

2010-2011



Department of Athletic Training

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, 2010**

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 – 406-265-4109

Thank you for your cooperation!

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FRESHMEN/TRANSFER 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: _____

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?

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- 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 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)

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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 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

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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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General Medical

- 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 _____

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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 _____ 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
Genitalia _____ 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, absence of one kidney, eye, testicle, or ovary, etc.)

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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 _____

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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.

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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 _____

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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 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 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 _____

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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 _____

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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 Montana State University-Northern (MSU-Northern) to test you for the banned drugs that are listed in the MSU-Northern Banned Drug List. This means that you agree to allow MSU-Northern to test on a year round bases for the banned drugs appearing on the MSU-Northern 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 MSU-Northern 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 MSU-Northern 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 MSU-Northern Drug Testing Consent Form and agree to abide by the MSU-Northern Substance Abuse Policy.

Student-Athlete Print Name _____

Student-Athlete Sign Name _____

Date _____

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BANNED DRUG LIST:

(a) Stimulants:

amiphenazole methylenedioxy methamphetamine amphetamine (MDMA, ecstasy) bemigrade methylphenidate benzphetamine nikethamide bromantan pemoline caffeine¹ (guarana) pentetrazol chlorphentermine phendimetrazine cocaine phenmetrazine cropropamide 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 clostebol norandrostenedione dehydrochlormethyl-norethandrolone testosterone oxandrolone dehydroepiandro-oxymesterone sterone (DHEA) oxymetholone dihydrotestosterone stanozolol (DHT) testosterone 2-dromostanolone 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: acetazolamide bendroflumethiazide benzthiazide bumetanide chlorothiazide chlorthalidone

ethacrynic acid flumethiazide furosemide hydrochlorothiazide hydroflumethiazide methyclothiazide metolazone polythiazide 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.