Schreiner University Pre-Participation Screening and Exam

Athlete Name: _____ Sport: _____

Date					
Height					
Weight					
Blood Pressure					
Pulse					
Vision-Right					
Vision-Left					

Physical Exam		**Normal**	**Abnormal Findings/Comments**
Skin/Appearance			
Head and Neck	Lymph Nodes		
	Thyroid		
Eyes	Pupil Equality		
	Pupil Reaction		
Ears			
Nose			
Mouth/Throat	Teeth		
	Tonsils		
Heart	Pericardial Activity		
	1^{st} and 2^{nd} sounds		
	Murmurs		
Pulses	Brachial/Femoral		
Lungs			
Abdomen			

Musculoskeletal	**Normal**	**Abnormal Findings/Comments**
Neck		
Back/Spine		
Shoulder/Arm		
Elbow/Forearm		
Wrist Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

_____Cleared _____Not Cleared Reason and/or Referral:

Physician Signature Date

Schreiner University
Primary Insurance Information
2017-2018

Athlete Name: _____
Last Name First Name M.I.
SSN#: _____ DOB: _____

Local/Cell Phone: _____ Sport: _____

Name and Address of Persons Providing Primary Insurance Coverage (Subscriber)

Name: _____
Last Name First Name M.I.
SSN: _____ **DOB**: _____

Home Address: _____
Address City State Zip
Home Phone: _____ **Cell Phone**: _____

Employer: _____ **Work Phone**: _____

Email: _____

Insurance Information

Insurance Company: _____ Phone #: _____
Insurance Co Address: _____
Address City State Zip
Policy #: _____Group #: _____

Does your insurance require a second opinion? Yes No

Does your insurance require pre-authorization for services Yes No

The University's insurance coverage is considered secondary to the athlete's or family's own medical benefit plan coverage. Therefore, it is necessary that claims be submitted to the athlete's personal, family or employer group medical benefit plan first so that the insurance company may contribute their maximum benefit first. Then, any costs not covered by the personal or family policy will be submitted to the Schreiner University athletic insurance carrier for consideration. Provided the claims are submitted within the 52 week time limit, and are **related to athletic injury while participating in Schreiner Athletics ONLY.**

*This information is for official athletic department use only, and will only be released to athletic department staff, university nurse, and medical consultants, orthopedic consultants, medical specialty consultants, clinics and hospitals you may be referred to by the Schreiner University Athletic Trainer.

I authorize Schreiner University or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

_____ _____
Athlete's Signature/Date **Signature of Policyholder/Date**

Example of how to place the copies of your primary insurance card

Copy of the front of your primary insurance card

Copy of the back of your primary insurance card

Schreiner University
Student-Athlete Information Form and Emergency Contacts
2017-2018

Personal Information:

Athlete Name:

_____

Last Name First Name M.I.

SSN#_____ **Sport**: _____

DOB: _____ **Gender**: **Male** **Female**

Campus/Local Address:

_____

Address City State Zip

Campus Email: _____

Cell Phone/Local Phone: _____

Permanent Address:

_____

Address City State Zip

Home Phone: _____

Parent/Guardian Emergency Contact Information:

Primary Contact:
Name: _____ **Relationship**: _____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____ **Email:** _____

Secondary Contact:

Name: _____ **Relationship**: _____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____ **Email:** _____

Schreiner University
Pre-Participation Health History Questionnaire
2017-2018

Athlete's Name:_____

Sport:_____ **Academic Level (Fr, So, etc.):**_____

Allergies:

Agent	**Yes**	**No**	**Specific Agent and Reaction**
Medications			
Foods			
Pollens			
Other			

Medications:
List all medications you are currently on or have taken within the last year for a medical condition. These include any allergy, heart, asthma, ADHD, etc. medications.

Medication Name	**Are you taking this medication at the present time?**	
	Yes	No

Surgical History:
List any **non-orthopedic** surgeries you have had in your life. These include hernia, wisdom teeth removal, organ removal, corrective eye surgery, etc.

Type of Surgery	**Date**

Concussion History: Very Important!
Please list all concussions you have experienced both from participation in athletics or other causes.

Date	**Period of restriction from athletics**

Prior Medical Conditions:
Have you ever been told that you have any of the following conditions or experienced any of the following problems? Check ***ONLY*** those that apply to you specifically and explain positive responses in the space provided.

Condition	**Yes**	**Condition**	**Yes**	**Condition**	**Yes**
Anemia		High Blood Pressure		Fainting Episodes	
Arthritis		Kidney Stones		Chest Pain	
Asthma		Gout		Racing Heart Rate	
Bleeding Problems		Liver Disease		Urinary Infections	
Cancer		Lung Disease		Infectious Mononucleosis	
Diabetes		Migraines		Eating Disorder	
Eye Problems		Rheumatic Fever		Ovarian Cyst	
Hearing Loss		Stomach Problems		Vision Disturbance	
HIV		Thyroid Problems		Motor Vehicle Accident	
Hernia		Seizures			

Explanation:

Injury History:

Have you had any of the following orthopedic injuries?

(*Please detail those injuries in the space provided including any treatment, surgery, date of injury, and period of limited activity*)

	Yes		Yes		Yes
Ankle sprain		Arthroscopic Surgery		Rotator cuff injury	
Back Pain		Joint reconstruction		Bone Chip or spur	
Bursitis		Compartment Syndrome		Plantar fasciitis	
Fracture		Stress Fracture		Shin splints	
Knee Injury		Neck Injury		Joint dislocation	
Muscle strain		Tendonitis		Joint separation	
Joint Instability		Tendon, Joint or bursa injection			

Explanation:

Prior Medical Conditions II:

Have you been told that you have any of the following conditions? (*Please explain any positive responses including any testing or treatment dates and results*)

	No	If Yes, please explain
Attention Deficit Hyperactivity Disorder (ADHD)		
Heart murmur or other heart condition		
Sickle Cell Disease or Trait		
Single Kidney		
Single Testes		
Single Eye		
Heat Stroke		
Muscle Cramping		
Stinger/Burners		
Has a doctor ever recommended that you not participate in sports?		

Review of Symptoms:

Please indicate on the table below if you currently have any of the following symptoms.

Score	Never 0	Rarely 1	Occasionally 2	Daily 3	Frequently 4	Continuous 5
Symptom						
Blurred Vision						
Dizziness						
Drowsiness						
Easily Distracted						
Fatigue						
“Head in a Fog”						
Sluggish						
Headache						
Irritability						
Unstable Emotions						
Loss of Consciousness						
Disorientation						
Poor Memory						
Nausea						
Nervousness						
Personality Change						
Poor balance						
Lack of Coordination						
Poor concentration						
Ringing in ears						
Sadness						
Sensitivity to Light						
Sensitivity to noise						
Frequent awakening from sleep						
Vomiting						

Health Habits: Please answer all questions in the space provided

Dietary	What is your ideal body weight?			
	Are there any foods you avoid? (Check those that apply)		No food Avoided	
			Meats	
			Breads/Grains	
			Milk products/Cheese	
			Vegetables	
			Fruits	
			Other (specify)	
Tobacco	Have you ever smoked on a daily basis?		Yes	No
	Do you use smokeless tobacco?		Yes	No
Alcohol	Have you ever passed out while driving due to alcohol?		Yes	No
	Have you gotten into a fight or arrest while drinking?		Yes	No

Family History: Has any member of your close family (parents, brothers/sisters, aunts/uncles or cousins) had any of the following conditions? (Explain your answer in the space provided)

Condition	No	Yes with Explanation
Heart attack before age 50		
Angioplasty or Bypass Surgery before age 50		
Sudden or Unexplained death		
Collapse during physical activity		
High blood pressure		
Heart Murmur		
Valve replacement		
Marfan's Syndrome		
Seizure disorder or Epilepsy		
Asthma		
Sickle Cell Disease or trait		
Diabetes		
Depression		

Female Student-Athletes Only Section	Answer
How old where you when you started to menstruate?	
When was the start of your last menstrual cycle?	
Is your menstrual cycle regular and predictable?	
Have you ever gone more than 3 months without a cycle?	
Do you have significant pain or cramping with your cycles?	
Do you take oral contraceptives?	
When was your last Pap smear?	

For all Student-Athletes

By signing this form I verify that I am completing the information truthfully and to the best of my ability.

_____ _____

Athlete's Signature Date

If Athlete is under 18 years of age:

_____ _____

Parent's Signature Date

Schreiner University
Right to Confidentiality, Authorization to Release Medical Records, & Drug Testing Consent Form
2017-2018

Right to Confidentiality

In compliance of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Right to Privacy Act of 1974 (FERPA), also known as the Buckley Amendment, the Schreiner University Athletic Department makes the student-athlete aware of his/her right to privacy of medical records. In doing so, the Athletic Department requests permission to access medical records solely for the purpose of health care for the student-athlete. The Athletic Trainer is the only individual who has the authority to obtain personal medical records for the Athletic Department for student-athletes. These records will be filed in the Athletic Trainer's office and solely used in the interests of the student-athlete's health. By granting this request, you give the athletic trainer permission to access any and all records of injuries or illnesses prior to your attendance at Schreiner University that may disqualify you from participation in the athletics programs, and permission to access any records that occur as a result of injury or illness through participation in the athletics program or as a student at Schreiner University. Such access is requested in order to keep the student-athlete's health in the University's best interests. The student-athlete has the right to revoke this clause at any time while at Schreiner University, but he/she must do so in writing.

_____I DO give consent for Schreiner University athletics personnel to obtain medical records.

_____I DO NOT give consent for Schreiner University athletics personnel to obtain medical records.

Athlete Signature/Legal Guardian if under 18 years of age **Date**

Authorization to Release Medical Records

The Athletic Department also makes the student-athlete aware of his/her right to refuse the release of medical records in the athletic department's possession. This includes all records of injuries, illnesses, and treatments prior to attendance at Schreiner University, while a student at Schreiner University, or as a student-athlete at Schreiner University. The following are examples of entities in which the Athletic Trainer may be requested to release medical records to. Please check whom you would allow the release of you medical records.

Yes	No		Yes	No	
☐	☐	Team Physicians	☐	☐	Emergency Medical Personal
☐	☐	Family Physicians	☐	☐	Emergency Contacts on File
☐	☐	Athletic Trainers at Host Institutions	☐	☐	Insurance Providers (Personal/University)
☐	☐	Schreiner University Health and Wellness Center			

If the student-athlete chooses "no" to any of the above entities, the athletic trainer, as a representative of the athletic department, assumes the right to request the student-athlete to come in at a future date and alter decision. The student-athlete has the right to change or revoke this clause at any time while at Schreiner University, but he/she must do so in writing.

Athlete Signature/Legal Guardian if under 18 years of age **Date**

Drug Testing

The student-athlete verifies the knowledge of Schreiner University's drug testing policy and has received the list of NCAA banned substances.

Athlete Signature/Legal Guardian if under 18 years of age **Date**

Schreiner University
Indemnity and Hold Harmless Agreement and Release
And Authorization of Consent to Treatment
2016-2017

For and in consideration of the opportunity granted of the undersigned student to participate in the athletic programs of **Schreiner University**, the undersigned persons, _____, of **Schreiner University**, herein "STUDENT" joined herein by such student's parents or legal guardians, _____, herein "PARENT", each of whom are acting herein jointly and severally, do hereby release Schreiner University; and further do hereby agree to indemnify and hold Schreiner University, its officers, Trustees, directors, its employees, legal representatives, and assigns, harmless, from and against any and all damages arising from any injury, liability or loss which the STUDENT may sustain (i) as a result of such STUDENT'S participation in any and all athletic programs or events offered by or occurring in connection with Schreiner University, and (ii) which the STUDENT or the PARENT may sustain as a result of any claims, demands, costs, or judgments arising from such STUDENT'S participation in any such athletic programs or events on Schreiner University's property or elsewhere effective immediately.

Awareness of Risk: STUDENT and PARENT are totally aware (i) that STUDENT has been medically diagnosed with certain medical problems and (ii) that STUDENT'S participation in athletic programs and events could be hazardous to STUDENT'S health. Nonetheless, STUDENT and PARENT elect of their own free will for STUDENT to participate in such athletic programs. STUDENT and PARENT understand fully the danger of any such participation by STUDENT in any athletic programs.

Assumption of Risk: It is understood and agreed by the STUDENT and PARENT that such STUDENT participates in any such athletic programs or events at his or her own risk and such risk is expressly assumed by the STUDENT regardless of any existing medical risk known to the STUDENT or Schreiner University.

Prior Representations Superseded: This Indemnity Agreement and Release shall supersede any prior representations of any kind, whether oral or written, if any, given by Schreiner University, its employees, agents and representatives, in regard to Schreiner University athletic events and programs. This document contains the entire agreement between the parties hereto. The terms of this release are contractual and not a mere recital.

In making this Release, it is **Understood** and **Agreed** that STUDENT and PARENT rely wholly upon their own respective judgment, belief and knowledge of the nature, extent and duration of the potential injuries and damages involved, as well as the liability questions involved, and they have not been influenced to any extent whatsoever, in making this Agreement and Release by any representations or statements regarding said potential injuries, or liability, or any other matters, made by Schreiner University and its representatives hereby RELEASED, or by any person representing, or acting for Schreiner University, or by any paramedic, physician or surgeon employed by Schreiner University.

Consent to Treat: I/We the undersigned STUDENT and PARENT do hereby authorize Schreiner University athletic and administrative personnel, as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, operation and/or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the Medical Practice Act, whether such x-ray examination, anesthesia, medical or surgical diagnosis, operation and/or treatment is rendered at the office of said physician, at a hospital, or, if necessary, at an athletic site.

It is understood that this authorization is given in advance of any aforementioned care being rendered, but is given to provide authority and power on the part of our aforesaid agent(s) to given specific consent to any and all such x-ray examination, anesthetic, medical or surgical diagnosis, operation and/or treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

Signature of Student-Athlete Date

Signature of Parent/Guardian if Student-Athlete is under 18 at date of physical Date

Schreiner University
LEARNING BY HEART℠

ATHLETICS
2100 MEMORIAL BLVD.
KERRVILLE, TEXAS 78028-5697
830.792.7289

Release of Newborn Screening Records Authorization Form

Were you born in Texas? (circle one) Yes No

If not, where were you born? _____

Student-athlete's Full Name (First, Middle, Last):_____

Student-athlete's Date of Birth:_____

Full name (First, Middle, Last) of student-athlete's mother at time of student-athlete's birth:

_____

If athlete is age 18 or older:

I,_____(name of student-athlete), hereby authorize the Texas Department of State Health Services Newborn Screening Lab to release all of my newborn screening results to Janel Carlile, the Head Athletic Trainer and representative of Schreiner University's Athletics Department.

Student-athlete's signature:_____

If athlete is under age 18:

I,_____(name of parent or guardian), Parent/guardian), hereby authorize the Texas Department of State Health Services Newborn Screening Lab to release all of my newborn screening results to Janel Carlile, the Head Athletic Trainer and representative of Schreiner University's Athletics Department.

Parent/Guardian's Signature:_____

Student-athlete's signature:_____

Please fax results back to:

Janel Carlile, MS, ATC/LAT – Head Athletic Trainer

Schreiner University – Kerrville, Texas

(830) 217-3723