Report of Physical Health Assessment

ALL PHYSICAL EXAMS FOR GENERAL AND NURSING STUDENTS MUST BE COMPLETED ON OR AFTER JANUARY 1. EXAMS BEFORE JANUARY 1 WILL NOT BE ACCEPTED. ALL ATHLETES ARE REQUIRED TO SUBMIT A SICKLE CELL SCREEN AND YEARLY PHYSICAL EXAMS. ATHLETIC PHYSICAL EXAMS MUST BE COMPLETED ON OR AFTER JUNE 1 AND ARE DUE BY AUGUST 1. ALL NURSING STUDENTS MUST SUBMIT AN INITIAL 2-STEP PPD; FOLLOWED BY AN ANNUAL 1-STEP PPD. ALL NURSING STUDENTS ARE REQUIRED TO HAVE THE INFLUENZA VACCINE ANNUALLY.

Student Contact Information

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>Student First Name:</th>
<th>Student Middle Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student Home Address:</th>
<th>City, State, Zip Code:</th>
<th>Student Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Telephone Number:</th>
<th>Cellular Telephone Number:</th>
<th>E-mail Address:</th>
</tr>
</thead>
</table>

Plan to Enroll: In Fall 20____ In Spring 20____

Classification: Freshman____ Transfer____ Graduate____
Emergency Contact Information  
(Please Print)

Names, Addresses and Phone Numbers of TWO persons to be contacted in case of an emergency

1. Name_______________________________________ Phone(_____)_________________
   Relationship________________________________________________________________
   Address____________________________________________________________________

2. Name_______________________________________ Phone(_____)_________________
   Relationship________________________________________________________________
   Address____________________________________________________________________

Name of Primary  
Physician______________________________________________________  
Address of Primary  
Physician______________________________________________________  
Phone of Primary Physician (_____) _________________________  
Student’s Signature _______________________ Date _________________________

Medical Insurance Information

Name of Group Insurance Company _________________  
Address:____________________________________________________________________  
Phone(___)_______________  
Group Policy # ____________________ Account # _________________ ID#__________

PLEASE SUBMIT A COPY OF THE FRONT AND BACK OF YOUR MEDICAL INSURANCE CARDS.  
STUDENTS SHOULD ALSO CARRY A COPY OF THEIR INSURANCE AND PRESCRIPTION CARDS.
If you are presently under the care of a physician for a chronic disease or other medical condition(s), ask your physician to forward information pertaining both to your medical problem and its treatment to the Wellness Center or Athletic Trainer. This will assist in the continuity of your care. If you will be under age 18 at the time of enrollment, the Wellness Center must have permission from either your parent(s) or guardian(s) to provide medical care until your 18th birthday. Please have one or both of them consent by signing below.

I hereby grant permission to the Wesley College Wellness Center or the Athletic Trainer to render medical care to my dependent.

Parent/Guardian’s Name ______________________________ Relationship ______________________
Parent/Guardian’s Signature __________________________ Date __________________________

Parent/Guardian’s Name ______________________________ Relationship ______________________
Parent/Guardian’s Signature __________________________ Date __________________________

I authorize the Wellness Center and the Athletic Training Department to exchange and release information to each other that may impact on my athletic participation. I understand that this information could include but not limited to the physical exam, immunization record, consent for treatment and questionnaire.

STUDENT SIGNATURE _______________________________
### Medical History

Please answer the following regarding your own medical history.  
If you answered Yes to any of the following please explain.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you have a current illness/injury or currently under a doctor's care?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>Have you ever been hospitalized?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Have you ever had surgery?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td>Have you ever assed out during or after exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
<td>Have you ever had chest pain during or after exercise?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>Have you ever had racing of your heart or skipping heartbeats?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>7</td>
<td>Have you ever been told you have a heart murmur?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>8</td>
<td>Have you had a serve viral infection (ex. Myocarditis or Mononucleosis) within the last month?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9</td>
<td>Has a physician ever denied or restricted your participation in sports for any heart problems?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>10</td>
<td>Have you ever had a head injury or concussion?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>11</td>
<td>Have you ever been knocked out, become unconscious, or lost our memory?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>12</td>
<td>If yes, how many times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>When was your last concussion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How much time was lost from physical activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Have you ever had a seizure?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever been diagnosed with ADD/ ADHD by a physician?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>15</td>
<td>Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

### Please explain any yes answers:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**Family History:** Has anyone in your immediate family, parents, siblings, and grandparents had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Y</td>
<td>N</td>
<td>Cancer</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stroke</td>
<td>Y</td>
<td>N</td>
<td>Tuberculosis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sudden Death (before age 50)</td>
<td>Y</td>
<td>N</td>
<td>Asthma</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Marfan’s Sydrome (Heart)</td>
<td>Y</td>
<td>N</td>
<td>Sickle Cell Anemia</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Migraine/Headaches</td>
<td>Y</td>
<td>N</td>
<td>Eating disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify to any items answered "YES"

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**Medications/Supplements** — Please list any medications or supplements (ex. Creatine, Metabolife) you are currently taking

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Healthcare Provider to Complete

Does the applicant have a problem that would exempt him/her from Physical Education Courses?
(If yes, please comment and attach a signed statement from physician)

☐ Yes
☐ No

Corrected Vision: Right 20/ _______________ Left 20/ _______________

Uncorrected Vision: Right 20/ _______________ Left 20/ _______________

Normal

Color Vision: ________ Abnormal ________

Height _______ in. Weight _______ lbs. Blood Pressure _______ HCB (or HCT) _______ Urinalysis _______ Sugar _______

Irregularities:

<table>
<thead>
<tr>
<th>Head, Ears, Nose or Throat</th>
<th>Yes/No</th>
<th>Genitourinary</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>Yes/No</td>
<td>Musculoskeletal</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Yes/No</td>
<td>Metabolic/Endocrine</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Yes/No</td>
<td>Neuro-Psychiatric</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Eyes (other than acuity)</td>
<td>Yes/No</td>
<td>Skin</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Hernia</td>
<td>Yes/No</td>
<td>Teeth</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Lymphatic System</td>
<td>Yes/No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain any yes answers:
## Musculoskeletal (Athletics only)

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/Arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/Forearm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/Hand/Fingers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg/Ankle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot/Toes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Athletics Sick Cell Trait Test is required only for New or Transfer Sports Students**

<table>
<thead>
<tr>
<th>Sickle Cell Trait Hemoglobin (Hbg) Solubility Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickled Cell Trait Status: Positive________</td>
</tr>
<tr>
<td>Date of test________________</td>
</tr>
</tbody>
</table>

*Must Attach Copy of Sickle Cell Test Results*

**PHYSICIAN CLEARANCE**

I certify that I have on this date examined this student and that, on the basis of the examination requested by the NCAA and the student’s medical history as furnished to me, this student is;

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**CLEARED TO PARTICIPATE:** Yes________ No________ WITH:

- □ No Restrictions
- □ The following restrictions (explain on next page)

**Explanations/Recommendations:**
Has this student ever been under observation or treatment for severe physical or emotional disease or drug problem? If so, indicate family physician, psychiatrist, psychologist, or other and include contact information.
Explain:

Is this student currently being treated for severe physical, emotional or drug related problems?
Explain:

Examiner’s Name (print)

Examiner’s Signature

Examiner’s Office Name & Address

Office Telephone Number:

Date of Exam:
Release of Medical Information

I hereby authorize Wesley College to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, insurance information and other data covering medical illnesses and injuries, confinements and or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original.

_________________________________________________________               __________________________
Student-Athlete Signature                                           Date

_________________________________________________________               __________________________
Parent Signature (if under 18)                                       Date

Consent for Treatment

I hereby grant permission to Wesley College, its’ physicians, and/or Athletic Trainers to render aid, treatment, medical or surgical care deemed necessary to protect the health and well-being of ____________________________(Student-Athlete’s Name)

I additionally grant, when necessary to protect the health and well-being of ___________________________ permission for hospitalization, treatment, or surgery at a competent and/or accredited facility.

_________________________________________________________               __________________________
Student-Athlete Signature                                           Date

_________________________________________________________               __________________________
Parent Signature (if under 18)                                       Date

*Please Include a Photo Copy (Front/Back) of the Insurance Cards
I, ____________________________, acknowledge that I have to be an active participant in my own healthcare. As such, I have direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physician, athletic training staff). I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution. I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. After reading the NCAA Concussion fact sheet, I am aware of the following information.

- I have read and understood the NCAA Concussion Fact Sheet.
- A concussion is a brain injury, which should be reported to the sports medicine staff.
- A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and perform in the classroom.
- A concussion cannot be “seen.” Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the sports medicine staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that causes any concussion-related symptoms.
- Following concussion the brain needs time to heal. I understand that I am much more likely to have another concussion or more brain injury if return to play occurs before concussion symptoms go away.
- Sometimes, repeat concussions can cause serious and long-lasting problems.
- I understand that following a concussion I must proceed through a standard return-to-play protocol and progression in order to return to functional activity.

By signing below, I acknowledge that my institution has provided me with specific educational materials on what a concussion is and given me an opportunity, to ask questions about areas and issues that are not clear to me on this issue.

Signature (if 18 years old) __________________________________________________________

Parent or guardian signature (if under 18 years old): __________________________________
Wesley College Sports Medicine
Student-Athlete Insurance Questionnaire

You will not be able to practice or play until this form is completed and returned to the Athletic Training Staff

Athletic Insurance Procedures Explained
When injuries occur we attempt to provide our athletes with the very best possible care. Medical bills are incurred when the student-athlete is treated, whether it is locally or during an away contest.

The NCAA does not permit us or any college or university to provide coverage or pay the bills incurred for expenses related to illnesses or conditions, which are not sustained as a direct result of participation in our intercollegiate sports program. The coverage we offer is excess or secondary coverage and only provides benefits after all other insurance has made settlement.

Eligibility and Coverage

Bollinger Specialty Group
Claims To: Bollinger Inc. P.O. Box 1329
Morristown, NJ 07962
PH: 866-267-0092
Policy Number: MCB-0214360

The Athletic Accident benefits provide coverage for all full-time student-athletes participating in a Covered Event and will cover students from the first to the last date they are required to be on campus for participation in a Covered Event.

This is an Excess plan and will only pay after any other valid and collectible insurance has paid or denied an eligible claim.

HMO, PPO, or similar arrangements must be utilized. This is not a primary plan

The institution is not financially responsible and should never promise full payment to a provider for charges incurred by a student-athlete. Eligibility is determined by Administrative Concepts Inc. and is based solely on Policy Provisions.

Medical bills incurred, as a result of an injury in the intercollegiate sports program will be sent directly to the athlete’s home address. In some cases, the sports medicine department will get a copy of the bill, but in no case will be the primary place for the bill to be sent.

Medical bills should be submitted to family or employer group coverage first. The insurance company will do one of the two things:

A. Honor the claim and pay all or a portion of the chargers incurred
B. Not honor the claim and send a letter of denial
The most common reasons for a claim to be denied by family insurance carriers is because the services were not approved by the primary care physician (PCP) or they were provided by a medical professional who was not affiliated with that provider plan.

Our Team Physician is Dr. Stephen Manifold, MD.

Whether the family or employer group insurance has contributed towards the claim, the explanation of benefits (EOB) from the insurance company and a copy of the itemized bills should be sent to the Sports Medicine Department at Wesley College.

Once the bills and EOB’s have been received by the College, our insurance carrier’s office will be contacted with the claim.

Acknowledgement of Receipt of Insurance Information

I acknowledge receiving a copy of the Wesley College Description of the Athletic Insurance of a copy of the Athletic Injury and Medical Policy; I understand the College’s responsibility to the student who becomes injured as a result of participation in the Intercollegiate sports program at Wesley College.

________________________________________________________               __________________________
Student-Athlete Signature                                      Date

________________________________________________________               __________________________
Parent Signature (if under 18)                                  Date
WHAT IS A CONCUSSION?
A concussion is a brain injury that:
- Is caused by a blow to the head or body.
- From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

HOW CAN I PREVENT A CONCUSSION?
Basic steps you can take to protect yourself from concussion:
- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletic department’s rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?
Don’t hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion.
Sports have injury timeouts and player substitutions so that you can get checked out.
Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.
Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play.
A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.
Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

IT’S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.
WHEN IN DOUBT, GET CHECKED OUT.
For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.