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 MSU-Northern 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, nor receive any evaluation or treatment, until all the information is provided.

**PLEASE HAVE THE FOLLOWING FORMS COMPLETED AND RETURNED BY AUGUST 1, 2012**

ALL STUDENT-ATHLETES:
A. Assumption of Risk
B. Buckley Amendment
C. Drug Testing Consent
D. General Physical Examination (completed by family MD, DO, PA, NP only)

**Physical examinations from chiropractors will not be accepted.**
E. Insurance Notification
F. Insurance Travel Form
G. Medical History Forms
H. Permission to Provide Medical Treatment
I. Permission to Share Medical Information
J. Xerox Copy of Health Insurance Card (Front & Back)

Mail or Fax Completed Forms to:

MSU-Northern Athletic Training
Box 7751
Havre, MT 59501
Fax (406) 265-4129

Please address any of your questions to: MSU-Northern Athletic Training – 406-265-3593

Thank you for your cooperation!
RETURNERS MEDICAL HISTORY FORM

Name: ____________________________________________ Today’s Date: ___ / ___ / ___

Last First Middle
SSN: _____-____-______ Birthday: ___/___/_____ Age: _____ Sex: M F

Sport(s): ____________________ 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 & Cell Phone # _____________________ __________________(___)______________ Street    City   Cell Phone

Allergies to Medications: ______________________________________________________________

Medications are you are currently taking: ________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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.

Please write below, in detail, any injuries or general medical disorders that have occurred to you over the months of May, June, July and August. If nothing has occurred, please put NA in the area below.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Thank you for you cooperation,
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   _____Normal   _____Abnormal

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    _____Normal   _____Abnormal
   Abdomen    _____Normal   _____Abnormal
   Genitilia    _____Normal   _____Abnormal
   Skin    _____Normal   _____Abnormal

5. Assessment:  A. _____No Problem identified   B. ____Other

6. Sickle Cell Trait    _____Normal    _____Abnormal

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:
(The 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, sickle
cell trait, absence of one kidney, eye, testicle, or ovary, etc.)
Department of Athletic Training

Insurance Notification

The purpose of this form is to inform you of the health insurance policy that went into effect at Montana State University-Northern in the Fall of 2005. 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 MSU-Northern until this document is completed and handed in. If you have any questions, please call:

Christian Oberquell LAT, ATC- Head Athletic Trainer 406-265-4109
Nichole Borst LAT, ATC- Athletic Trainer 406-265-3593

Health Insurance Coverage Agreement

As the parent/legal guardian/participant of ________________________, I understand that Montana State University-Northern 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 MSU-Northern 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 MSU-Northern. 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 MSU-Northern 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 Montana State University-Northern. Should the insurance not cover athletics or in the state of Montana 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, postseason 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 Montana State University-Northern. It is the recommendation by the MSU-Northern 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 _______________________________________________

• Date Signed _____________

Print Parent/ Legal Guardian’s Name _____________________________________

*Signature of Parent/ Legal Guardian ____________________________________
Insurance Travel Form

Student-Athlete Name: ______________________  SS #: ____________

Sport (s): _______________________________

Age: _________   Birthdate: __________

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 if 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 #: ____________________________
Permission to Share Medical Information

I, _________________________, do allow the Montana State University-Northern 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
- MSU-Northern 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.
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 Montana State University-Northern or at any College or University in which Montana State University-Northern 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 made 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 ____________
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 Montana State University-Northern (MSU-Northern). 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 MSU-Northern 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, MSU-Northern, any of its affiliated organizations, owners, officers, employees, agents, servants, or contractors as a result of my participation in this activity.

I hereby release MSU-Northern, 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 from 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 MSU-Northern 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 MSU-Northern and its affiliates. I sign of my own free will.

Student-Athlete Print Name ________________________

Student-Athlete Sign Name ________________________

Date ____________
Buckley Amendment Consent

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

You understand that this entire form and the results of any Montana State University-Northern 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 MSU-Northern 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 ____________
2012-2013

蒙大拿州立大学-北方

运动训练部门

药物测试同意书

通过签署此文件，您确认自己同意在任何时间，任何原因在学年中接受药物测试。

您同意允许蒙大拿州立大学-北方（MSU-北方）测试您所使用的被MSU-北方禁止的药物。这表示您同意允许MSU-北方在学年期间测试您所使用的被列为MSU-北方禁止的药物，这张清单在学生的运动员手册中和本文件的末尾。此外，您也同意接受安非他命测试，高剂量的HGH，利尿剂，尿液操纵剂，以及任何药物遮蔽剂。

您理解如果测试呈阳性，您将对自己的药物测试费用负责。如果测试呈阴性，学校团队/运动将承担费用。

您理解如果测试呈阳性，您将被通知由头运动训练师，在立即暂停参加MSU-北方的所有运动，并且将与头运动训练师和运动主任会面进一步咨询。您理解如果测试呈阳性，您可能在一年期间接受随机测试。您理解头运动训练师将保留您的药物测试结果的副本。

您理解每位教练可能设有更高的标准，如果测试呈阳性，将应用这些标准。

您理解如果第二次测试呈阳性，您和您的父母/监护人将被通知由头运动训练师。您将再次对自己的药物测试费用负责。此外，运动主任将联系校园生活办公室和财务援助办公室关于您的药物测试结果。您理解您将被暂停参加MSU-北方的活动一学年。

您理解这项同意书和任何药物测试结果的披露，只有在 accordance with the provisions of the Buckley Amendment Consent。

您同意披露您的药物测试结果只用于与您的参赛资格，联邦政府资助指南，和无药物学校法案相关的目的。

我已经阅读了上述MSU-北方药物测试同意书，并同意遵守MSU-北方药物滥用政策。

学生运动员打印签名 ________________________________

学生运动员签名 ________________________________

日期 ____________
BANNED DRUG LIST:

(a) **Stimulants:**
amiphenazole methylenedioxy methamphetamine amphetamine (MDMA, ecstasy) bemigride methylphenidate benzphetamine nikethamide bromantan pemoline caffeine1 (guarana) pentetrazol chlorpentermine phendimetrazine cocaine phenmetrazine cropropanamide phentermine crothetamide phenylpropanolamine (ppa) diethylpropion picrotoxine dimethylamphetamine pipradol doxapram prolintane ephedrine (ephedra, strychnine ma huang) synephrine (citrus aurantium, ethamivan zhi shi, bitter orange) ethylamphetamine and related compounds. fencamfamine The following stimulants are not meclofenoxate banned: methamphetamine phenylephrine pseudoephedrine

(b) **Anabolic Agents:** anabolic steroids
androstenediol methyltestosterone androstenedione nandrolone boldenone norandrostenediol closeabol norandrostenedione dehydrochormethyl-norethandrolone testosterone oxandrolone dehydroepiandro-oxymesterone sterone (DHEA) oxymetholone dihydrotestosterone stanozolol (DHT) testosterone2dromostanolone tetrahydrogestrinone (THG) epitrenbolone trenbolone fluoxymesterone and related compounds gestrinone mesterolone other anabolic agents methandienone methenolone clenbuterol

(c) **Substances Banned for Specific Sports:**
Rifle: alcohol pindolol atenolol propranolol metoprolol timolol nadolol and related compounds

(d) **Diuretics:** acetazolamidedibendroflumethiazide benzthiazide bumetanide chlorothiazide chlorthalidone ethacrynic acid flumethiazide furosemide hydrochlorothiazide hydroflumethiazide methyclothiazidenorflazonepolythiazide quinethazone spironolactone (canrenone) triamterene trichlormethiazide and related compounds

(e) **Street Drugs:** heroin tetrahydrocannabinol marijuana3 (THC)3

(f) **Peptide Hormones and Analogues:** corticotrophin (ACTH) human chorionic gonadotrophin (hCG) luteinizing hormone (LH) growth hormone(HGH, somatotrophin) insulin like growth hormone (IGF-1) All the respective releasing factors of the above-mentioned substances also are banned: erythropoietin (EPO) sermorelin darbepoetin

(g) **Definitions of positive depends on the following:** for caffeine—if the concentration in urine exceeds 15 micrograms/ml. 2for testosterone—if the administration of testosterone or use of any other manipulation has the result of increasing the ratio of the total concentration of testosterone to that of epitestosterone in the urine to greater than 6:1, unless there is evidence that this ratio is due to a physiological or pathological condition. 3for marijuana and THC—if the concentration in the urine of THC metabolite exceeds 15 nanograms/ml.