June 9, 2008

Dear Student-Athlete,

Athletic Training Services would like to take this opportunity to welcome you to Webster University and the Department of Intercollegiate Athletics. It is our hope that this letter will aid the process of completing all necessary health forms to participate in the intercollegiate athletic program. The deadlines listed are based upon the anticipated start dates for your sport season so as to allow proper medical review by the athletic training staff and final medical clearance by the team physician. **To assist in the processing of this paper work, please do not attach additional pieces of paper to these forms; provide all information in the spaces provided. Incomplete forms will be sent back.**

Medical History: This form provides past and present medical history as well as family history. It must be signed by the student-athlete, and if under the age of 18 years, the parent / legal guardian must also sign.

Pre-Participation Physical: All student-athletes are required to have a complete medical physical performed by a physician every year prior to the year of sport participation. All new student-athletes are required to have a physical performed within three (3) months prior to entering the university. **This physical *MUST* be completed by a medical doctor (MD) or a doctor of osteopath (DO); if it is completed by a certified nurse practiconer (CNP), it *MUST* be over-signed by a MD or DO.** The physician must sign and print their name in the space provided as well as provide an office stamp in the designated space to verify completion. ****NOTE** If you are an international student or if you will be residing in campus housing you must complete a Health Services physical in addition to a Webster University athletics physical. The Health Services physical can be obtained by calling 314-968-6922.**

Emergency Information: All sections must be completed. If you have a medical insurance plan that is an HMO, and you are not from the St. Louis area, it is advised that you designate a local physician as your primary care physician. This will assist in the event a medical referral is necessary for an athletically related injury or illness.

Immunizations: These immunizations are required to assist in the health and well being of your athletic participation. The immunizations are required of all student-athletes and are consistent with university housing and international student requirements. Please provide the required dates in the spaces provided. ***Do not*** send a photocopy of your immunizations.
3 doses of Hepatitis B
2 doses of MMR (Measles, Mumps, Rubella)
3 doses of Polio
Tetanus/Diphtheria booster within the past ten (10) years
Tuberculosis Test (PPD/Mantoux Only) within six (6) months of entering the university

Health Insurance: Medical insurance is required of all student-athletes during your entire sport season and *MUST* cover athletically related injuries. If your insurance does not cover athletic injuries, or lapses during your participation, you will be financially responsible for any and all medical costs associated with athletically related injuries**.**

You must provide a photocopy of the front and back of your insurance card in the space provided. If you are covered by more than one health insurance policy, you must provide a photocopy of each card.

Webster University does have a student insurance plan that you can purchase. Call Health Service at (314) 968-6922 for more information. If your plan is an HMO, please designate a St. Louis area physician as your primary care physician.

Authorization and Release: Required of all student-athletes each year. It ***MUST*** be signed by the student-athlete and parent / legal guardian.

Deadlines:	**August 4**	**August 18**	**September 22**
	Soccer	Baseball	Basketball
	Volleyball	Softball	
	Cross Country	Tennis	
	Golf	Track & Field	

Secondary Insurance Coverage: Webster University provides secondary Athletic Accident insurance which provides coverage for certain medical expenses associated with injuries that occur **while** participating in supervised athletic activity during your sport season. The Athletic Accident policy is an excess policy, therefore all athletic claims must be submitted to your primary insurance first.

Once your primary insurance has been billed, remaining amounts due may be submitted to secondary insurance. The policy carries a $250.00 deductible, and includes certain exceptions and exclusions. Please understand that any pre-existing injuries/conditions or aggravation of them through athletic participation are **not** covered by this insurance policy. Even with secondary insurance, students may still incur out-of-pocket expenses for treatment of their athletic injuries.

It is the student-athletes' responsibility to report the injury immediately to the athletic training staff. If necessary, a referral to the Team Physician, and/or his/her designee, will be made for diagnosis and treatment. Any and all medical bills associated with the Team Physicians' evaluation will be filed with your primary insurance carrier first. All remaining balances will be filed through the secondary insurance carrier.

The student-athlete and/or parent/legal guardian will work in conjunction with Athletic Training Services to ensure procedural steps are followed in filing a secondary insurance claim. Failure to follow this procedure may result in denial of the claim, therefore leaving all expenses the sole responsibility of the student-athlete. If you so choose, you may consult a physician outside of Athletic Training Services for evaluation or treatment, but please note*: any and all costs associated with treatment outside of Athletic Training Services will be the sole financial responsibility of the student-athlete.*

Medical Review and Clearance for Participation: Upon receipt of this packet to Athletic Training Services, your information will undergo a medical review by the athletic training staff. If information is missing or incomplete, it **will** result in a delay of your participation in Intercollegiate Athletics.

The head coach of your sport will be notified when you have submitted a complete packet, the information has been reviewed, and final medical clearance has been given. Only after this process is complete will you be allowed to participate in any sport related activity.

We highly suggest that you make, and keep a copy, of all forms you send to Webster University. Please keep these two sheets for reference.

Best of luck to you and your teammates this year. If you have any questions, please call 314-961-2660 ext. 7715 and leave a message.

Sincerely,

Amy W. Schork, MA, ATC, LAT
Coordinator of Athletic Training Services

Martin Fields, ATC, LAT
Athletic Trainer

Student-Athlete Check List: **Completed:** **Date forms sent to Webster: _____**

1. Medical History ___
2. Physical Form ___
3. Immunizations ___
4. Emergency Information ___
5. Photocopy of Insurance Card (front & back) ___
6. Authorization and Acknowledgement ___

08/09

WEBSTER UNIVERSITY STUDENT ATHLETE PREPARTICIPATION MEDICAL EVALUATION

DATE: _____ **CHECK BOX IF YOU ARE LIVING ON CAMPUS** ❑

Last Name_____ First Name_____ MI_____

Year of Athletic Participation: 1st 2nd 3rd 4th 5th Date of Birth: (MM/DD/YY) _____ / _____ / _____

Student ID # _____ Sex: M F Social Security # _____ - _____ - _____

Local Phone #__(____)_____ Cell Phone #__(_____)_____

Please explain all "Yes" answers below. Circle those questions you do not know the answers to.

		YES	NO
1.	Have you had a medical illness or injury since your last athletic physical or regular check up?	☐	☐
2.	Do you have an ongoing or chronic illness?	☐	☐
3.	Have you ever been hospitalized overnight?	☐	☐
4.	Have you ever had surgery?	☐	☐
5.	Are you currently taking any prescription or non-prescription (over-the-counter) medications, pills or an inhaler?	☐	☐
6.	Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance (ie Creatine, HMB, Ripped Fuel)?	☐	☐
7.	Do you have any allergies (ie pollen, medicine, food, or stinging insects)?	☐	☐
8.	Have you ever had a rash or hives develop during or after exercise?	☐	☐
9.	Have you ever passed out during or after exercise?	☐	☐
10.	Have you ever been dizzy during or after exercise?	☐	☐
11.	Have you ever had chest pain during or after exercise?	☐	☐
12.	Do you get tired more quickly than your friends during exercise?	☐	☐
13.	Have you ever had a racing heart rate or skipped beats?	☐	☐
14.	Have you had high blood pressure or high cholesterol?	☐	☐
15.	Have you ever been told you have a heart murmur?	☐	☐
16.	Has any family member or relative died of heart problems or of sudden death before the age of 50?	☐	☐
17.	Have you ever had a severe viral infection (ie myocarditis or Mononucleosis) within the last 6 months?	☐	☐
18.	Has a physician ever denied or restricted your participation in sports for any reason?	☐	☐
19.	Do you have any current skin problems (ie itching, rashes, acne, warts, fungus or blisters)?	☐	☐
20.	Have you ever had a head injury or concussion?	☐	☐
21.	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
22.	Have you ever had a seizure?	☐	☐
23.	Do you have frequent or severe headaches?	☐	☐
24.	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
25.	Have you ever had a stinger, burner or pinched nerve?	☐	☐
26.	Have you ever become ill from exercising in the heat?	☐	☐
27.	Do you cough, wheeze or have trouble breathing during or after exercise?	☐	☐
28.	Do you have asthma?	☐	☐
29.	Do you have seasonal allergies?	☐	☐
30.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (ie knee brace, orthotics, retainer, hearing aid)?	☐	☐
31.	Have you ever had any problems with your eyes or vision?	☐	☐
32.	Do you wear glasses, contacts or protective eyewear?	☐	☐
33.	Have you had a sprain, strain or swelling after an injury?	☐	☐
34.	Have you ever broken or fractured any bones or dislocated any joints?	☐	☐
35.	Have you had any problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐
	IF YES, circle the appropriate area and explain below		
	Head / Neck / Back / Chest / Shoulder / Upper Arm	Elbow / Forearm / Wrist / Hand / Finger / Foot	Hip / Thigh / Knee / Shin/Calf / Ankle / Toes
36.	Do you want to weigh more or less than you do now?	☐	☐
37.	Do you lose weight regularly to meet sport weight requirements?	❑	☐
38.	Do you feel stressed out?	☐	☐
39.	Are there any groups of foods you avoid?	☐	☐
40.	Are you a vegetarian?	☐	☐
41.	Do you take a calcium supplement?	☐	☐
42.	Do you take a multivitamin?	☐	☐
43.	Do you take an iron supplement?	☐	☐
44.	Do you smoke or use smokeless tobacco?	❑	❑
45.	Have you ever used illegal substances such as marijuana, cocaine, LSD, ecstasy or other illegal substances?	❑	❑
46.	Have you ever been told not to donate blood?	❑	❑

Explain YES answers below or you may use an additional sheet of paper:
Examples: # 4 Right Knee ACL Surgery, September 2001
5 Allegra, Birth Control, Inhaler for Asthma

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of Athlete_____ Date_____

Signature of Parent (if under the age of 18 years) _____ Date _____

08/09

PLEASE PRINT CLEARLY **STUDENT ATHLETE INFORMATION** **DATE** _____

SECTION 1: EMERGENCY INFORMATION: PLEASE PRINT LEGIBLY

Last Name	First Name	MI
Permanent Address	SS#	Student ID#
City, State, Zip	❑ Male ❑ Female	Date of Birth mm/dd/year
Emergency Contact Name:	Relationship:	
Home Phone ( )	Work Phone ( )	Cell Phone ( )

SECTION 2: HEALTH INSURANCE INFORMATION

Policy Holder Name:_____ Relationship to Student:_____

Employer Name:_____ Occupation:_____

Employer Address:_____

SS#_____ Office Phone: ( ) Home Phone ( )

Insurance Company Name:_____

Address:_____

Plan / Policy Number(s):_____

Phone ( ) Is your insurance policy an HMO? YES ❑ NO ❑

HMO Primary Care Physician: _____ Phone: ( )

By providing proof of health insurance, you are indicating:
1) Your coverage is comparable or better than the Webster Student Health Insurance.
2) Your coverage will remain in effect throughout your entire sport season and cover athletically related injuries and illnesses.
3) If your insurance information changes, you will notify Athletic Training Services immediately.

PLEASE PROVIDE A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD ONLY IN THE SPACES PROVIDED BELOW. DO NOT ATTACH A SEPARATE COPY OF YOUR CARD TO THESE FORMS

FRONT OF INSURANCE CARD (Attach here only)	**BACK OF INSURANCE CARD (Attach here only)**

For office use only. Do not write in this space.

Meds: **Allergies/Conditions:** **Tetanus:**

08/09

WEBSTER UNIVERSITY ATHLETIC PHYSICAL FORM

This form *must* be completed by a medical doctor (MD), doctor of osteopathic (DO) or Certified Nurse Practioner (CNP).

*****CAMPUS HOUSING NOTE***** If you will be living in campus housing, this form will not satisfy the requirements for the Health Service. Contact Athletic Training Services with any questions.

Name_____

SS#_____ ID#_____

Sport(s)_____

Physician Office Stamp (REQUIRED)

Ht_____ Wt_____ BP_____

Pulse _____ Resp_____ Temp_____

Vision: Right 20 / _____ Left 20 / _____

Glasses: Constant ❑ Reading ❑ Contacts: Hard ❑ Soft ❑

CLINICAL EVALUATION			**REMARKS**
Check each item in appropriate column, at right. Enter "N.E." if not evaluated.	WNL	Abnormal	Please Print
1. SKULL, SCALP, FACE			
2. NOSE, SINUSES			
3. MOUTH, THROAT, THYROID			
4. EARS, EYES			
5. LUNGS, CHEST			
6. HEART			
7. ABDOMEN, VISCERA			
8. ANUS, RECTUM			
9. ENDOCRINE SYSTEM			
10. G-U SYSTEM			
11. UPPER EXTREMITIES			
12. LOWER EXTREMITIES			
13. FEET			
14. OTHER MUSCULOSKELETAL			
15. SKIN			
16. LYMPHATIC GLANDS			
17. NEUROLOGIC			
Please list any conditions which require special attention for participation in a collegiate athletic program:			**DRUG ALLERGIES:**

Recommendations for participation in the Webster University intercollegiate athletics program (please check one):

_____ No Limitations / Unrestricted Physical Activity
_____ Limited Participation With The Following Conditions:_____
_____ No Participation Until:_____

Physician's Name (PRINT)_____ Phone ( ) _____

Physician's Signature_____ MD / DO Date_____

MANDATORY IMMUNIZATIONS
*****NEW STUDENT-ATHLETES ONLY*****

This section must be completed. Photocopies of immunization records will NOT be accepted.
The information in this section will be shared with the Health Service for university database purposes only. If you will be residing in campus housing: you need not fill out this section if it has already been provided to the Health Service; this information must be provided to the Health Service and/or to Athletic Training Services prior to the start of your sport season.

	Dose 1	**Dose 2**	**Dose 3**	**Date of Disease**
Hepatitis B				
Polio				
MMR			**N / A**	
Varicella (chick. pox)			**N / A**	
Tetanus/Diphtheria		**Date Must Be Within 10 Years**		

Tuberculosis Test (PPD/Mantoux Only) – Must be within six (6) months of entering the University.

Date Administered _____ Induration in MM_____
The PPD is required regardless of BCG inoculation. A chest x-ray is required for reactions larger than 10mm.
Results of the chest x-ray must be included with this form.

WEBSTER UNIVERSITY ATHLETIC TRAINING SERVICES

Authorization and Acknowledgement Release

I. Acknowledgement Waiver: I am aware that playing or practicing to play/participate in intercollegiate athletics can be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing to play/participate in intercollegiate athletics include, but are not limited to, death, serious neck and spinal injuries that may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to play/participate in intercollegiate athletics may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and to generally enjoy life.

I also acknowledge that it is essential for my well-being that I not participate or practice to play/participate in intercollegiate athletics unless I am in good health and physical condition. With this in mind, I have correctly answered the questions of the Medical History Questionnaire and I have advised the athletic training staff and Team Physician of any limitations on my activities for medical reasons.

Because of the dangers of participating in intercollegiate athletics, I recognize the importance of following the coaches' instructions regarding playing techniques, training, and other rules, etc., and agree to obey such instructions. I also recognize the importance of following orders given by the team physicians and certified athletic trainers regarding any limitations or treatments they feel are necessary for my health and well-being.

In consideration of Webster University permitting me to try out for or for participating on Webster University intercollegiate athletic teams and to engage in all activities related to the team, including but not limited to, trying out, practicing or play/participating in that sport, I hereby assume all the risks associated with participating and agree to hold Webster University, its employees, agents, representatives, coaches, physicians, athletic trainers, student first aiders, and volunteers, harmless from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature at all that may arise by or in connection with my participation in any activities related to the Webster University intercollegiate athletic teams.

The terms hereof shall serve as a release and acknowledgement of my assumption of risk for my heirs, estate, executor, administrator, assignees, all members of my family and anyone who can assert a claim on my or their behalf.

II. Authorization to Provide Medical Care: I hereby consent to permit the Webster University Athletic Training Staff (and/or) designee at away contests, coaches, and student first aiders to provide emergency first-aid or medical treatment to me, including hospitalization and physician follow-up according to their best judgment, in the event I suffer an injury or illness while playing or practicing to participate in intercollegiate athletics.

III. Authorization to Release/Obtain Medical/Insurance Data*: I hereby authorize Webster University and Webster University's various insurance providers to release/obtain personal medical/insurance data about me for the purpose of certification of injury, illness, physical examinations and other legitimate reasons related to health coverage and intercollegiate athletics. *In accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information is released on the condition that you will not permit any other party access outside of Webster University and Webster University's various insurance providers to the information without the written consent of the individual.

We have read and understand the information as stated, and authorize and acknowledge the above activities.

Date **Signature of Student Athlete**

Date **Signature of Parent/Guardian (REQUIRED)**

PLEASE PRINT NAME:

LAST **FIRST**