Last Name, First:_____ Sport:_____

MEDICAL HISTORY

Name: _____
Last First Middle

Sport: _____ Sex: ☐M ☐F Date: _____

Please answer the following questions and explain all "Yes" answers below:

YES	NO	
☐	☐	Have you ever been hospitalized?
☐	☐	Are you presently taking any medications or pills?
☐	☐	Have you ever passed out during or after exercise?
☐	☐	Have you ever been dizzy or passed out in the heat?
☐	☐	Have you ever had high blood pressure?
☐	☐	Have you ever been told that you had a heart murmur?
☐	☐	Have you ever had racing of your heart or skipped heartbeats?
☐	☐	Has anyone in your family died of heart problems or a sudden death before the age of 50?
☐	☐	Have you ever been knocked out or unconscious?
☐	☐	Have you ever had a seizure?
☐	☐	Do you have trouble breathing or do you cough after your activity?
☐	☐	Have you ever dislocated, fractured, broken or had repeated swelling, or other injuries of any bones or joints? If yes, please indicate:

☐Head ☐Neck ☐Shoulder ☐Forearm ☐Wrist
☐Hand ☐Chest ☐Back ☐Hip ☐Thigh
☐Knee ☐Ankle ☐Foot ☐Shin/Calf

☐	☐	Have you had any other medical problems (infectious mononucleosis, diabetes, hepatitis, asthma, etc.)?
☐	☐	Do you have any allergies (includes medicines, bees, etc.)?

When was your last tetanus shot? Month_____ Year_____

Explain all "yes" answers:_____

_____

_____

_____

_____

_____

Last Name, First:_____ Sport:_____

ATHLETIC PHYSICAL EVALUATION
This section MUST be completed by a medical doctor.

Athlete's Name_____

Height _____ Weight _____ lbs Blood Pressure: _____ / _____

Pulse_____ Vision checked: ☐ Uncorrected ☐ Corrected

R 20/_____ L20/_____ Both 20/_____

	Normal	**Abnormal Findings**
Eyes (Anisocoria)	_____	_____
Ears	_____	_____
Throat	_____	_____
Heart	_____	_____
Lungs	_____	_____
Abdomen (Organomegaly)	_____	_____
Hernia	_____	_____
Skin	_____	_____
Musculoskelatal		
Neck	_____	_____
Shoulder	_____	_____
Elbow	_____	_____
Wrist	_____	_____
Hand	_____	_____
Back	_____	_____
Hip	_____	_____
Knee	_____	_____
Ankle	_____	_____
Foot	_____	_____
Other	_____	_____

Intercollegiate Participation is: ☐ Granted ☐ Granted w/ limitations ☐ Postponed

Comments: _____
_____
_____

_____
Please print physicians name **Phone #**

_____
Physician Signature **Date**

Last Name, First:_____ Sport:_____

RELEASE AGREEMENT FOR POTENTIAL INJURY OR LIABILITY

Name: _____
Last First Middle

Sport (s): _____ Age: _____

ACCEPTANCE OF RISK AND RESPONSIBILITY

I am aware of my responsibility in preventing potential injuries, reporting actual injuries, complying with the treatment plan of the Warner Pacific Athletic Department, and that there is a risk of injury, which includes some spinal cord and brain injury that may result in paralysis and the possibility of other permanent injury or death. I agree to participate in activities sponsored by Warner Pacific College and understand that all activities have risk for injury, death, illness, or disease, or damage to myself, participants, or property arising from participation. Athletes rightfully assume that those who are responsible for the conduct of sport (administrators, coaches, physicians, athletic trainers, and others) have taken reasonable precautions to minimize the risk of significant injury. I also agree and accept that Warner Pacific College, its' board of regents and trustees, officers, employees, volunteers, and agents assume no responsibility or liability in connection with any activities, or the transportation to or from such activities. I understand that Warner Pacific College reserves the right to withdraw any or all announced parts of any activities should conditions warrant, and also to decline to accept or retain participants as members of any activity. My participation in athletics is purely voluntary; and I elect to participate in spite of the risks.

INFORMED CONSENT

I have read the above and agree to accept any risks which may be associated with Warner Pacific College intercollegiate activities or related activities. I also authorize the coach, athletic director or qualified medical personnel to take whatever first aid action is deemed necessary, in their sole judgment, to protect my health or safety in the event of any accident or emergency.

_____ Date_____
Student-Athlete Signature

PARENT/GUARDIAN SIGNATURE IS REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE

_____ Date_____
Parent/Guardian Signature

Last Name, First:_____ **Sport:**_____
Date of Birth: _____ **Cell Phone Number:** _____

WARNER PACIFIC COLLEGE
STUDENT-ATHLETE INSURANCE INFORMATION

Complete this section if the student athlete is the insurance Subscriber.

Health Insurance Company Name_____

Company Address:_____Company Phone # _____

Policy/Group #_____ ID #_____ Type: (Circle One) HMO / PPO

Complete this section if the Parent/Guardian is the insurance subscriber

PARENT / GUARDIAN

Name _____Date of Birth_____

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

Health Insurance Company Name_____

Company Address:_____Company Phone # _____

Policy/Group #_____ ID #_____Type: (Circle One) HMO / PPO

Emergency contact(s) (if not parent or guardian)

Name:_____Relationship:_____

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

Name: _____**Relationship:**_____

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

Is the insurance company or plan considered a HMO or a Preferred Provider Organization (PPO)
If yes, list Preferred Providers in the Portland Metropolitan Area:

_____ _____ _____

_____ _____ _____

Name of personal physician:_____ Phone:_____

By my signature below, I recognize that the above information is accurate and that my primary insurance covers injuries sustained by my son/daughter or myself while competing in interscholastic athletics. I attest that this insurance is current and will remain in effect for the entire year. If my insurance changes I will notify the Warner Pacific athletic trainer immediately and provide current information. Furthermore, I authorize Warner Pacific College to inspect and/or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A copy of this authorization shall be deemed as effective and valid as the original. I the undersigned give Warner Pacific College permission to contact those listed above in emergency situations to be determined by Warner Pacific College staff.

_____

Parent/Guardian Signature Date

_____

Student-Athlete Signature Date

HIPPA Release Authorization Form
For Uses and Disclosures of Patient Protected Health Information

Student-Athlete: _____ Sport: _____

Student ID Number: _____ Date of Birth: _____

I hereby authorize Warner Pacific College (WPC) Department of Athletics to release my protected health information. I understand that this authorization will only be used on a need to know basis to insure quality treatment/care. Protected health information may include:

I. Injury or illness relevant to past, present, or future participation in intercollegiate athletics at WPC
II. Information contained in my personal medical record unrelated to my participation in intercollegiate athletics at WP
III. Information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports, and any other documentation regarding my health status.

Authorization is granted for release of my protected health information to:

- Health care providers (including but not limited to athletic trainers, physicians, nurses, physician assistants, or physical therapist) allowing for open communication channels to ensure my safety and proper treatment while participating in my intercollegiate sport(s).
- My parents/guardian and/or spouse for the purpose of assisting me in making healthcare decisions while I am a student-athlete.
- The coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
- My teammates so that they may be aware of limitations that I may be under while I am a student athlete.
- Academic departments including specifically Warner Pacific College Registrars office for the purpose of making decisions regarding my ability and suitability to perform academically while I am a student-athlete.
- The Cascade Conference and the National Association of Intercollegiate Athletes (NAIA) for the purpose of making determination regarding my eligibility status while I am a student-athlete.
- Applicable insurance providers for the purpose of processing insurance claim while I am a student-athlete.
- The media, including specifically the Warner Pacific College sports information director, to advise the print, radio, television and other media of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses for the purpose of reporting on it while I am a student-athlete.
- Professional athletic teams, their scouts, athletic trainers, physicians, servants, or employees for the purpose of making decisions regarding my prospect as a professional athlete.
- Amateur athletic organizations for the purpose of making decisions regarding my prospect as an athletic participant.

I understand my rights, as described herein:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain Treatment.
- I may revoke this authorization at any time by delivering a signed and dated letter to the Head Athletic Trainer (Amy Engilis, MA, ATC).
- If I revoke this authorization it does not affect any uses or disclosures made before my revoke was received.
- If the persons or entities that are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
- The information authorized for release may include records, which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, HIV, AIDS and/or mental health information.
- Warner Pacific College will not receive compensation for its use or disclosure of your protected health information.
- The HIPPA Release will remain in effect as long as I am a student-athlete at Warner Pacific College

Signature of student-athlete: _____ Date: _____

Last Name, First:_____ Sport:_____

STUDENT ATHLETE BIO and Media Release
(please print all information - this will be used for website profile)

Student Information (complete every line)

Your Name_____ Phone Number at School: _____

E-mail Address_____ Cell Phone Number: _____

Address While in school:_____

Address When Not in School: _____

Date of Birth_____Birthplace_____

Parent's Names_____

Names of Brothers and Sisters_____

Media Information (this information is important)

Year of Eligibility: o FR o SO o JR o SR Hometown_____ Major_____

Height_____ Weight (men only)_____ Position_____

High School Attended: _____Year Graduated_____

High School Athletics (years and sports played)_____

Name of High School Coach(es)_____

HS Awards/Honors (include all-league, records set, team accomplishments etc)_____

_____

_____

Previous College Attended:_____ Name of College Coach(es)_____

College Awards/Honors. _____

_____

_____

Hometown Newspaper(s): _____

Release: I authorize Warner Pacific College to use my picture, videotape or other information for local, regional and national media outlets. This release is valid for the entire duration of my participation in sports at Warner Pacific College.

_____

Signature Date