

Athletic and Activities Pre-Participation Forms

Dear Parent and Student-Athlete,

Welcome to Huston-Tillotson University! While at HT, we are confident that you will have a safe and enjoyable athletic experience. The purpose of this packet is to acquaint you with the necessary athletic and medical forms that you will need as a participant of any intercollegiate athletic team here at HT. We are pleased to have you as a Huston-Tillotson University student-athlete; and we look forward to your achievements of academic and athletic success during your time here.

The following paperwork must be completed each academic year before a student may participate in an athletics program:

1. Student-Athlete Information Form
2. Insurance Information Form (**attach a copy of current health insurance card and page signed by policy holder**)
3. Pre-Participation Physical Evaluation: Medical History Form
4. Pre-Participation Physical Evaluation: Physical Examination Form
5. Athletic Accidental Insurance and Medical Referral Guidelines (**signed by parent/guardian**)
6. Athletics Assumption of Risk and Consent to Treat Form
7. Release of Information Form
8. Sickle Cell Trait Testing Waiver
9. ADD/ADHD Supplemental Form
10. Drug Testing Consent Form – Will be available later

Please return all paperwork by July 15th to:

Amii R. Johnson, MS, LAT
Head Athletic Trainer
Huston-Tillotson University
900 Chicon St.
Austin, TX 78702
Fax: (512) 505-6405
Email: arjohnson@htu.edu



Student-Athlete Information Form

Name: _____

Student ID: _____ Date of Birth: _____

Email: _____ Social Security: _____

Classification (circle one): Freshman Sophomore Junior Senior 5th Yr. Senior

Sports (circle all that apply):

Volleyball	Women's Basketball	Baseball	Cheerleading
Women's Soccer	Men's Basketball	Women's Track	Intramurals
Men's Soccer	Softball	Men's Track	Student Athletic Trainer

Mother/Guardian: _____

Address: _____

Phone: Work: _____ Cell: _____ Home: _____

Email: _____

Father/Guardian: _____

Address: _____

Phone: Work: _____ Cell: _____ Home: _____

Email: _____

Student Local Address: _____

City & State: _____ Zip: _____

Cell Phone: _____

Insurance Information Form

(MUST BE SIGNED BY POLICYHOLDER)

Name: _____

Select One:

- I am enrolling and purchasing student insurance offered by Huston-Tillotson University
 I am enrolled in a parent or guardian's individual insurance plan
 I am enrolled in my own individual insurance plan

Insurance Policy Holder Information:

Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to Student: _____

Insurance Information:

Policy Holder's Employer: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Type: HMO PPO Other If "Other", describe: _____

HMO/PPO Physician: _____ Phone: _____

Group Number: _____ Policy Number: _____

Please attach a clean copy of the FRONT and BACK of the insurance card.

I, _____ (print name), verify that all of the above information and the copy of the insurance card provided is correct and current. I understand that I must maintain current medical insurance coverage as a student-athlete. I further understand that the above-named insurance company will be utilized for medical expenses incurred during my participation in Huston-Tillotson University's intercollegiate athletic program. If any information should change, I will inform the HT Athletic Training Staff as soon as possible and provide a copy of the new insurance card.

Signature of Policy Holder

Date

Pre-Participation Physical Evaluation: Medical History Form

This **Medical History Form** must be completed **annually** by parent/guardian (if under age 18) and athlete in order for the athlete to participate in athletic activities. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in an athletic event.

Full Name _____ Sex ____ Age ____ Date of Birth ____/____/____
 Address _____ City _____ State ____ Zip Code _____

Sports (circle all that apply):

Volleyball	Men's Soccer	Men's Basketball	Baseball	Men's Track	Intramurals
Women's Soccer	Women's Basketball	Softball	Women's Track	Cheerleading	Student Athletic Trainer

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST, EITHER IN-SEASON OR OUT-OF-SEASON.
 Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below. Some questions answered with "Yes" require further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participating in HT athletic practices, scrimmages or contests.

GENERAL MEDICAL HISTORY	Y	N	HEAD INJURY HISTORY, cont'd	Y	N
1. Have you had a medical illness or injury since your last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	7. How severe was each one? (Explain below) _____		
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently taking any prescriptions or non-prescription (over the counter) medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (pollen, medicine, food or insects)?	<input type="checkbox"/>	<input type="checkbox"/>	CARDIAC HISTORY		
6. Do you have seasonal allergies that require medical attention?	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a severe viral infection (ex: myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any current skin problems (ex: itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any problems with your ears or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you or anyone in your family been diagnosed with sickle cell or sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been diagnosed with ADD/ADHD? If yes, see additional form.	<input type="checkbox"/>	<input type="checkbox"/>	8. Has any family member been diagnosed with an enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome, or abnormal heart rhythm?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	9. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you cough, wheeze, or have trouble breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	ORTHOPEDIC HISTORY		
16. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	1. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had a sprain or strain?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you fear becoming fat?	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you made repeated attempts to diet or restrict your eating?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, circle appropriate area and explain below:		
21. Do you feel fat even though friends and family say you are not?	<input type="checkbox"/>	<input type="checkbox"/>	Head Shoulder Upper Arm Elbow Hand Finger Wrist Chest Thigh Forearm Shin/Calf Back Hip Knee Neck Ankle		
22. Do you feel overly stressed, anxious or depressed?	<input type="checkbox"/>	<input type="checkbox"/>			
23. Are you under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
HEAD INJURY HISTORY			1. When was your first menstrual period? _____		
1. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	2. When was your most recent menstrual period? _____		
2. Have you ever been knocked out, lost consciousness, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	3. How much time do you usually have from the start of one period to the start of another? _____		
If yes, how many times? _____			4. What was the longest time between periods in the last year? _____		
When was your last concussion? _____			5. How many periods have you had in the last year? _____		

Please explain "YES" answers from above: _____

If, between this date and the beginning of athletic competition, any illness or injury occurs that may limit my participation, I agree to notify the HT Athletic Training Staff.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide untruthful responses could subject me, the athlete in question, to penalties determined by the Huston-Tillotson Athletics Department.

Athlete Signature: _____ Parent/guardian Signature: _____ Date signed: _____

HUSTON-TILLOTSON UNIVERSITY ATHLETICS

Pre-Participation Physical Evaluation: Physical Examination Form

THIS PAGE MUST BE COMPLETED BY THE LICENSED MEDICAL PROFESSIONAL CONDUCTING THE PHYSICAL EXAMINATION

Must be completed before an athlete participates in any practice, scrimmage, or contest, either in-season or out-of-season.

Name: _____ Sex: _____ Age: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ BP: ____/____ (____/____, ____/____)
Brachial blood pressure while sitting

Vision: R 20/____ L 20/____ Corrected: Yes No If yes, with? Glasses Contacts Pupils: Equal Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in the supine position.			
Heart- Auscultation of the heart in the standing position.			
Heart - Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia - (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum joint, hypermobility, scoliosis)			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Neck			
Back/Spine			
Shoulders/Arms			
Elbows/Forearms			
Wrist/Hand			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet			

*Station-based Examination Only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____
 Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by the State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. **Examination forms signed by any other health care practitioner will not be accepted.**

Name: _____ Date of Examination: _____
 Address: _____
 Phone Number: _____ Fax Number: _____
 Signature: _____

Athletic Accident Medical Insurance and Medical Referral Guidelines Form

Name: _____ Date of Birth: _____

Athletic Accident Medical Insurance

The Huston-Tillotson University Athletics Department carries Athletic Accident Medical Insurance coverage provided by Summit America. This policy provides secondary coverage **ONLY** and includes a \$3,000 deductible. In the event of injury, each student-athlete is responsible for his or her medical bills and could incur an expense up to \$3,000 depending on the student-athlete's primary health insurance coverage. HT's secondary insurance coverage applies only to athletic injuries sustained during participation in scheduled and supervised intercollegiate athletic events/activities; or while traveling to a related event. Each student-athlete must file a claim with his or her primary health insurance company should an athletic injury occur.

All student-athletes are required to carry primary health insurance coverage and provide proof of coverage each academic year that they participate in intercollegiate athletics at HT. All changes to primary insurance coverage must be reported immediately; and if applicable, new copies of insurance cards must be submitted immediately to the HT Athletic Training Staff. HT will not be responsible for any injuries sustained by student-athletes who do not maintain primary health insurance coverage. It is the responsibility of the student-athlete to abide by rules and regulations, as well as, become knowledgeable of the services and coverage provided under their primary health insurance policy.

Student-athletes are responsible for providing the HT Athletic Training Staff with any billing statements that they receive in error. The student-athlete must also provide the HT Athletic Training Staff with the Explanation of Benefits documents (EOB) from their primary health insurance company that corresponds with the billing statements. Student-athletes who fail to provide the necessary paperwork will be liable for the cost of any medical expenses incurred as a result of their injury.

Medical Referral Guidelines

Student-athletes are responsible for immediately reporting all injuries to the HT Athletic Training staff. Student-athletes will be evaluated and treated accordingly. Upon evaluation, if deemed necessary, student-athletes will be referred for consultations by HT's Team Physicians. Student-athletes have 60 days to request a medical consultation.

All injuries needing medical attention must be immediately reported to the HT Athletic Training Staff. All injuries must be referred by HT's Athletic Training Staff. **Do not seek medical treatment for any injury without first consulting with a member of HT's Athletic Training Staff.** Seeking initial treatment for any athletic injury without first consulting HT's Athletic Training Staff, as well as, seeking treatment by physicians other than HT's sports medicine providers, will negate application of HT's Athletic Accident Medical Insurance coverage; and the student athlete will assume financial responsibility of any medical expenses incurred.

Student-Athlete's Signature

Date

Parent's Signature (if under age 18)

Date

Athletics Assumption of Risk and Consent to Treat Form

Assumption of Risks

Student-athletes should be aware that any athletic participation will always have inherent dangers. By participating in intercollegiate athletics at Huston-Tillotson University, a student-athlete assumes certain risks and responsibilities in addition to those assumed by the school. Student-athlete responsibilities include an obligation to engage in safe conduct during practice and competition; and a strict adherence to the rules of the sport that are designed to safeguard the well-being of the participants. Although rare, death or catastrophic injury can result from participation in sports. Care and prevention should be taken by all involved to minimize such dangers through the use of appropriate equipment, proper training methods and common sense. Each student-athlete also has an obligation to inform the HT Athletic Training Staff and/or team physician of any medical problems encountered on or off the field of play.

Consent to Treat

I, _____, do hereby authorize consent to the Huston-Tillotson University's Athletic Training Staff/ Athletic Trainer or official university representative to provide relevant medical treatment deemed necessary by any licensed physician/surgeon in the event of illness or injury to myself, the above named student-athlete. This consent is intended to cover any illness or injury sustained while participating in any Huston-Tillotson University athletic competition, practice, sponsored activity; and while traveling to and from NAIA sponsored athletic activities.

I understand that this authorization is given in advance of any specific diagnosis and resulting from treatment or hospital care required. This authorization is given to provide the abovementioned representative(s) the power to give specific consent to all such diagnosis and resulting treatment or hospital care deemed advisable by the aforementioned physician/surgeon in the event the athlete is unable to give consent and/or emergency contacts are not reachable. I hereby authorize any hospital, which has provided treatment to me, the above-named student-athlete, to surrender custody of me, the above-named student-athlete to the Huston-Tillotson University Athletic Trainer or university representative upon completion of treatment.

Student-Athlete Signature

Date

Parent/Guardian Signature (if under age 18)

Date

Release of Health Information Consent Form

Student-Athlete's Name: _____ Date of Birth: ____ / ____ / ____

I hereby authorize Huston-Tillotson University's Sports Medicine Department to obtain, use, and disclose my protected health information ("Health Information") as defined by federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to provide or receive my health information is not a health plan or health-care provider, then the disclosed health information may no longer be protected from further disclosure by federal or state law.

Any and all of the following health information may be obtained, used, or disclosed by Huston-Tillotson University's Sports Medicine Department:

Please check the appropriate box:

- All **records**, including those listed below
- Pre-participation Physical Forms only
- Medical Records only
- Insurance Claims/Medical Billing and/or Medicaid Information only

This information may be obtained from, used by/for, or disclosed to, the following individual(s) and/or entities:

Please check the appropriate box:

- All of the individuals/entities listed below
- Huston-Tillotson University Athletic Trainer only
- Affiliated Team Physicians only
- Affiliated Health Care Providers such as Chiropractor, Physical Therapists, Counselors, etc. only
- Family Physician only (Physician's Name(s): _____)
- University Athletic Accident Insurance Policy Provider only
- Primary Insurance Policy Provider only
- Another school(s) in the event of a student transfer only.
- Other: _____

I understand that my healthcare will not be affected if I do not sign this form. This authorization shall expire one year from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the Huston-Tillotson Sports Medicine Department in writing. I understand that my revocation of this authorization will not affect any actions taken by Huston-Tillotson Sports Medicine Department in reliance on this authorization prior to the time it received my revocation. I understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

Relationship to student-athlete listed above (please check one):

- Self
- Parent/ Legal guardian (if under age 18)

***A photocopy or facsimile of this document shall be considered the same as the original document.*

Sickle Cell Trait Testing Waiver Form

In order to provide the highest quality of healthcare to its student-athletes, the NAIA has adopted the NCAA recommendations for testing athletes for the sickle cell trait.

About Sickle Cell Trait

- Sickle cell trait is an inherited condition of the oxygen carrying protein, hemoglobin, in the red blood cells
- Sickle cell is a common condition, and is most prevalent in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry. However, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells. Red blood cells change from their normal disc shape to a crescent or “sickle” shape, which can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.

Sickle Cell Trait Testing

- All NAIA student-athletes should have knowledge of their sickle cell trait status before the student-athlete participates in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions etc. The Huston Tillotson sports medicine staff recommends such testing. All student-athletes and parents must read and understand the NCAA Fact Sheet before deciding to be screened (blood test) for the trait or to waive the screening. Please visit www.NCAA.org/health-safety.

Sickle Cell Trait Testing Waiver: *(Please choose one below)*

I, _____, understand and acknowledge:

- The NAIA and the Huston-Tillotson University Department of Intercollegiate Athletics recommend that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned factors 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, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Huston-Tillotson University Sports Medicine personnel.
 - I **do** wish to undergo Sickle Cell Trait testing. ____ (initial)
 - I **do not** wish to undergo Sickle Cell Trait as part of my pre-participation physical examination and I voluntarily agree to release, discharge, indemnify and hold harmless Huston-Tillotson University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands or causes of action on account of any loss or personal injury that might result from my non-compliance with the mandate of the NAIA at Huston-Tillotson University Department of Intercollegiate Athletics. _____ (initial)

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 Signature

Parent/Guardian Signature

Date

ADD/ADHD Medical Exemption Form

Attention Deficit Hyperactivity Disorder (ADHD) Medication Exemption Information

Primary Care Physician/Health Care Provider:

The student-athlete presenting this form to you plans to or already participates in intercollegiate athletics at Huston-Tillotson University. Our institution is governed by the rules and regulations of the NAIA, which has adopted the rules of the NCAA regarding ADD/ADHD Medical Exemption. New legislation beginning August 1, 2009, involves the collection of medical records for those student-athletes diagnosed/treated for ADHD/ADD utilizing specific medication which may be banned by the NCAA. The following information must be provided in order for student-athletes to continue/begin their participation in intercollegiate athletics at Huston-Tillotson University while also continuing to take their ADHD/ADD medication.

Please return this form/information to the following address or fax number:

Huston-Tillotson University
c/o Amii Johnson, Head Athletic Trainer
900 Chicon St.
Austin, TX 78702
Phone: 512.505.3199
Fax: 512.505.3193

Student-Athlete Name:

Date of Birth:

Date of Initial Evaluation:

Date of most recent follow-up:

Blood Pressure:

Pulse:

Diagnosis:

Medication Prescribed/Follow-up Orders:

- Please attach a brief summary of the comprehensive clinical evaluations used to diagnose this student-athlete with ADHD/ADD (reference DSM-IV criteria) and any supporting documentation.
- Please attach note-worthy alternative non-banned medications that have been tried or considered and why they were not utilized.
- Please attach any ADHD Rating Scale (ex: Connors, ASRS, CAARS) scores and report summaries.

If available, please provide copies of the following:

- ADHD/ADD symptoms by other health care providers
- Any psychological testing results
- Laboratory/testing results
- Previous ADHD/ADD diagnosis summaries not completed/diagnosed by the current physician

Name of Clinician (print):

Address:

Specialty:

Signature:

Date:



