ARKANSAS

ATHLETICS

SPORTS MEDICINE PRE-PARTICIPATION PHYSICAL EXAMINATION FORMS

NEW ATHLETE

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UNIVERSITY OF ARKANSAS ATHLETIC TRAINING
DEMOGRAPHIC INFORMATION FORM

Full Name: _____ M F Date: _____
(Last) (First) (MI) (Circle) (m/dd/yy)

Nickname (Optional): _____ Sport: _____ Class: _____

Date of Birth: _____ Soc. Sec. #: _____ UA ID#: _____
(m/dd/yy)

Campus/Local Address: _____
(Street address)

_____
(City) (State) (Zip)

Student/Athlete Cell Phone: _____ Email: _____

Father's Name: _____ Home Phone: _____
(Last) (First) (MI) Cell Phone: _____

Mother's Name: _____ Home Phone: _____
(Last) (First) (MI) Cell Phone: _____

To whom should we send medical correspondence? Mother Father Guardian Self Other
(Please Circle)

Name: _____

Local Address: _____
(Street address)

_____
(City) (State) (Zip)

CONTACT PERSON IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

UNIVERSITY OF ARKANSAS DEPARTMENT OF INTERCOLLEGIATE ATHLETICS
BARNHILL ARENA / 285 STADIUM DRIVE / FAYETTEVILLE, AR 72701 / OFFICE: 479.575.4208 / FAX: 479.575.2471
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POLICIES AND RELEASE FORMS

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ARKANSAS RAZORBACK SPORTS MEDICINE PRIVACY INFORMATION

It is the intent of the University of Arkansas Sports Medicine Department to provide appropriate and necessary medical care for each student athlete as part of our Intercollegiate Athletics Program. Communication needs to be open between the athletic training staff and healthcare providers allowing for continuity in the care provided to our student athletes.

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records. This law applies to the University of Arkansas, including personnel dealing with certain information concerning student athletes. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law protecting the privacy of a patient's health information created, received or maintained by a healthcare provider. HIPAA may apply to healthcare providers (including physicians) who independently contract with the University of Arkansas Athletic Department, as well as to the University Health Center. Each healthcare provider may have separate privacy procedures.

Under FERPA, you have the right to decline a request for the release of your student education records (including covered medical information), except to the extent that release of your information is required or authorized by law without your consent. (See University wide Administrative Memorandum 515.1). Pursuant to your authorization, we may use or disclose your medical information for proper treatment of injury/illness by athletic training staff and healthcare providers (including physicians), for payment of healthcare services (i.e. billing information) and/or for professional development (i.e. comparison studies about injury/illness). Furthermore, with your authorization, we may release and discuss your medical information with parents, academic staff, instructors, coaches, sports information, media, talent scouts, representatives of professional and /or amateur sports organizations, your primary insurance company, the university's excess insurance company, business office personnel and/or university accounts payable department.

Your rights apply to all medical information acquired while you are enrolled at the University of Arkansas. You may request, in writing, that we not disclose/release any medical information for certain cases or circumstances. However, FERPA allows the disclosure of medical records, without consent, to university officials with a legitimate educational interest, to other universities to which a student-athlete is transferring and/or to appropriate officials in cases of health and safety emergencies, among other circumstances. You have the right to request access to or a copy of your medical file. If you feel the information in the file is incorrect or incomplete, you have the right to request that we amend the records.

The athletic training staff may require from your healthcare provider certain medical information in order for our staff to continue with the appropriate care necessary for any specific incidents for which you have obtained medical treatment or advice. To enable our staff to obtain the appropriate medical information about you, we will provide to you an "Authorization to Release Medical Information" to sign permitting your physician(s) to release your pertinent medical information to our athletic training staff in compliance with the HIPAA regulations. The Authorization is good for the duration of my association with the Athletics Department at the University of Arkansas or until the revocation of this authorization in writing.

This summary is provided for informational purposes only.
Revised May 2010

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AUTHORIZATION FOR ARKANSAS SPORTS MEDICINE TO RELEASE MEDICAL INFORMATION FROM STUDENT RECORDS (FERPA AUTHORIZATION)

Student-athlete's Name (please print): _____ Date of Birth:_____

As a participant of the University of Arkansas, Fayetteville's ("University") Intercollegiate Athletics program, I, the undersigned student-athlete, do hereby authorize and give permission for:

- The Athletic Department's athletic training staff and the Athletic Department's designated health care professionals, health care facilities, and other health care providers and administrators charged with my medical care (collectively, "Authorized Persons") to share my "education records," as defined in the Family Educational Rights and Privacy Act, including, but not limited to, any medical records and information, with each other for diagnosis and treatment purposes as well as with other professionals for educational purposes (i.e., comparison studies about injury/illness).
- The Authorized Persons as well as the Athletic Department administrative staff to release and discuss with my parents and/or legal guardians any education records and/or medical information due to an emergency, illness, or injury.
- The Authorized Persons as well as the Athletic Department's academic staff members to release and discuss with my instructors medical information that may affect my ability to attend and participate in any aspect of class, including homework and tests.
- The Authorized Persons to release and discuss any of my medical information that may affect my participation in my sport with any members of the coaching staff.
- The Authorized Persons as well as the Athletic Department's communications staff to release and discuss medical information related to an injury/illness that may affect my participation in my sport with the media.
- The Authorized Persons to share medical information with the NCAA or Southeastern Conference for the purpose of petitioning for a medical redshirt, hardship or exemption or for reporting/compliance purposes.
- The Authorized Persons to release and to discuss my medical records with talent scouts or representatives of professional and/or amateur sports organizations.

This consent applies to all medical records (including prescription information) maintained by the University of Arkansas, Fayetteville Athletic Department, including but not limited to, health histories, physician's notes, diagnostic testing results, and/or laboratory test results.

Furthermore, I authorize the following regarding payment for services for any medically-related service that may affect my athletic participation:

- The Authorized Persons charged with my care, including their business offices and medical records departments, to utilize, release and discuss any record necessary for the payment of services with respect to any claim filed on my behalf.
- The Authorized Person as well as the Athletic Department staff to release and discuss with my primary insurance carrier as well as the University's excess insurance carrier any medical information needed to process such a claim.
- The Authorized Persons as well as the Athletic Department's business office and the University's accounts payable department, to utilize, release and discuss such medical information needed to process the payment of services which the Athletic Department has authorized.

I understand that once information is disclosed per my authorization the information is subject to re-disclosure and may no longer be protected. I understand that I can revoke this authorization with respect to any of the aforementioned persons at any time, in writing, including limiting the authorization of medical information at my discretion. I understand that the permission I am granting in this consent form cannot be revoked for records already released in reliance upon this authorization. Also, I understand the Athletic Training Staff will provide a copy of this authorization to me and the Authorized Persons upon request.

This consent form shall be valid for the duration of my association with the Athletic Department at the University of Arkansas, Fayetteville or until I revoke this authorization in writing. I certify that I am 18 years of age or older. If I am under 18 years of age, I understand that this form may be signed by my parent(s) or legal guardian(s).

Student-Athlete:_____ Date:_____
Parent:_____ Date:_____

(Parent Signature is required if Athlete is under 18 Years of Age)

A **copy of this authorization shall he considered as effective and valid as an original signed copy.** (Updated, June, 2010)

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ARKANSAS RAZORBACK SPORTS MEDICINE
WAIVER, WARRANTY AND RELEASE

Name _____ Date _____ Sport _____

I am aware that involvement in intercollegiate athletics constitutes an assumption of risk because of the nature of the activity.

In consideration of myself being permitted to participate in the varsity athletics program at the University of Arkansas, I hereby waive and release The University of Arkansas, the Athletics Department, and/or the faculty or staff involved in this program from liability for any personal injuries incurred as a result of my participation in this sport.

It is my intent to release and not hold responsible The University of Arkansas, Athletic Department and its faculty and staff for injuries received both while traveling to and from the site of the contest using private vehicles or any other mode of transportation, and while participating in the activities associated with the sport.

In addition, I agree that I have made a full and complete disclosure to the Arkansas Athletic Training staff of all present or prior physical or mental defects, illnesses, injuries or conditions known to me which might prevent, hinder or impair the performance of my services to my team and/or institution. The information I have provided on all forms is, to the best of my knowledge and belief, true, correct and complete.

By signing this form, I acknowledge that I have been made aware of the Razorback Student-Athlete Planner & Calendar handbook. I understand this handbook contains information pertinent to Razorback Student-Athletes as it relates to athletic training policies and procedures and that I will be responsible for reading and adhering to these policies and procedures. A copy of this handbook is available online at www.arkansasrazorbacks.com

_____ _____
Signature of Athlete Date

_____ _____
Signature of Parent/Guardian Date
(Parent Signature is required if Athlete is under 18 Years of Age)

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CONCUSSION MANAGEMENT PLAN

Name _____ Date_____

PARTICIPATION IN SPORT MAY RESULT IN INJURY OR ILLNESS, INCLUDING CONCUSSIONS

A concussion or Mild Traumatic Brain Injury (MTBI) or *comotio cerebri* is defined as a complex pathophysiologic process affecting the brain's function. It is induced by traumatic biomechanical forces after impact to the head, face, neck or body that leads to a functional, not structural, disturbance which may or may not involve LOC (Loss of Conciousness).

Student-athletes are responsible for reporting their injuries and illnesses to the medical staff; including signs and symptoms of concussions (MTBI's). Signs and symptoms include, but are not limited to:

Vomiting	Sensitivity to light	Sadness
Imbalance	Sensitivity to noise	Fatigue
Dizziness	Numbness/tingling	Difficulty remembering
Nervousness	Headache	Difficulty concentrating
Nausea	Drowsiness	Loss of consciousness

Signs and symptoms must be reported to the University of Arkansas Sports Medicine staff immediately upon onset, before the continuation of any activity. Return to any activity will be determined by the University of Arkansas Sports Medicine staff after proper evaluation.

This is to certify that I have carefully read, fully understand, and that I am aware of the signs/ symptoms of concussions. I have received education on the signs/symptoms associated with concussions. I acknowledge that all signs and symptoms of concussions must be reported to the University of Arkansas Sports Medicine staff immediately upon onset.

_____ _____
Student-Athlete's Signature Date

_____ _____
Parent or Guardian's Signature Date

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HELMET POLICY/RELEASE

Football Only

Name_____ Date _____

WARNING
NO HELMET CAN PREVENT SERIOUS HEAD OR NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN FOOTBALL

Do not use your helmet to butt, ram, or spear an opposing player. This is in violation of the football rules and such use can result in severe head or neck injuries, paralysis or death to you and possible injury to your opponent.

Contact in football may result in CONCUSSION-BRAIN INJURY which no helmet can prevent. Symptoms include: loss of consciousness or memory, dizziness, headache, nausea or confusion. If you have symptoms, immediately stop playing and report them to your coach, athletic trainer or parents. Do not return to a game or practice until all symptoms are gone and you have received MEDICAL CLEARANCE. Ignoring this warning may lead to another and more serious or fatal brain injury.

This is to certify that I have carefully read and that I fully understand the warning labels (s) attached inside and/or outside the football helmet issued to me by the University of Arkansas Athletic Department.

_____ _____
Student-Athlete's Signature Date

_____ _____
Parent or Guardian's Signature Date
(Parent Signature is required if Athlete is under 18 Years of Age)

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UNIVERSITY OF ARKANSAS ATHLETIC DEPARTMENT
CONSENT FOR MEDICAL TREATMENT

I, _____, hereby consent to the University of Arkansas Athletic Training and Medical Staff, or anyone they may designate, to render care, including evaluation, diagnostic procedures, treatment and rehabilitation for any illness or injury I may incur while participating as an intercollegiate athlete for the University of Arkansas _____ team. I acknowledge no guarantees have been made that the evaluation, treatment and rehabilitation of an injury or illness will cure or fully return me to participation.

I consent to necessary medical treatment and admission to any medical facility designated by the University of Arkansas Athletic Training and Medical Staff. I understand I have the right to make decisions concerning my health care including the right to refuse medical and surgical procedures. I also understand the final decision on whether I may continue to participate rests solely with the UA Athletic Training and Medical Staff.

Date	Signature of Student-Athlete
Date	Signature of Parent or Witness (Parent Signature Required if Athlete is Under 18 Years of Age)

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PREGNANCY POLICY (Female Student-Athletes Only)

The University Of Arkansas, Department Of Athletics is committed to the personal health and development of all Razorback student-athletes and to the educational mission of the University of Arkansas. We strive to provide an environment that respects all pregnancy and parenting decisions and urges all participants to work cooperatively toward degree completion. This policy sets forth the protections that should be provided for pregnant and parenting students, including those with pregnancy related conditions. It also prohibits retaliation against any student or employee who expresses concerns about issues related to the enforcement of this Pregnancy Policy. We want to protect the physical and psychological health of all student-athletes, along with their ability to complete their degree programs.

In the event a student-athlete discloses a pregnancy, the student-athlete will be referred to the University of Arkansas Title IX Coordinator and to the University of Arkansas Sports Medicine Staff. The University of Arkansas Sports Medicine Staff will offer support to the student-athlete and will assist the student-athlete with referrals for further counseling and evaluations pertaining to her pregnancy. The University of Arkansas Team Physician will be responsible for coordinating medical care and determining the participation status for the student-athlete.

University of Arkansas Department of Athletics personnel, including coaches, shall not influence or give personal opinions regarding the choices a pregnant student-athlete may have or may make.

Athletic Department Contacts and University Resources

If you would like to review the Pregnancy Policy in its entirety, if you have any questions about the Pregnancy Policy, or if you are seeking resources for yourself or a pregnant student-athlete, you may contact the following Razorback Athletics personnel and University of Arkansas campus resources:

- Julie Cromer Peoples (Senior Associate Athletic Director and SWA)……...479-575-8678
- Tracey Stehlik (Associate Athletic Director for Compliance)……479-575-6738
- Marcus Sedberry (Asst. AD for Student-Athlete Development & Administration)……...479-575-4424
- Felecia Saine (Director of Academic Services)……..479-575-4026
- Trish Matysak (Head Athletic Trainer for Olympic Sports)……...479-575-4809
- Dr. Mike Johnson (Director of Clinical and Sport Psychology)…….479-575-5163
- Pat Walker Health Center……....479-575-4451
- Pat Walker Health Center Women's Health Clinic…….479-575-4478
- Melissa Harwood Rom (Dean of Students)……479-575-5004
- U of A Health Promotion and Education…….479-575-4077
- U of A Counseling and Psychological Services (CAPS)…….479-575-5276

Reporting

- Razorback Athletics will not require any student-athlete to reveal pregnancy or parenting status to coaches or teammates. Our department will work to create an environment which encourages the student-athlete to voluntarily reveal her pregnancy and his or her parenting status, in order for our institution to provide optimal support for physical and mental health with professional health care. The coach's attitude toward pregnancy and parenting can be pivotal in creating such a safe environment.
- No athletics department personnel will publicly release personally identifiable health information about pregnancy without written, timely authorization from the student-athlete.
- Athletics personnel who suspect that a student-athlete is pregnant may report their concerns to the team physician or to a university-designated athletics department representative trained in pregnancy and parenting support options.
- Teammates of pregnant student-athletes may report their concerns to the team physician or to a university-designated athletic department representative trained in pregnancy and parenting support options.

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Participation While Pregnant

- Razorback Athletics will only require a pregnant or parenting student-athlete's physician to certify physical and emotional fitness as a condition for participating in athletics when such certification is required of student-athletes who experience other temporary disabilities.
- Razorback Athletics will allow a pregnant or parenting student-athlete to fully participate on the team, including all team-related activities, unless the student-athlete's physician or other medical caregivers, including team physicians certifies that participation is not medically safe.
- Razorback Athletics will allow a pregnant student-athlete to continue to participate in a limited manner on the team, including all team-related activities, unless the student-athlete's physician or other medical caregiver, including a Team Physician, certifies that partial participation is not medically safe.
- Medical decisions regarding the need for and the nature of limitations on sports participation rest with the student-athlete and her medical professionals. Where the opinions or recommendations of these professionals differ from those of the Team Physician or trainers, coaches should defer to the student-athlete's health care providers who are obstetricians or other experts in pregnancy or related conditions.
- Razorback Athletics will help the pregnant or parenting student-athlete plan for his or her continued academic progress, in accord with the university's educational mission.
- Medically necessary absences from team activities due to pregnancy shall be considered excused absences.
- No coach or other athletics department personnel shall suggest to any student-athlete that his or her continued participation on a team will be affected in any way by pregnancy or parental or marital status.

Medical Care

- Razorback Athletics can provide health benefits for pregnancy, including counseling, physical examinations, medical treatment, medication and rehabilitation expenses, to the same degree that student-athletes who experience other temporary disabilities are provided these benefits. The University of Arkansas Department of Athletics' medical coverage policy for student-athletes can be found at ArkansasRazorbacks.com.

Scholarship and Aid

- Razorback Athletics will not terminate or reduce a student-athlete's athletics aid because of the student-athlete's pregnancy, marital or parental status during the term of the award.
- Razorback Athletics will renew a pregnant, formerly pregnant, or parenting student-athlete's award, so long as the student-athlete is in good standing academically, remains engaged with our athletics department and meets NCAA eligibility standards. Returning students may be evaluated athletically in the same manner as any other team member to determine their specific position on the team.

Federal Laws

- Title IX of the Education Amendments of 1972 bars discrimination on the basis of sex, which includes the guarantee of equal educational opportunity to pregnant and parenting students. This means that our student-athletes cannot be discriminated against because of their parental or marital status, pregnancy, childbirth, false pregnancy, termination of pregnancy or recovery there from. In addition, a student's medical information may be protected by other federal laws. Some actions that may be permissible under NCAA rules are impermissible under federal law, and our institution adheres to federal law.

Name _____ Date_____

_____
Student-Athlete Signature

_____
Parent/Guardian Signature
(Parent Signature is required if Athlete is under 18 Years of Age)

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INSURANCE FORMS

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MEDICAL INSURANCE INFORMATION

TO: The Parents/ Guardians of our New Student-Athletes
FROM: University of Arkansas Sports Medicine Department
RE: IMPORTANT MEDICAL INSURANCE INFORMATION

The University of Arkansas' Athletic Department wishes to welcome your son/daughter as a participant on one of our fine athletic teams. Every sport carries with it some degree of risk to the participant. Our medical staff provides specialized services, care, and supervision to safe guard their health and well-being.

To complement these medical services, we have also arranged for secondary insurance coverage in the event that your son/daughter sustains an injury resulting from athletic participation. All student-athletes participating under the supervision of the UA Athletics Department are eligible for secondary coverage under a basic accidental injury insurance plan. This plan provides "secondary" coverage to student-athletes for injuries sustained while participating in intercollegiate athletics after your primary policy (usually your family policy) has reached its limits of coverage. The coverage also applies to an injury sustained by a student-athlete while traveling with the team directly to or from scheduled practices and games sponsored by UA Athletics.

How does "Secondary" insurance work?

FOR ATHLETIC RELATED INJURIES:

- UA Athletics, through the medical providers and our insurance processors, initiates the claims process. In most cases, all medical bills specific to your son/daughter's care will be filed directly with your insurance company. At that point, you may receive an Explanation of Benefits (EOB) from your insurance company detailing the status of the claim. We make every attempt to ensure that no bills are sent directly to you. In rare cases, medical bills may be mailed to you along with a written request to submit the bills to your insurance company. It may be necessary for you to obtain appropriate claim forms from your employer before submitting the expenses. Therefore, if you do receive bills, please contact us for assistance in expediting the claims process.
- If there is a balance due after your insurance carrier has made payment and it is verified through your carrier's Explanation of Benefits (EOB), either our secondary insurance policy or our athletic department will cover the remaining balance. However, in order for us to do so, we will need copies of your insurance carrier's EOB.

Please remember that we do not expect you to pay "out of pocket" expenses for medical care related to your son/daughter's athletic injury and participation.

1. You will never pay a deductible even if your own policy has one --- for any athletic injury. Our policy will pay that deductible. If you are ever asked to pay anything on an athletic injury, DO NOT! Call us at (479) 575-4208 and we will follow up on any problems.
2. If you ever receive notice that an expense (for an athletic injury) is not covered by your policy, do not pay this. Again, please call us.
3. If your insurance company denies a claim related to your son/daughter's injury, then the department will assume responsibility for all medical bills subject to the rules of the department and the NCAA.

PLEASE BE ADVISED IF YOU PAY ANY OUT OF POCKET EXPENSE FOR AN ATHLETIC INJURY, YOU WILL NOT BE REIMBURSED BY THE STATE OF ARKANSAS, THE UNIVERSITY OF ARKANSAS, OR THE ATHLETIC DEPARTMENT.

FOR PRE-EXISTING INJURIES:

- If it is determined during the pre-participation medical screening that your son/daughter requires follow-up care for an injury/illness sustained prior to their enrollment at UA, medical expenses for such care will be submitted to your insurance company for coverage. If there are balances due after your insurance carrier has made payment, you will be responsible for those charges.

FOR NON-ATHLETIC RELATED INJURIES/ILLNESS:

- Note that there are a number of expenses for which the Department cannot assume responsibility. These include, but are not limited to: emergency room visits, hospital stays, diagnostic tests, laboratory studies, physician evaluations, and medications for out-of season illness. The period known as "out-of-season" is all times of the year prior to the sport's official start date and any time following your child's last competition or NCAA championship event. Injuries that occur outside of intercollegiate athletics such as intramural activities, physical education class, dormitory or household accidents, and motor vehicle accidents are the sole responsibility of you and your insurance carrier.

For non-athletic related injuries, your son/daughter will be instructed to send bills directly to you for payment or submission to your insurance carrier.

- UA Athletics cannot assume responsibility for the medical costs incurred for dermatology care.

- UA Athletics cannot assume responsibility for the medical costs incurred from long-term psychological care, including physician prescribed hospitalization for eating disorder treatment or drug and alcohol addiction.

- UA Athletics cannot assume responsibility for the medical costs incurred from extended allergy/asthma care unless such care is deemed by a physician to be medically necessary for safe participation. The medical expenses resulting from such care will first be filed with your primary insurance policy and any balances will be paid by UA Athletics.

- UA Athletics cannot assume responsibility for the medical costs incurred from gynecological care unless such care is deemed necessary for the purpose of injury prevention (i.e., hormone therapy). Routine examinations, diagnostic tests, treatments, and prescriptions for all other gynecological concerns (including birth control) shall be the responsibility of the athlete.

What type of primary insurance coverage should my child have?

- There is always the possibility that an injury or illness related circumstance as described above will require extensive medical care. It will be you and your son/daughter's responsibility to cover the expenses incurred from such care. Therefore, if your son/daughter is not covered under your existing primary insurance policy, we strongly encourage you to provide them with a policy which covers injury (both athletic and non-athletic) and illness. It is important that you send a copy (front and back) of your medical insurance and prescription drug benefits card(s) with your son/daughter to school.

- In the instances of HMO or POS coverage, you may want to review your insurance policy and determine if your son/daughter's medical expenses will be covered outside the network area. In most cases, policies of this nature will not cover your son/daughter while they are at school or will cover only a minimal percentage of expenses incurred. In the case where your son/daughter may require a surgical procedure to continue their athletic participation, every effort will be made to accommodate all facets of your insurance policy. If your HMO or POS does not release care/payment to our Fayetteville providers, and returning your son/daughter to "in-system" care would neither jeopardize their academic or athletic progress, they may be required to return to your network provider for service.

- If you would like information on purchasing an insurance policy that would cover your son/daughter while in school, please contact Laura Jones, UA Athletics Insurance Coordinator, at (479) 575-4208 for assistance. Laura may periodically contact you for information regarding your insurance plan, please assist her in this process.

Thank you for your cooperation. If you have any questions, please do not hesitate to call Laura at (479) 575-4208.

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INSURANCE QUESTIONNAIRE/INFORMATION

PLEASE ATTACH A COPY OF YOUR CURRENT MEDICAL INSURANCE and PRESCRIPTION DRUG BENEFITS CARD(S) (Front and Back)

SECTION I: MEDICAL SERVICE INSURANCE AGREEMENT – I acknowledge receiving the UA Athletics insurance procedural letter. I understand the extent of the University's responsibility to a student-athlete who becomes injured or ill as a result of participation in the intercollegiate sports program at The University of Arkansas. I also understand that there is an assumed risk involved in playing intercollegiate athletics. This form must be filled out, signed and returned before the student-athlete will be allowed to participate in intercollegiate athletics at The University of Arkansas.

Student-Athlete's Name - PRINT _____ Social Security # _____ Date of Birth _____

Student-Athlete's Signature _____ Date of Signature _____ Sport _____

Parent/Guardian's Signature _____ Date of Signature _____ Year of College (Fr., So., etc.) _____

Father's Name - PRINT _____ Mother's Name - PRINT _____

Parents please indicate whether your child is covered under your present insurance policy. (Please circle) YES or NO
IF he/she is covered, please provide us with the following health insurance information

SECTION II: HEALTH INSURANCE INFORMATION

Parent/Guardian's / POLICY HOLDER's Name: _____ Home Phone: _____

Parent/Guardian's/Policy Holder's Address: _____

City/State/Zip: _____

Employed By: _____ Business Phone: _____

SECTION III: INSURANCE SPECIFICS

***Name of your insurance company:** _____ HMO PPO POS (Please Circle If Applicable)

Address of your insurance company: _____

City/State/Zip: _____ Phone: _____

***Policy Holder's Social Security #:** _____ ***Policy Holder's Date of Birth:** _____

***Policy Number:** _____ *Group Number: _____

SECTION IV: RX INFO

*Rx Company Name: _____ *Rx Address : _____

*Rx Phone #: _____ *Rx PCN: _____

*Rx ID#: _____ *Rx Bin: _____ *Rx Group: _____

* Relation to Dependent (01,02,03): _____ *Rx Cardholders Name: _____

Dental Coverage YES or NO (Need a Copy of Dental Card)

Vision Coverage YES or NO (Need a Copy of Vision Card)

Rx Coverage YES or NO (Need a Copy of Rx Card)

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MEDICAL HISTORY FORMS

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MEDICAL HISTORY

NAME: _____ DATE: _____

PLEASE CIRCLE YES OR NO

GENERAL MEDICAL ALLERGIES- Are you allergic to:

Aspirin	Yes	No	Any Foods	Yes	No
Codeine	Yes	No	Any Other Drug	Yes	No
Sulfa	Yes	No	Tetanus Antitoxin or Serums	Yes	No
Penicillin	Yes	No	Novocain or Other Anesthetics	Yes	No
Hay Fever	Yes	No	Insect Stings	Yes	No
Animal Allergies	Yes	No	Other _____	Yes	No
			_____	Yes	No

OTHER DISEASES AND ILLNESSES- Do you have or have you ever had:

Pneumonia	Yes	No	Hemorrhoids	Yes	No
Frequent Headache	Yes	No	Hernia	Yes	No
Migraine Headaches	Yes	No	Kidney or Bladder Infections	Yes	No
Frequent Sore Throat	Yes	No	Kidney or Bladder Stone(s)	Yes	No
Mononucleosis	Yes	No	Positive Sickle Cell Trait	Yes	No
Thyroid Disease	Yes	No	Diabetes	Yes	No
Seizures/Convulsions	Yes	No	Ear Disease or Hearing Problems	Yes	No
Epileptic Attacks	Yes	No	Frequent Respiratory Infections	Yes	No
Bleeding Problems	Yes	No	Frequent Skin Infections	Yes	No
Hepatitis	Yes	No	Stomach (GI) Disease	Yes	No

ARKANSAS
ATHLETICS

MEDICAL HISTORY CONTINUED

NAME: _____ DATE: _____

Appendicitis	Yes	No	Frequent Diarrhea	Yes	No
Cancer	Yes	No	Life-threatening allergic reaction	Yes	No
Anxiety or Depression	Yes	No	Fainting	Yes	No
Anemia (low iron)	Yes	No	Pregnant or nursing	Yes	No
Eating Disorder	Yes	No	Osteoporosis	Yes	No
Stress Fractures	Yes	No	Has any family member under the age of 50 died unexpectedly	Yes	No
			Please Explain:_____		

Were you born with any generalized abnormalities Yes No
If Yes:_____

Absent Organs Yes No
If Yes:_____

Concussion Yes No
If Yes: Did you lose consciousness? _____

GENERAL MEDICAL QUESTIONS

Have you had a serious illness or injury in the past year?	Yes	No
Have you had trouble breathing with exercise?	Yes	No
Have you been diagnosed with asthma?	Yes	No
Do you use an inhaler?	Yes	No
Unexplained weight loss or change in eating patterns?	Yes	No
Missed training due to fatigue?	Yes	No
Laxative use?	Yes	No
Diagnosed with MRSA (bacterial skin infection)?	Yes	No

When was your last tetanus shot? _____

ARKANSAS
ATHLETICS

MEDICAL HISTORY CONTINUED

NAME: _____ DATE: _____

MEDICATIONS CURRENTLY ON OR FREQUENTLY USED

(Including prescription and non-prescription medications)

Pain Medication	Yes	No	If Yes, what do you take: _____
Anti-inflammatory	Yes	No	If Yes, what do you take: _____
Allergy/Sinus	Yes	No	If Yes, what do you take: _____
Antibiotics	Yes	No	If Yes, what do you take: _____
Birth Control of any kind	Yes	No	If Yes, what do you take: _____
Vitamins	Yes	No	If Yes, what do you take: _____
Creatine/Supplements	Yes	No	If Yes, what do you take: _____

Other Medications and for what purpose: _____

FAMILY HISTORY

(If any blood relative has had any of the following, circle the number)

1. Alcoholism	5. Bleed easily	9. Epilepsy	13. Stroke
2. Anemia	6. Cancer	10. Headaches/Migraines	14. Thyroid Disease
3. Arthritis	7. Diabetes	11. High blood pressure	15. Unknown
4. Asthma	8. Drug Addiction	12. Mental illness/Depression	16. Other: _____

EYE QUESTIONS:

Have you or anyone in your immediate family have any eye conditions or disease of the eye? Yes No

Have you ever had eye surgery or experienced trauma to the eye? Yes No

If Yes, please explain: _____

Do you wear glasses, contacts, or protective eyewear? Yes No

If Yes, do you have your glasses with you? Do you have plenty of contacts for the season?

_____

Date of last eye exam_____

ARKANSAS
ATHLETICS

MEDICAL HISTORY CONTINUED

NAME: _____ DATE: _____

HEAT RELATED PROBLEMS:

Have you ever experienced any of the following?

	Circle		When	Where
Heat Exhaustion	Yes	No	_____	
Heat Cramps	Yes	No	_____	
Heat Stroke	Yes	No	_____	

Explain the treatment you received for any of the above problems:

Have you ever been hospitalized for a heat related problem? Yes No

If Yes, When: _____

Where: _____

SURGERY/OPERATIONS:

List ALL previous surgeries:

1. Operational Procedure: _____

Body Part: _____

Date: _____ Physician: _____

City and Hospital: _____

2. Operational Procedure: _____

Body Part: _____

Date: _____ Physician: _____

City and Hospital: _____

3. Operational Procedure: _____

Body Part: _____

Date: _____ Physician: _____

City and Hospital: _____

ARKANSAS
ATHLETICS

NAME:_____ DATE:_____

Sport: _____ Position: _____

CARDIOLOGY / HEART HISTORY

Do you have or have you ever had:

1. High blood pressure	Yes	No
2. Heart murmur	Yes	No
3. Heart disease	Yes	No
4. Chest pain with exercise	Yes	No
5. Palpations with exercise	Yes	No
6. Trouble breathing with exercise	Yes	No
7. Frequent coughing with exercise	Yes	No
8. Frequent coughing at night	Yes	No
9. Fainting	Yes	No
10. Prior restriction from participation in sports	Yes	No
11. Family history of heart disease (including early, less than age 55, unexplained sudden death in a family member)	Yes	No
12. Specific knowledge of certain cardiac conditions in family members (hypertrophic or dilated cardiomyopathy, long QT syndrome or other ion channelopathies, Marfan syndrome or clinically important arrhythmias)	Yes	No
13. Tests performed for your heart (if Yes, explain below)	Yes	No
14. Heart surgery (if Yes, explain below)	Yes	No
15. Been diagnosed with a heart condition (if Yes, explain below)	Yes	No

_____

_____

TEAM PHYSICIAN ONLY:

ECHO	Normal	ABN
12-Lead ECG	Normal	ABN
Cleared for Participation	YES	NO

NOTES: _____

_____

_____

_____ _____

Cardiologist Signature Date:

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MEDICAL HISTORY CONTINUED

NAME: _____ DATE: _____

ATTENTION DEFICIT DISORDER-(ADD)
ATTENTION DEFICIT HYPERACTIVITY DISORDER-(ADHD)

Effective in August 2009, a stricter application of the NCAA Medical Exception policy was put in place, specifically for the use of banned stimulant medications used to treat ADD/ADHD, therefore, it is very important that you answer the following questions:

1. Have you ever been diagnosed with ADD/ADHD? Yes No
2. If Yes, did this diagnosis include clinical evaluation and testing? Yes No
3. Do you currently take medication for the treatment of ADD/ADHD? Yes No

If Yes, what medication do you take? _____

I do hereby state that, to the best of my knowledge and belief, that these answers to these ADD/ADHD questions are complete and accurate.

Signature: _____

Date: _____

FEMALE ATHLETES ONLY

Age you experienced your first menstrual period: _____

The longest time you've gone between periods: _____

Length of period (# of days) _____ Date of last menstrual period: _____

How many periods have you had in the past 12 months? _____

When was your last Gynecological Exam (Pap Test)? _____

Have you ever had an abnormal Pap Test? Yes No

Do you lose your period with training? Yes No

Any past pregnancies? Yes No

Are you using any form of birth control? Yes No

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ATHLETICS

ORTHOPEDIC HISTORY

NAME: _____ DATE: _____

HAVE YOU EVER HAD?

NECK

Pinched Nerves	Yes	No
Fractures	Yes	No
Sprains	Yes	No
Pain	Yes	No

If Yes, explain: _____

_____

SPINE/BACK

Fractures	Yes	No
Muscle Spasms	Yes	No
Ruptured Disc	Yes	No
Stiffness	Yes	No
Pain	Yes	No
Pain with Lifting	Yes	No

If Yes, explain: _____

_____

Shoulder & Neck Pain

NUMBER OF BURNERS/STINGERS IN THE PAST TWO (2) YEARS _____

	Circle		When	Where
NUMBNESS IN ARMS	Yes	No	_____	
NUMBNESS IN FINGERS	Yes	No	_____	

Explain the tests and treatments you received for any of the above conditions: (Hospitalized, MRI, CT Scan):

_____

_____

Do you wear a neck roll or neck collar?	Yes	No
Have you ever worn a neck roll or neck collar?	Yes	No
Have you ever been advised to wear a neck roll or neck collar?	Yes	No
Have you ever had your neck X-Rayed?	Yes	No

ARKANSAS
ATHLETICS

ORTHOPEDIC HISTORY CONTINUED

NAME: _____ DATE: _____

THIGHS

Quad Pulls	Yes	No	Rt./Lt.
Ham Pulls	Yes	No	Rt./Lt.
# In last 2 years	Rt. _____	Lt._____	
Torn Muscles	Yes	No	Rt./Lt.
Calcium Deposits	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____
_____

LEGS

Shin Splints	Yes	No	Rt./Lt.
Torn Muscles	Yes	No	Rt./Lt.
Calcium Deposits	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____
_____

HAND, WRIST & FINGERS

Fractures	Yes	No	Rt./Lt.
Sprains	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Navicular Fracture	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____

FEET/TOES

Fractures	Yes	No	Rt./Lt.
Sprains	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Turf Toe	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____

PELVIS

Groin Pulls	Yes	No	Rt./Lt.
Contusions	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____

ARM

Calcium Deposits	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____

ARKANSAS
ATHLETICS

ORTHOPEDIC HISTORY CONTINUED

NAME: _____ DATE: _____

KNEES

Sprained Ligaments	Yes	No	Rt./Lt.
Which Ligaments: _____			
Which Ligaments: _____			
Torn Ligaments	Yes	No	Rt./Lt.
Torn Cartilages	Yes	No	Rt./Lt.
Injured Knee Caps	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Swelling	Yes	No	Rt./Lt.
Locking	Yes	No	Rt./Lt.
Giving way	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.
Wear Braces	Yes	No	Rt./Lt.
Tendonitis	Yes	No	Rt./Lt.

Explain: _____
_____

ANKLES

Sprains	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Fractures	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

SHOULDER/CLAVICLE

Fractures	Yes	No	Rt./Lt.
Separations	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Slipping in joint	Yes	No	Rt./Lt.
Burners	Yes	No	Rt./Lt.
Inflammation	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.
Pain with throwing	Yes	No	Rt./Lt.

Explain: _____
_____

ELBOW

Fractures	Yes	No	Rt./Lt.
Sprains	Yes	No	Rt./Lt.
Dislocations	Yes	No	Rt./Lt.
Inflammation	Yes	No	Rt./Lt.
Pain	Yes	No	Rt./Lt.

Explain: _____
_____

# of Ankle Sprains in last 2 years Rt.____ Lt.___

I do hereby state that, to the best of my knowledge and belief, my answers on the forgoing Medical History and Orthopedic forms are complete and correct.

Signature: _____ Date: _____

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PPE FORMS

FOR PHYSICIAN USE ONLY

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ARKANSAS RAZORBACK PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Name _____ Sport _____ Date _____

Height _____ Weight _____ Date of Birth ____/____/____

VISION	Glasses	Contacts	Without
Vision R 20/ _____ L 20/ _____ Both 20/_____			

HEENT	N	AB	COMMENTS
Discharge			
Ulcers			
Sinus/Septum			
PULMONARY Lungs: PFT _____ _____ _____			
Wheezing, Rales			
ABDOMINAL/THORAX Organ Enlargement			
Hernia			
Masses			
GENITALIA Paired Organs			
Hernia			
Discharge			
Health History Review			
SKIN Moles/Sun Spots			
Rash			
Texture			
Acne			
NEUROLOGICAL Reflexes			
Cranial Nerves			
Motor/Gait/Balance			
Sensory			

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PPE FORM CONTINUED

Name _____ Date _____

EXTREMITIES	N	AB	COMMENTS
Atrophy			
Edema			
Veins			
Pulses			
MENTAL Affect			
Irritability/ Agitation			
Depression/ Anxiety			
CARDIOVASCULAR Blood Pressure ____/ ____			
Heart: Murmurs Standing _____ Supine _____ Pulse Brachial _____ Femoral_____			
Marfan's Syndrome			

PHYSICIAN'S SUMMARY:

Needs Further Evaluation	Yes	No
Cleared for Participation	Yes	No
Dictation Made	Yes	No
Sickle Cell Tested	Yes	No
Cleared by Cardiologist	Yes	No

_____
Physician's Signature

_____
Date

For ATHLETIC TRAINERS ONLY:

Sickle Cell Test Results on File	Yes	No

Revised 5/9/12

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ORTHOPEDIC EXAMINATION

Name _____ Date _____

	N	AB	COMMENTS
NECK			
SHOULDER			
ELBOW			
WRIST			
HAND			
HIP			
ANKLE			
FEET			
LOW BACK			
FUNCTIONAL TEST (a) Hop on one leg (b) Run in place (c) Full squat	YES	NO	COMMENTS
PATELLA (a) Pain			
(b) Apprehension Test			
(c) Crepitation			
THIGH (a) Tone _____ (b) Atrophy _____ (c) Hamstrings _____			

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ORTHOPEDIC EXAMINATION

Name _____ Date _____

KNEE		RIGHT				LEFT			
(A)	LCL								
	1. Extension	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	2. 30°	Neg.	1+	2+	3+	Neg.	1+	2+	3+
(B)	MCL								
	1. Extension	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	2. 30°	Neg.	1+	2+	3+	Neg.	1+	2+	3+
(C)	ACL/PCL								
	1. Lachman	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	*Endpoint		A	B			A	B	
	2. Anterior Drawer	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	3. Posterior Drawer	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	4. Pivot Shift	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	5. Reverse Pivot Shift	Neg.	1+	2+	3+	Neg.	1+	2+	3+
	6. Palpation								
	Scar	YES	NO	_____					
	Pain	YES	NO	_____					
	Effusion	YES	NO	_____					
	Soft Tissue Swelling	YES	NO	_____					

(D)	MENISCUS	RIGHT	LEFT
	McMurray's Sign	Pos. / Neg.	Pos. / Neg.

X-ray Finding: _____

Examiner Name: _____ Date: _____

Examiner Signature _____

Comments: _____

Needs Further Evaluation	Yes	No
Cleared for Participation	Yes	No
Dictation Made	Yes	No