WEST VIRGINIA WESLEYAN COLLEGE
DEPARTMENT OF ATHLETICS
BUCKHANNON WV 26201
304-473-8099

Dear Returning Student-Athlete:

I hope that you enjoy your summer and stay healthy. The Athletic Training staff and I are preparing for the start of a new season. Enclosed are the athletic training forms that will need completed prior to your return to campus this Fall. Please complete the forms, then scan and email them to mason_d@wvwc.edu. Incomplete paperwork or multiple files will not be accepted. WVWC Athletic Training **will not** be accepting any paperwork from athletes for the 2016-2017 academic year that is not in PDF electronic format. WVWC athletic training in addition **will not** be accepting any athletic training paperwork via fax.

All paperwork needs to be emailed by August 1, 2016. Failure to have paperwork completed by this date will result in your inability to participate in preseason activities.

It is your responsibility to have a physical at home. The physical needs to be completed on the provided WVWC Physical Form. Any athlete that does not have a physical when he/she reports to school will be prohibited from participating in any athletic practice/contest. Also, any athlete whose forms have not been received will not be permitted to participate. Finally, any form that is returned incomplete will also prevent you from participating. **THERE WILL BE NO EXCEPTIONS!**

A completed physical form includes a copy of your current insurance card (valid for 2016-17 term). Please copy the front and back of your card. You may also find the WVWC Physical Form on our athletic web page or the WVWC Student Health Center page.

We look forward to seeing you on campus next fall. If you have further questions or concerns please contact the athletic training office at (304) 473-8349 or via email at mason_d@wvwc.edu.
Again, all forms must be scanned and emailed to mason_d@wvwc.edu in PDF or JPEG format by August 1, 2016.

Thank you
Drew Mason MS, ATC
Athletic Trainer WVWC

Barnhart Memorial Health and Counseling Center
59 College Avenue
Buckhannon, WV 26201
304-473-8100

WVWC Athletes are <u>required</u> to complete this packet in order to participate in chosen sport. Failure to complete these forms will prevent the ability to practice and or train in chosen sport.

WVWC Return Athlete Check List

✓	Check When Completed
	Medical History Completed
	Physical Exam by a Licensed Provider Completed, this calendar year
	Insurance Information Completed
	Copy of Insurance Card Front and Back Attached
	Athletic Information Completed
	If refused Sickle Cell test, waiver must be signed yearly.

Due by August 1, 2016

No paper copies will be accepted.

Completed forms must be scanned into PDF or JPEG and emailed to:

mason_d@wvwc.edu
Subject line: Return Athlete Form and specify sport

Questions: please call Drew Mason at 304-473-8349

Medical History

This information is strictly for the use of WVWC Health and Counseling Center and will not be released without your knowledge and written consent or as required by law.

Student Information: Please Print

Last Name:	First Name:	Middle Name:	Gender:
Address:	City:	State/Providence:	Zip/Postal Code:
Student Email Address:		Date of Birth (mm/dd/yyyy)	Student Cell phone:
Parent/Guardian last name:	Parent/Guardian first name:	Home Phone:	Cell Phone:

Contact person in Case of an Emergency:

Name:_____ Cell Phone:_____

Home Phone:_____

Consent for Medical Treatment/ Emergency Care

I consent and authorize WVWC Health and Counseling Center staff to consult with or defer my treatment to other health professionals as deemed necessary or advisable and to contact my parents/guardians, or other named individuals in the event of an emergency. I also give WVWC Health and Counseling Center permission to share my medical information with the Emergency Department in the event of an emergency. I understand that some illnesses, injuries, and accidents on campus will need to be reported for safety purposes, should such an event occur.

_____ _____ _____ _____

Signature of Student Date Signature of Parent/Guardian (if under 18) Date

All medical records are confidential and other than as described above, no information is released without written authorization. I authorize the release of medical information to my parents/guardians as deemed necessary for my medical treatment and follow-up care. I understand I may revoke this authorization in writing at any time.

_____ _____

Signature of Student Date

Family History

Have any of your relatives ever had any of the following?	No	Yes	Relationship
Alcohol/Drug Problem			
Asthma/Allergies			
Cancer			
Depression			

Have any of your relatives ever had any of the following?	No	Yes	Relationship
Diabetes			
Heart Disease/ Stroke			
Stomach Disease/ Ulcer			
Tuberculosis			

WESLEYAN

Student's Health History

___ADD/ADHD	___Anemia	___Anxiety	___Asthma
___Back Problems	___Chicken Pox	___Dental Problems	___Diabetes, Type 1
___ Diabetes, Type 2	___Dizziness/Fainting	___Ear/Nose/Throat Problems	___Epilepsy/Seizures
___ Eye Problems	___Gallbladder Problems	___ Headaches	___Headaches, Migraines
___ Head Injury/Concussion	___Heart Murmur	___Hemophilia	___ Insomnia
___ Hernia	___High Blood Pressure	___ Irregular Heartbeat/ Palpitations	___Measles
___Joint Disease/Injury	___ Kidney Problems	___Liver Problems	___ Mumps
___Measles, German	___Menstrual Problems, Female	___ Mononucleosis	___ Stomach/GERD/ Ulcer
___ Pain in Chest	___Psoriasis	___ Sinusitis	
___ Thyroid Problems	___ Tumor/Cancer cyst	___Weight, recent gain or loss	

Hospitalization History

Dates: mm/yyyy	Diagnosis	Procedures/treatments/outcomes

Additional Health Information

Please, answer the following questions	Yes	No	Please provide details or list
Has your physical activity been restricted during the past four years?			
Have you received treatment/counseling for alcohol or other drug abuse, an eating disorder, depression, anxiety, or any other reason?			
Have you had any significant illness or injury within the last 12 months?			

If any additional information needs to be provided about the student's health, that you think we need to know, please attach an additional page to explain.

WESLEYAN

Allergy History

◊ No Known Drug Allergies

List the Name of the Allergy	List the Reaction, if known

Medication List

Name of Medication	Strength	How many Pills?	How many times a day do you take the medication?

Extra medications :

Physical Examination

(must be completed by Physician, ANP, PAC)

Patient's Name_____

Vitals: TPR_____ BP_____ WGT_____ HGT_____

System	Within Normal Limits	Abnormal (Explanation)
Neurological		
Cardiovascular		
Mouth		
Integumentary		
Respiratory		
Gastrointestinal		
Genitourinary		
ENT		
Eyes		
Any conditions that prevent living in residence hall or any special accommodations needed?	___No ___Yes Explain:	
Any conditions that would prevent normal activity as an athletic training major, nursing major, or participation in	___No ___Yes Explain:	
Sickle Cell Trait test results are required by the NCAA for all student athletes. Read attached resource sheet.	Attach Sickle Cell Trait test results to this form. Student athletes will not be permitted to practice in any	

Required Information for Consultation or Verification

Health Care Provider (Print Name)_____ Date_____

Signature_____ Phone_____ Fax_____

All WVWC College Athletes Must Complete Form

Name (print) _____ Sport _____

Please answer all of the following questions and sign below. If you answer "yes" explain in the space provided.	Yes	No
1. Have you had any recent illnesses? Explain:		
2. Have you ever been told to give up sports because of a health problem? Explain:		
3. Do you wish to discuss a specific problem with the doctor or Athletic Trainer? Explain:		
4. Has anyone (under the age of 50) in your close family died suddenly? Explain:		
5. Has anyone (under the age of 50) in your close family had a heart attack? Explain:		
6. Has anyone in your immediate family had high blood pressure? Explain:		
7. Do you get chest pain with exercise? Explain:		
8. Do you have faintness or dizziness with exercise? Explain:		
9. Heart trouble or a heart murmur? Explain:		
10. Heat illness (dehydration with exercise)? Explain:		
11. Coughing after strenuous exercise? Explain:		
12. Do you exercise continuously for at least 30 minutes, three or more times a week? Explain:		
13. Do you eat any special foods or follow a special diet during the sports season? Explain:		
14. Is your pregame meal a special part of your game preparation? Explain:		
15. Have you ever taken any supplements or vitamins to help you lose or gain weight or improve performance? Explain:		

Consent and Authorization:

I give authorization to the Athletic Training staff and/or medical consultants to evaluate and treat any injuries that occur during my participation in athletics at West Virginia Wesleyan College. I understand the Athletic Trainer has the authority to prohibit me from further participation because of an injury and/or because of undue liability risk to West Virginia Wesleyan College.

Student Athlete's signature _____ **Date** _____

Parent/Guardian Name (print) _____ **Parent/Guardian Signature** _____ **Date** _____

Insurance Information

IMPORTANT: STUDENTS ARE REQUIRED TO HAVE INSURANCE COVERAGE WHILE ATTENDING WVWC.

The information below will be kept on file at the Health and Counseling Center in the case the student needs medical attention outside the College.

Family Insurance Information

Student's Last Name (Print):	Student's First Name:	Middle Name:	Gender Male Female
Name of Health Insurance Company		Address	
Phone Number	Policy /ID Number	Group Number	
Policy Holder's Name	Relationship to Student	Policy Holder's Date of Birth	
Policy Holder's Place of Employment:		Employer's Address:	

Please attach a copy of the FRONT and BACK of your family insurance card HERE

Contact your medical insurance company to be sure medical providers in our area are in your Network.

WVWC Athletic Training Information Sheet

Please print legibly. Date:_____

Sport: _____

Full Name:_____ Age:_____

Date of Birth:_____ Campus Box:_____

Local Phone #:_____ Cell Phone #:_____

Campus Address (Dorm & Room #): _____

Home Address:_____

City: _____State: _____Zip: _____

Home Phone:_____

Mother:_____ Father:_____

Mother's birthdate: _____ Father's birthdate: _____

Parents' email address:_____

Emergency contact name and number:_____

** note – emergency contact must be different than home phone number

Environmental allergies (ie. bee stings, pollen, etc):_____

_____

Allergies to medications:_____

_____

Current medical conditions (ie. asthma, diabetes, epilepsy, etc)

_____

Current medications:_____

_____

Signature:_____ Date:_____

WVWC Medical Consent Form

NAME: _____ **SPORT:** _____

MEDICAL CONSENT, RELEASE OF INFORMATION, SHARED RESPONSIBILITY

TERMINOLOGY:

A. MEDICAL CONSENT	*TO PERMIT WEST VIRGINIA WESLEYAN COLLEGE ATHLETIC TRAINERS TO TREAT ANY INJURY THAT MAY OCCUR WHILE AT WVWC*
B. RELEASE OF INFORMATION	*TO PERMIT THE RELEASE OF MEDICAL RECORDS TO THE ATHLETIC TRAINERS FROM THE WVWC MEDICAL CENTER OR TREATING PHYSICIAN WHICH MAY BE FORWARDED TO YOUR COACH/ADVISOR/DIRECTOR CONCERNING YOUR PHYSICAL HEALTH AND ABILITY TO PERFORM IN THE ABOVE ACTIVITY*
C. SHARED RESPONSIBILITY	*SHOWS THAT YOU RECOGNIZE THAT THERE ARE CERTAIN INHERENT RISKS THAT ARE POSSIBLE WHEN PARTICIPATING IN INTERCOLLEGIATE ATHLETICS OR DANCE AND ARE WILLING TO TAKE RESPONSIBILITY FOR THESE POTENTIAL RISKS THAT MAY OCCUR WHEN PARTICIPATING IN THE ABOVE ACTIVITY*

MEDICAL CONSENT

In signing this medical consent form, you give permission to the WVWC athletic training staff to render any treatment that may Be necessary regarding your health and well-being. Also, by permitting necessary treatment, you realize that you are authorizing the athletic trainers to render any treatment that may fall under the headings of preventative care, first-aid, rehabilitation and emergency care. During these instances the athletic trainer will be working under the standing orders of the WVWC physician. You also realize that by giving consent for proper care, you are giving permission for hospitalization when necessary.

DATE: _____ _____
Signature of student-athlete

DATE: _____ _____
Signature of Parent/Guardian, if under 18

AUTHORIZATION FOR RELEASE OF INFORMATION

In signing this information release form, you authorize hospitals, physicians, rehabilitation clinics, & WVWC Health Center to release medical information pertaining to your participation status to the athletic training staff, coaches, advisors & directors. The medical information may relate to your past, present or future injuries or illnesses that may occur or already have occurred while participating in athletics or your above activities. Also, by giving authorization for release of medical information, you permit the medical staff to disclose this information to your coach and advisor.

DATE: _____ _____
Signature of student-athlete

DATE: _____ _____
Signature of Parent/Guardian, if under 18

SHARED RESPONSIBILITY FOR SAFETY

By signing the shared responsibility for safety form, you realize participation in sport/activity requires an acceptance of risk of injury. You rightfully assume that those who are responsible for the conduct of sport/activity have taken reasonable precautions to minimize such risks. However, you acknowledge that these risks exist and you are willing to participate recognizing said risk. Also, you assume responsibility for adhering to medical staff guidelines, prevention, and precautions regarding participation status in the above sport/activity. Understanding that these guidelines are in accordance with medical practice standards for the prevention of additional injuries, your choice to comply with these directions will decrease the risk of initial or additional injuries.

DATE: _____ _____
Signature of student-athlete

DATE: _____ _____
Signature of Parent/Guardian, if under 18

West Virginia Wesleyan College Department of Athletic Training

***(HIPAA Release)* Student-Athlete Authorization / Consent For Disclosure of Protected Health Information**

I, _____ (Print name), hereby authorize West Virginia Wesleyan College and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for participation in intercollegiate athletics to any West Virginia Wesleyan College Advisory Team Physician, Allied Health Personnel affiliated with WVWC, WVWC's Third Party Claim Administrator, the Director of Athletics, my Head Coach, my Assistant Coach or member of the Media Relations Department.

I understand that my injury/illness information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and 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 or payment, enrollment in a health plan or receipt of any benefits (if applicable) 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 MEC competition. If you refuse to sign this release, you will not be denied treatment from the Athletic Training Department however you will not be allowed to *participate in your sport* in order to protect your medical condition and associated medical information.

I also understand that the MEC Conference is not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the MEC Conference's use or 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 West Virginia Wesleyan College. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization / consent.

By signing this waiver, I hereby give permission to the Head Certified Athletic Trainer to discuss injuries and/or conditions to current coaches, medical personal for further treatments, and other associated Certified Athletic Trainers at participating Colleges when traveling is necessary.

Sport: _____

Name: _____ Date: _____
(Printed)

Signature: _____ Date: _____

***Signature of parent/guardian if under 18 years of age:**

_____ Date: _____

West Virginia Wesleyan College
Intercollegiate Athletic Department

Acknowledgement of Risk and Liability Waiver

I, _____, acknowledge that I am aware that my participation in intercollegiate athletics carries with it the risk that I will suffer injury as a result of such participation. In consideration of the College permitting me to participate in athletic programs which it sponsors, I hereby admit to assume any and all risk of injury associated with my participation in intercollegiate athletics. I further agree that I will do my best to reduce the risk of injury by keeping myself in the best possible physical condition and follow the advice of the team physician, athletic trainer, and/or coach concerning the prevention, treatment and rehabilitation of athletic injuries. As further consideration of the WVWC permitting me to participate in such athletic activities, I do hereby waive my right to assert any claim against the WVWC, its agents, employees or those operating under its direction and control for any injury or injuries arising out of my participation in intercollegiate athletics. I further agree to indemnify and hold harmless the College from any and all claims and/or liabilities relating to and/or arising from such injuries.

_____ _____
Signature of Student Athlete Date

_____
Signature of parent if under 18 years of age

_____ _____
Age Sport

West Virginia Wesleyan College Intercollegiate Athletic Department
Excess Athletic Insurance Policy:

West Virginia Wesleyan College has obtained an excess insurance policy for your protection in the event you sustain an injury during an official, supervised practice/game while participating in intercollegiate athletics. This excess insurance policy requires that the injured student-athlete first make a claim under his/her personal insurance. It is the responsibility of all student-athletes to carry a primary insurance policy that provides athletic injury benefits.

For medical expenses to be considered for payment under the WVWC excess athletic insurance policy, a claim form must be completed in its entirety and returned to the Athletic Training staff and/or claims administrator. Additional documentation (other than the claim form) will also be required by the claims administrator for consideration of benefits. The athletic training staff will assist you in understanding the claims submission process if you need to submit a claim.

The excess athletic policy may then provide a maximum of $90,000.00 in medical fees benefits for an athletic **accident** and is subject to certain limitations/exclusions. The excess athletic policy also includes a medical fees benefit for certain athletic related conditions which would be otherwise covered by your primary insurance and is also subject to certain limitations/exclusions and condition benefit maximums. Submission of an athletic claim does not guarantee payment. Determination of all benefits is made by the claims administrator and insurance carrier.

Please read initial each below:

_____ I acknowledge that I have read the foregoing information concerning insurance and understand its meaning.

_____ I acknowledge that I am aware that WVWC maintains an excess insurance policy which has a maximum benefit of $90,000.00 for an athletic **accident** and is subject to certain limitations/exclusions. The excess athletic policy also includes a medical fees benefit for certain athletic related conditions which would be otherwise covered by your primary insurance and is also subject to certain limitations/exclusions and condition benefit maximums. Benefits may be **reduced** for services rendered if pre-authorization by the primary carrier is not obtained for injuries suffered related to participation in athletics at West Virginia Wesleyan College.

_____ I acknowledge that I have secured a primary insurance policy that provides medical benefits for athletically related injuries and/or conditions.

_____ I acknowledge that I am responsible for any and all medical bills incurred for injuries/illnesses/conditions related to athletics that are not be eligible for benefits through my primary insurance or the excess athletic insurance policy provided by WVWC.

_____ _____

Signature of Student Athlete Date

_____

Signature of parent if under 18 years of age

WEST VIIRGINIA WESLEYAN COLLEGE

Student-Athlete Insurance Verification Form

I, _____ do hereby authorize West Virginia Wesleyan College to verify the Medical Health Information I have provided via my student insurance waiver on _____/____/2016. The authorization is valid for 12 months from the signature date below.

The insurance information I have submitted is as follows:

STUDENT INFORMATION:

Name: _____

Student ID: _____

DOB: _____ (Month/Day/Year)

What intercollegiate sport team(s) you will participate on? _____

PRIMARY INSURED'S INFORMATION:

Name: _____

Phone #: _____

Relationship to Student: _____

INSURANCE COMPANY INFORMATION:

Name: _____

Phone #: _____

Insurance Identification #: _____ (On ID Card)

Insurance Group: _____ (On ID Card)

Policy Effective Date: _____ (Month/Day/Year)

Policy Termination Date: _____ (Month/Day/Year)

Annual Deducible Amount: _____

Is this a Health Savings Account (HSA) Plan? Yes No

Are Injuries Covered? Yes No

Are any injuries excluded? Yes No

If yes, what injuries? _____

I understand that it is my responsibility to notify West Virginia Wesleyan College and the Department of Athletics I there is a loss or change in my insurance coverage. *(Please make sure policy holder signature is signed.)*

STUDENT SIGNATURE: _____ Date: _____

POLICY HOLDER SIGNATURE: _____ Date: _____

West Virginia Wesleyan College
Athletic Department
Sickle Cell Trait Informed Consent/Refusal

What is Sickle Cell Trait?

Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

What happens during exercise to individuals with Sickle Cell Trait?

During intense exercise, red blood cells with the sickle hemoglobin may change shape and "sickle". These sickled cells can accumulate in the bloodstream and block normal blood flow to the tissues and muscles. This can lead to significant physical distress and a collapse.

Why do we need to know if you have Sickle Cell Trait?

This information can help the Athletic Training Staff so that the proper precautions can be put into place for your care. You will not be excluded from participation due to Sickle Cell Trait.

Is testing required?

Beginning on August 1, 2012, you will be **required** by the NCAA to provide the results of a Sickle Cell Trait test or sign a written release declining the test before competing. You may provide the results of the test administered at birth (All 50 states require testing at birth for all infants) or during a routine medical exam. **WVWC WILL ONLY NEED TO RECEIVE YOUR SICKLE CELL TEST RESULTS ONE TIME.** Your results will then be kept on file for your remaining time at WVWC. You will not be permitted to practice in any capacity until WVWC has your Sickle Cell Trait test are on file or you have signed the waiver below.

SICKLE CELL TRAIT TESTING DECLINATION (MANDATORY)

I understand I may be at risk of carrying the sickle cell trait. I have been given the opportunity to be tested for sickle cell trait at my own expense. However, I decline sickle cell trait testing at this time. I understand that by declining this testing, I continue to be at risk of suffering the potential effects of sickle cell trait or a sickle emergency. If in the future, I wish to be tested for sickle cell trait, I can receive, at my own expense, the appropriate medical testing.

_____ _____

Printed name Date

_____ _____

Signature Parent Signature (if under 18 years old)

West Virginia Wesleyan Athletic Training
Helmet Warning

In an effort to warn players and parents of the risk of injury, the NOCSAE Board of Directors has developed a warning statement which is found on all sport helmets. This statement is intended to warn participants of the possibility of severe head or neck injury despite the fact that a certified helmet is being worn. The helmet is designed to protect the head. **A SPORT HELMET CANNONT PROTECT THE PLAYERS NECK.**

NOCSAE urges that the following warning statement be shared with the members of the athletic team and that all coaches and staff alert participants and parents to the potential for injury.

WARNING

Do not strike opponents with any part of this helmet or face mask. This is a violation of rules and may cause you to suffer brain or neck injury, including paralysis or death. Severe brain or neck injuries may also occur accidentally while playing football.

1. Do not modify, change, or alter the helmet in any way.
2. Do not remove or cover any of the labels in or on the helmet.
3. Do not paint or clean the helmet as this can reduce helmet protection.
    a. Clean with approved cleaners or with mild soap and water only
4. Each helmet has been fitted according to the manufacturer's instructions but should be inspected daily before use in order to insure proper protection.
    a. Check the helmet for proper fit.
    b. Check for damage to the liner and shell.
    c. Check for loose hardware (nuts, bolts, screws, plastic).
    d. Check for damaged facemask (cracked, loose, or metal exposed).

Remember, never wear a damaged helmet. In the event that nay equipment problems should arise, do not hesitate to report this to the coaching or athletic training staff immediately. This information has been given in an effort to educate players associated with the WVWC Athletic Team. If you have any questions, please contact:

Drew Mason – Associate Head ATC	304-473-8349
Tammie Hammon Moody – Head Softball ATC	304-473-8682
Hide Masuda – Head Baseball ATC	304-473-8681

I have read this information and understand it fully.

Printed Name: _____

Student Athlete Signature: _____ Date: _____