical procedures are required, such as surgery, I understand that every attempt will be make to contact my parent(s)/ guardian(s) for consent (if minor). I understand that if I suffer a potentially life-threatening injury or illness, and in the event that my parent(s)/ guardian(s) can not be reached within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had time to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment Agreement.

Student-Athlete Print Name _____

Student-Athlete Sign Name _____

Date _____

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Missouri Valley College
Permission to Share Medical Information

I, _____, do allow the Missouri Valley College Athletic Training Staff to discuss my Protected Health Information with my coaching staff and others when necessary, (see below). I understand that this information may be pertinent to the decision of participating that day during practice or competition.

The following is the type of information that may need to be discussed:

- Injuries
- Illnesses
- Rehabilitations
- Progress notes
- Past medical information that may affect participation status
- X-rays
- Test results

The following are the people this information may need to be discussed with:

- Coaches of the sport(s) I participate in
- Other athletic training staff members
- Students of the athletic training education program (all have signed confidentiality agreements)
- Team physicians
- Campus nurse
- Personal physician
- Athletic Director
- Professional teams – only after a waiver has been signed for that particular request
- Parents/Guardian and/or spouse
- HAAC/NAIA – in regards to eligibility status

I understand that by not signing this release, I will not be denied treatment for injuries, however it may affect my participation status for the coaching staff. Should I choose to revoke the permission to share medical information I must do so in writing. This authorization will expire one academic year from the date it is signed.

Student-Athlete Print Name _____

Student-Athlete Signature_____

Date_____

* This information will be handled in strict accordance with the Family Educational Rights and Privacy Acts of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The student-athlete will be granted a copy of this form upon release of medical information, or upon request at any time.

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Missouri Valley College
Assumption of Risk/Release of Liability

All blanks must be filled in – Sign and date at the bottom!!

I, _____, hereby acknowledge that I have voluntarily applied to participate in the college _____ program at Missouri Valley College (MVC).

I am aware that _____ can be a hazardous activity, and I am voluntarily participating in this activity with the knowledge of the dangers involved and hereby accept any and all risks of injury or even death.

As lawful consideration for being permitted by MVC to participate in this activity and use its facilities, I hereby agree that I, my heirs, distributes, guardians, legal representatives, and assigns will not make claim against, sue, attach the property of, or prosecute, MVC, any of its affiliated organizations, owners, officers, employees, agents, servants, or contractors as a result of my participation in this activity.

I hereby release MVC, its affiliated organizations, owners, officers, employees, agents, servants, or contractors from all of its action, claims, or demands, I, my heirs, distributes, guardians, legal representatives, or assigns now have or may hereafter have for injury or damage resulting form my participation in _____.

I realize the possibility that I may die, become paralyzed, or suffer brain damage or other serious injuries as a result of my participation in _____. I realize neither the protective equipment, the safety rules, the coaching instruction, nor the sports medicine care I am provided will guarantee my safety or prevent all possible injuries. It is the intention of the undersigned to exempt and relieve MVC and associated parties from liability for personal injury, property damage, and wrongful death.

Furthermore, I attest that I am physically fit and have sufficiently trained for _____. I do not have any medical history or conditions that may exclude me from participation in _____.

** I have carefully read this agreement and understand its contents. I am aware that this release of liability is a contrast between myself and MVC and its affiliates. I sign of my own free will.

Student-Athlete Print Name _____

Student-Athlete Sign Name _____

Date _____

2005-2006

Missouri Valley College Athletic Department
Buckley Amendment Consent

By signing this form, you certify that you agree to disclose your educational records.

You understand that this entire from and the results of any Missouri Valley College drug test you may take are part of your educational records. These records are protected by the Family Educational Rights and Privacy Act of 1974, and they may not be disclosed without your consent.

You give your consent to disclose only to authorize representatives of this institution, its athletic conference and the NAIA, the following documents.

- This form
- Results of MVC drug tests
- Any transcripts from your high school, this institution, or any junior college or any other four year institutions you have attended.
- Pre-college test scores and appropriately related information and correspondence (ex. testing sites and dates, letters of test score certification or appeal)
- Records concerning your financial aid
- Any other papers or information obtained by this institution pertaining to your NAIA eligibility.

You agree to disclose these records only to determine your eligibility for intercollegiate athletics, your recruitment by this institution, your eligibility for related financial aid and the Drug Free Schools Act.

Student-Athlete Print Name _____

Student-Athlete Sign Name _____

Date _____

Missouri Valley College
Drug Testing Consent Form

By signing this form, you certify that you agree to be tested for drugs at any time, for any reason during the academic school year.

You agree to allow Missouri Valley College (MVC) to test you for the banned drugs that are listed in the MVC Banned Drug List. This means that you agree to allow MVC to test on a year round bases for the banned drugs appearing on the MVC Banned Drug List, this list is in the student-athlete handbook and at the end of this packet. Additionally, you also agree to be tested for anabolic steroids, elevated levels of HGH, diuretics, urine manipulators, and any drug masking agent.

You understand that if you test positive, you will be responsible for the payment of the drug testing fee. If you test negative, the institution/team/sport will assume the cost of the fees.

You understand that if you test positive, you will be notified by the head athletic trainer, as well as an immediate suspension from participation in all athletics at MVC for a minimum of two weeks will notify you. You will be required to meet with the head athletic trainer and athletic director for further counseling. You understand that if you test positive you may be drug tested on a random basis for a period of one year. You understand that the head athletic trainer will maintain copies of your drug testing results. You understand that each individual coach may have higher standards for a positive drug test, and that a positive test will result in an application of those standards.

You understand that if you test positive a second time, you and your parent(s)/guardian(s) will be notified by the head athletic trainer. You will once again be responsible for the drug testing fee. In addition, the athletic director will contact the Campus Life Office and the Financial Aid Office regarding your drug test results. You understand that you will be suspended from participating in MVC athletics for a full academic year.

You understand that this consent and results of your drug test, if any, will only be disclosed in accordance with the provisions of the Buckley Amendment Consent.

You agree to disclose your drug testing results only for the purpose related to your eligibility, the federal government financial aid guidelines, and Drug Free Schools Act.

I have read the above MVC Drug Testing Consent Form and agree to abide by the MVC Substance Abuse Policy.

Student-Athlete Print Name _____

Student-Athlete Sign Name _____

Date _____