



BRYN ATHYN COLLEGE



Returning Student Athlete Form

Required for Participation in NCAA Sports

BRYN ATHYN COLLEGE HEALTH SERVICES

2945 COLLEGE DRIVE, BRYN ATHYN PA 19009 | FAX 267-502-6024

Health History Questionnaire Part 1

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

MEDICATIONS (Prescription, non-prescription, vitamins, herbal, etc.)

Medication	Dose	Times Taken Per Day

ALLERGIES/REACTIONS

Medicine/Food/Agent	Reactions/ Side Effect

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

A. NEUROLOGICAL

- Concussion (list dates): _____
- Cerebral Palsy
- Migraines/ Headaches
- Seizure Disorders

B. CARDIOVASCULAR

- Fainting
- Blood Disorder
- Heart Condition (list): _____

- Blood Pressure Abnormalities
- Heart Murmur
- Chest Pain/ Discomfort

C. GASTROINTESTINAL

- Chronic Inflammatory Bowel Disease
- Digestive Problems (describe): _____

- Acid Reflux
- Hernia
- Gallbladder Disease
- Liver Disease

D. GENITOURINARY

- Urinary Tract Infections
- Kidney Stones
- Kidney Disease

E. INFECTIOUS DISEASES

- Chicken Pox
- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus)
Date: _____
- Positive TB Testing
Date: _____
- Preventative INH Treatment for Tuberculosis
Date: _____
Length of Treatment: _____

- HIV

F. METABOLIC/ ENDOCRINE

- Diabetes Type 1/ Type 2
- Thyroid Disorder
- Hypoglycemia

G. RESPIRATORY

- Asthma/ Sports- Induced Asthma
Asthma Medication: _____
- Seasonal Allergies: _____
- Shortness of breath

H. MEN'S HEALTH

- Testicular Problems

I. WOMEN'S HEALTH

- Irregular Menses
- Painful Menses
- Last menstrual period _____

Health History Questionnaire Part 2

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

J. PSYCHOLOGICAL OR SOCIAL

- Alcohol/ Drug Abuse Problems
- Anxiety
- Depression
- Eating Disorder
- Panic Attack
- Insomnia
- ADD/ ADHD
- Learning Disability
- Suicide Attempt
- Psychiatric Admission

K. ILLNESSES NOT LISTED ABOVE: _____

L. SURGERIES AND HOSPITALIZATIONS

Dates: _____ Specify reason: _____

M. ORTHOPEDIC HISTORY - Have You Ever Had an Injury to:

- Shoulder (describe): _____

- Elbow/Wrist/Arm/Hand (describe): _____

- Lower Leg (describe): _____

- Knee (describe): _____

- Ankle/Foot (describe): _____

- Hip/Groin (describe): _____

- Back/Ribs (describe): _____

Neck (describe): _____

Physical Disability (describe): _____

N. FAMILY HISTORY

Have any of your blood relatives had any of the following?
High Blood Pressure

- yes no

Heart Disease (heart murmur, hypertrophy, irregular heart beat, Marfan's Syndrome, heart attack, stroke)

- yes no

Diabetes

- yes no

Non-accidental/sudden death in immediate family before age 50

- yes no

Please explain any **YES** responses below: _____

O. CONCUSSION HISTORY

Have you ever been diagnosed with a concussion?

- yes no unsure

If yes:

Number of concussions _____

Date(s) of injury: _____

How long did it take you to recover? _____

Did you lose consciousness or get "knocked out"?

- yes no

Did you have to go to the hospital?

- yes no

Physical Form Part 1

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please submit this form to physician

Physician please review: Health History Questionnaire, Physical Form, Immunization and TB Forms.

Does the student have an illness/ condition **NOT** listed in the history, for which treatment is required? yes no
 Please explain: _____

Is the student under treatment for Eating Disorder, Behavioral, OR Psychiatric Problems? yes no
 Please explain: _____

Does the student have Physical Disabilities OR Assisted Devices? yes no
 Please explain: _____

CLINICAL EVALUATION	NORMAL	ABNORMAL (PLEASE EXPLAIN)
MEDICAL:		
BP _____ T _____ P _____ R _____		
Height _____ Weight _____		
Head, Face, Neck, and Scalp		
Visual acuity and ophthalmic exam		
Ears/Nose/Throat/Sinuses/Mouth		
Lungs and Chest		
Heart		
Abdomen		
Skin		
Neurological		
G-U		
Menstrual History		
MUSCULOSKELETAL:		
Neck		
Back/Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
REQUIRED FOR ATHLETES:		
Heart Murmur*		
Femoral Pulses to exclude Aortic Coarctation		
Physical Stigmata or Marfan Syndrome		
Bilateral, Brachial Artery BP, Sitting position**		

*Should be done supine and standing (or Valsalva Maneuver) to identify (L) Ventricular outflow obstruction

**Preferably done in both arms

Physical Form Part 2

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please submit this form to physician

Physician please review: Health History Questionnaire, Physical Form, Immunization and TB Forms.

NCAA SPORTS/COLLEGE INTRAMURAL CLEARANCES

ATTENTION PROVIDERS!!

- For the student to tryout/ participate in NCAA Athletics/ Intramural Activities, the **SIGNATURE SECTION MUST BE COMPLETED AND SIGNED** by the Health Care Provider (Physician, PA-C OR Nurse Practitioner).

CLEARED

CLEARED, with recommendation(s) for further evaluation or treatment for: _____

NOT CLEARED for the following types of sports/intramurals (please check those that apply):

Contact Non-Contact Strenuous Activities

Due to _____

Recommendation(s) / Referral(s) _____

SIGNATURE SECTION

I certify that I have examined this student; that the above statements and health history are correct; and that I find the student is neither mentally nor physically disqualified by reason of communicable disease or any chronic or acute defect from successful performance as a college student at Bryn Athyn College, except as noted. Furthermore the student is also cleared/not cleared as stated above for participation in NCAA sports/ college intramural activities.

Signature of Health Care Provider

License Number

Address

City

State

Zip Code

Phone

Fax

Print Name of Health Care Provider

Date of CIPPE

BRYN ATHYN COLLEGE

Athletic Department Participation Agreement, Assumption of Risk, Acknowledgement of Insurance, and Consent to Treat Form

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

I, _____, acknowledge that I am voluntarily agreeing to participate in Bryn Athyn College Athletics and I agree to the below listed statements.

I acknowledge that I fully appreciate and understand the risks and dangers which arise from participation in intercollegiate athletic activities, and acknowledge that there is the potential for personal injury involved with participation, which include, but are not limited to: death, serious neck and spinal injuries, complete or partial paralysis, brain damage and serious injury or impairment to virtually all internal organs, bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system and serious injury or impairment to other parts of the body, general health and wellbeing. I understand that an injury may affect future capacity to earn a living, to engage in other business, social and recreational activities and generally, to enjoy life.

I acknowledge that I will procure medical and accident insurance in excess of \$90,000 to cover injuries I may sustain as a result of my participation in athletic activities by carrying a primary medical insurance policy and passing a physical that will allow me to become a rostered member of a Bryn Athyn College Athletics team. By completing the requirements of becoming a rostered member of a Bryn Athyn College athletics team I become eligible for enrollment in the Bryn Athyn College secondary accident medical policy and have completed the requirement of \$90,000 of athletics insurance coverage. If there is any change in coverage or expiration of coverage, I agree to notify Bryn Athyn College of this development and update the insurance information I have on file with the College immediately. I understand and agree that Bryn Athyn College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Bryn Athyn College.

I have completed a physical form and a physician has stated that I am in good health and have no physical condition that would prevent me from participation in a sport. The certified health physical does not necessarily mean that I am physically able to participate, but only that the evaluator did not find any reason to deem me physically unable to participate.

I understand that in the event of injury, I am to report to the Athletic Trainer and follow the protocol that is given to me until I am told to stop by the Athletic Trainer. I further acknowledge and understand that it is my responsibility to continue to notify the Bryn Athyn College sports medicine staff of any new limitations on my medical condition that affects my enrollment or participation in sports or athletic activities at Bryn Athyn College.

I further acknowledge and understand that if I refuse or fail to treat and/or rehabilitate my injury, I must get a clearance note from a physician and the Bryn Athyn College sports medicine staff stating that I am cleared to participate in intercollegiate athletics, before I return to athletics at Bryn Athyn College. Because my insurance and the Bryn Athyn College student-athlete medical insurance may refuse coverage due to my failure to treat my injury, I will be responsible to pay for the medical bill incurred for treatment of the injury by medical providers.

I grant permission to the Bryn Athyn College sports medicine staff and its medical representatives to render and/or obtain treatment, medical/surgical procedures to the extent of their abilities and training necessary for my health and well-being with regard to injuries that may be sustained during participation in intercollegiate athletics.

In consideration of the opportunity afforded me to participate in the above mentioned program I hereby knowingly, freely and voluntarily release, and, moreover, covenant to indemnify and hold harmless Bryn Athyn College and anyone acting on its behalf, from any and all liability, claims, demands or causes of action whatsoever, arising out of any loss to me, in the course of or related to, participation in these programs or the use of equipment supplied to me in connection with any program. I, therefore, voluntarily assume all risks of loss, damage, illness, or injury that I may sustain while participating in intercollegiate athletic activities at Bryn Athyn College.

Signature of Student-Athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

(IF STUDENT-ATHLETE IS UNDER 18 YEARS OF AGE)

BRYN ATHYN COLLEGE

Student-Athlete Authorization/ Consent For Disclosure of Health and Educational Information

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby authorize the Bryn Athyn college and its physicians, athletic trainers, nurses, and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to all involved health care professionals and other necessary entities (e.g. Bryn Athyn College Athletic Administration, Bryn Athyn College Coaches, Conference Commissioners).

_____ (Student-Athlete Initials)

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 (THE BUCKLEY AMENDMENT)

I hereby grant the Athletic Department at Bryn Athyn College permission to access my protected educational records during my training for and participation in intercollegiate athletics. I authorize the Athletic Department to disclose this information to the appropriate entities for awards, honors, and eligibility requirements.

_____ (Student-Athlete Initials)

I understand that my injury/illness information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA). I understand that my educational records are protected under the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). I understand that this information may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics.

I also understand that the NCAA and media outlets are not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to their disclosure of my injury/illness information.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at Bryn Athyn College. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Student-Athlete Name (please print): _____

Student-Athlete Signature: _____ Date: _____

BRYN ATHYN COLLEGE

Sickle Cell Trait Form for NCAA Intercollegiate Athletics Part 1

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

ABOUT SICKLE CELL TRAIT

- Sickle cell trait is not a disease. Sickle cell trait is an inherited condition affecting the oxygen-carrying substance, hemoglobin, in the red blood cells. You are born with sickle cell trait; it cannot be developed over time or contracted like a disease.
- Sickle cell trait is a common condition (> three million Americans)
- Although Sickle cell trait occurs most commonly in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ethnicities may test positive for this condition.
- Those with sickle cell trait usually have no symptoms or any significant health problems. However, sometimes during very intense, sustained physical activity, as can occur with collegiate sports, certain dangerous conditions can develop in those with sickle cell trait, leading to blood vessel and organ (kidneys, muscles, heart) damage that can cause sudden collapse and death. Some of the settings in which this can occur include timed runs, all out exertion of any type for 2 to 3 continuous minutes without a rest period, intense drills and other bursts of exercise after doing prolonged conditioning training. Extreme heat and dehydration increase the risks. (NCAA: A Fact Sheet for Coaches, Sickle Cell Trait, http://web1.ncaa.org/web_files/health_safety/SickleCellTraitforCoaches.pdf)
- More information and resources regarding sickle cell trait and the NCAA's recommendation for sickle cell trait testing can be found at the NCAA website resource pages regarding the sickle cell trait, accessible at: www.NCAA.org/healthsafety.

SICKLE CELL TRAIT TESTING

- The NCAA recommends that all student-athletes have knowledge of their sickle cell trait status. Student-athletes must 1) show proof of a prior test with results; 2) have a blood test to check for sickle cell trait; or 3) sign a testing waiver declining options 1 and 2. Whichever option is chosen, it must be completed before the athlete participates in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc.
- Athletes who are positive for the trait will be allowed to participate in intercollegiate athletics; this does NOT prohibit you from playing.
- Additional information about obtaining your sickle cell trait status can be found on the Bryn Athyn Athletics sports medicine page.

ONE OF THE FOLLOWING OPTIONS MUST BE CHOSEN. INCLUDE ANY DOCUMENTATION IF NECESSARY:

1. Copy of athlete's newborn sickle cell testing result attached. _____ Date: _____
Most states require testing at birth, check with your hospital or pediatrician
2. Copy of recent sickle cell screening test result attached. _____ Date: _____
Cost of testing is the responsibility of the athlete

BRYN ATHYN COLLEGE

Sickle Cell Trait Form for NCAA Intercollegiate Athletics Part 2

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

SICKLE CELL TESTING WAIVER:

By signing this waiver I understand and acknowledge that the NCAA recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I certify that I have read and fully understand the aforementioned facts and I have had the opportunity to review the NCAA website for further information about sickle cell trait and sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Bryn Athyn College Athletic Department.

I do not wish to undergo sickle cell trait testing and, intending to be legally bound, I hereby release and agree to indemnify and hold harmless Bryn Athyn College, its trustees, officers, employees, agents and their successors and assigns from any and all liability, costs, claims, damages or expenses, including attorney's fees, arising from any loss or personal injury that might result from or arise out of my refusal to be tested, or from an undetected condition of sickle cell trait that I may have.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

STUDENT-ATHLETE'S SIGNATURE DATE

STUDENT-ATHLETE'S PRINT NAME SPORT(S) PLAYED

PARENT/GUARDIAN'S SIGNATURE (IF UNDER 18 YEARS OF AGE) DATE

PARENT/GUARDIAN'S PRINT NAME

Concussion Waiver Part 1

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

PURPOSE:

The sports medicine staff at Bryn Athyn College recognizes that sport-related concussions pose a significant health risk for Bryn Athyn college student-athletes. Therefore, the sports medicine staff has implemented policies and procedures to deal with the assessment, management, and return-to-play (RTP) considerations for student-athletes who have sustained a concussive episode as defined by NATA Position Statement on Concussions. In addition, the sports medicine staff recognizes the importance of baseline testing on student-athletes who participate in sports which are recognized as contact or collision as well as those who have a history of concussions upon entering athletic participation at Bryn Athyn College. Baseline concussion testing information will be extremely useful in RTP decisions. The baseline data, along with physical exam, diagnostic testing, symptom scaling, follow up testing and a gradual RTP protocol will all be used in conjunction with sound clinical judgment on an individualized basis to determine when it is safe for a student-athlete to return to competition.

COMMON SIGNS AND SYMPTOMS INCLUDE BUT ARE NOT LIMITED TO:

SIGNS OBSERVED:	SIGNS REPORTED BY STUDENT-ATHLETE:
Appears to be dazed or stunned	Headache
Is confused about assignment	Nausea
Is unsure of game, score, or opponent	Balance problems or dizziness
Moves clumsily	Double or fuzzy vision
Answers questions slowly	Sensitivity to light or noise
Loses consciousness a.k.a. "Blackout" (even temporarily)	Feeling sluggish
Shows behavior or personality change	Feeling "foggy"
Forgets events prior to hit (retrograde amnesia)	Change in sleep pattern
Forgets events after hit (anterograde amnesia)	Concentration or memory problems
Forgets plays	Muscular weakness

BASELINE ASSESSMENT:

All incoming freshmen and first year student-athletes at Bryn Athyn College who are participating in sports will have a baseline neurocognitive test performed by the sports medicine staff as part of their athletic medical screening. Bryn Athyn sports medicine staff utilizes the Sport Concussion Assessment Tool 3 (SCAT3). This test incorporates a symptom checklist, cognitive and physical evaluation, and a balance and coordination evaluation. The Bryn Athyn sports medicine staff also utilizes the impact concussion assessment tool.

CONCUSSION MANAGEMENT:

In any circumstance where any signs, symptoms or behaviors consistent with a concussion in a student-athlete are observed or reported, the first priority is to remove the student-athlete from athletic activity until a thorough sideline assessment can be completed. Furthermore, if there is a question about the state of mental clearing, as determined by the sports medicine staff, it is best to err in the direction of a conservative assessment and withhold the student-athlete from further athletic activity until a physician assessment can be arranged. If a student-athlete is diagnosed with a concussion, he/she shall be withheld from the competition or practice and not return to activity for the remainder of that day.

Concussion Waiver Part 2

Name: _____ Start Term: _____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

RETURN TO PLAY GUIDELINES (RTP):

The team physicians have final authority on when the return to play stepwise program shall commence and when the student-athlete can return to full athletic activity. The baseline results from the SCAT3/ impact testing will be used to compare to post concussion values to determine if a concussion has been sustained and to aid in the return to play criteria. RTP is a stepwise symptom-limited program with stages of progression. The student-athlete should be symptom free and have returned to baseline values before beginning this progression. The student-athlete should complete each level and progress to the next if he/she remains asymptomatic both at rest and with exercise. Generally, each step should take about 24 hours for a total of 6-7 days. Completing one step and moving on to the next is contingent upon finishing the prior day's activity with no return of symptoms. Should the student-athlete become symptomatic during the progression, he/she should stop the day's RTP activities, rest for a 24 hour period and return to previous asymptomatic level. The RTP levels are as follows:

1. Rest until asymptomatic (physical and mental rest)
2. Light aerobic exercise (jogging)
3. Sport specific exercises
4. Non-contact training drills
5. Full contact training after medical clearance
6. Return to competition (game play)

STUDENT-ATHLETE RESPONSIBILITIES:

It is the student-athlete's responsibility to report ALL injuries and symptoms including possible concussion symptoms to the athletic training staff. If a student-athlete fails to report possible concussion symptoms, he/she risks the chance of experiencing Second Impact Syndrome. This occurs when a student-athlete who has already sustained a head injury, sustains a second head injury before symptoms have cleared from the first injury. Many times this occurs because the student-athlete has returned to competition and plays before his/her first injury symptoms resolve. Second Impact Syndrome can result in unconsciousness, cessation of breathing, and ultimately death. Therefore, it is imperative that all Bryn Athyn College student-athletes report any and all possible concussion symptoms to the sports medicine staff. It is better to miss one game than the whole season. When in doubt, get checked out.

I hereby accept responsibility for reporting all injuries and illnesses to the sports medicine staff, including signs and symptoms of concussions. I understand the risks associated with continued participation and activity after not reporting any injury (including concussions) or illness I may sustain.

SIGNATURE OF STUDENT-ATHLETE (OR PARENT/GUARDIAN IF UNDER 18)

DATE

SIGNATURE OF ATHLETIC TRAINING STAFF

DATE



BRYN ATHYN
COLLEGE



FOUNDED IN 1877

Bryn Athyn College Health Services

2945 College Drive, Box 915, Bryn Athyn, PA 19009

Phone: 267-502-6070 | Fax: 267-502-6024

www.brynathyn.edu/health