



TO THE PARENTS OF ST. ANDREWS PRESBYTERIAN COLLEGE STUDENT-ATHLETES

We are extremely pleased to have your son/daughter as a student-athlete at St. Andrews and hope that he/she will achieve academic, social, and athletic success!

Enclosed are several forms for your completion. Please make sure all questions are answered. Also, please sign in the appropriate space provided. A copy of your current insurance card (front and back) must be provided to both student health and athletics.

THE STUDENT/ATHLETE WILL NOT BE ALLOWED TO PARTICIPATE UNTIL ALL FORMS WITH SIGNATURES ARE RETURNED.

Each student/athlete is required to have a physical examination prior to any participation in any intercollegiate sport. In the information you will find an Athletic Physical Exam form at the end of the document. If you choose to have a physical prior to arriving on campus please use the form provided. If you have not provided a physical with your paperwork, you will have a physical when you arrive on campus. Physicals will be performed by our team physician. The cost of this physical will be \$20.00.

So there is no confusion, the following should be returned to the department of athletics:

Medical Information Update
Emergency Consent and Health Information Form
Nutritional Supplement and Review Disclosure (must be signed even if you are not taking supplements)
Athletic Physical Examination form (if you choose to have it done at home)
Copy of front and back of your insurance card

If there is no physical or paperwork on file prior to the first practice, the athlete will be required to complete all paperwork, provide a copy of their insurance card and have a physical prior to participation. To avoid any delays, please schedule with your family physician back home in plenty of time to get the required physical completed prior to your arrival on campus. Otherwise, you will have to have a physical upon arrival and pay \$20.00.

The final decision on physical qualifications or reason for rejection is the responsibility of the team physician, athletic trainer, or athletic director. The team physician or athletic trainer also will make the decision on when an athlete may return to competition after an injury.

We want to thank you for your cooperation in this matter. We know it is time consuming to fill out the forms but it really make our job much easier. If you have any questions, please contact either the athletic trainers or athletic director.

Thank you,

St. Andrews Athletic Training
St. Andrews Athletic Department

**ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
MEDICAL INFORMATION UPDATE (Returning Athletes ONLY)**

Name of Athlete: _____ Date: _____

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M F _____

College/Local Address:		

Street		
_____	_____	_____
City	State	Zip

Athlete Cell Phone #		

Home/Permanent Address:		

Street		
_____	_____	_____
City	State	Zip

Home Phone		

all questions fully and provide explanation for each "YES" in the space provided. Failure to disclose any medical information may invalidate insurance coverage. The information provided is strictly confidential and used for health care purposes only.

Have you sustained a head injury or concussion in the last 12 months? YES NO

Have you been diagnosed with high blood pressure in the last 12 months? YES NO

Have you been diagnosed with diabetes in the last 12 months? YES NO

Have you had any dizzy spells, fainting or seizures in the last 12 months? YES NO

Have you had any infectious disease (ie. mono) or illness requiring a physician's visit in the last 12 months? YES NO

Have you sustained any musculoskeletal injury requiring a doctor's visit? If yes, describe the condition and what was done. This includes all injuries occurring during the past year's sport season. YES NO

Have you been diagnosed with asthma in the last 12 months? YES NO

Have you had any other significant medical problem in the last 12 months? YES NO

Injury and Concussion Acknowledgement:

I acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (i.e. team physician, athletic trainer, etc). I recognize that my true physical condition is dependent upon an accurate medical history and full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I am fully disclosing 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. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that my institution has/will 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. I also acknowledge the information provided in my updated medical history is accurate to the best of my knowledge.

Student Athlete Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

**ST ANDREWS PRESBYTERIAN COLLEGE ATHLETIC DEPARTMENT
EMERGENCY CONSENT and HEALTH INFORMATION FORM**

Name of Athlete: _____ Date: _____

Sport MSOC WSOC VB CC MBK WBK BB SB GOLF MLAX WLAX WR

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M F Social Security #: _____

College/Local Address:		
Street _____		
City _____	State _____	Zip _____
(_____)		
Athlete Cell Phone # _____		

Home/Permanent Address:		
Street _____		
City _____	State _____	Zip _____
(_____)		
Home Phone _____		

FATHER's Information:	MOTHER's Information:
Full Name: _____	Full Name: _____
DOB: _____	DOB: _____
Social Security #: _____	Social Security #: _____
Employed By: _____	Employed By: _____
Work Phone: _____	Work Phone: _____
Medical Insurance Plan: _____	Medical Insurance Plan: _____
Insurance Plan Address _____	Insurance Plan Address _____
Policy Number _____	Policy Number _____
Group Number _____	Group Number _____
Is son/daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is son/daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is this plan an HMO or PPO? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this plan an HMO or PPO? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is pre-authorization required for treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is pre-authorization required for treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is a second opinion required for surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is a second opinion required for surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO

Primary Care Physician _____ Phone _____

Previous Injuries/Surgeries: _____

Allergies: _____

Medications Used Regularly: (Include inhalers, birth control, etc) _____

Person to notify in case of emergency (other than parent):

Name: _____ Relationship to athlete: _____

Phone: _____ Alternate Phone: _____

Emergency Statement:
 I grant permission for transportation and treatment necessary for a condition arising during participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact my nearest relative prior to treatment.

Insurance Statement
 I hereby authorize St. Andrews College, First Agency Insurance Company and its representatives to secure copies of case history records, laboratory reports, diagnosis, x-rays and any other data covering this and/or disabilities. A photostatic copy of this authorization shall be deemed effective and valid as the original.

Parent's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

INSURANCE CARDS

ALL ATHLETES MUST
MAKE A COPY OF YOUR
CURRENT INSURANCE
CARD (FRONT AND BACK)
AND RETURN WITH ALL
THE PAPERWORK.

THANK YOU!

**St. Andrews Presbyterian College Athletic Department
Student-Athlete Nutritional Supplement Disclosure and Review Form**

I, the undersigned, am taking or intend to take the following nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements. I acknowledge the possible health risks that may be associated with taking an over-the-counter nutritional supplement.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate because they are not regulated by the Food and Drug Administration (FDA) and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or safe to use, or that the NCAA endorses a product or approves its usage. In other words, what's in the bottle is not always on the label. If I do not know what I'm taking, I'm risking both my health and my eligibility.

The NCAA does not accept ignorance as an excuse following a positive drug test for a banned substance. Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's head athletic trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's head athletic trainer.

Brand Name

Listed Ingredients

1. _____

2. _____

3. _____

Printed Name _____ Sport _____

Athlete Signature _____ Date ____ / ____ / ____

Do Not Write In This Box

Reviewed by Staff Athletic Trainer: _____ Date ____ / ____ / ____

Substance Listed are: Banned _____ Acceptable _____ Do Not Take _____

Athletic Physical Exam
(To be completed by a physician)

Student-Athlete's Full Name: _____ Date: _____

Sport(s): _____ Year in College _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: *Uncorrected:* Right 20/ _____ Left 20/ _____ *Corrected:* Right 20/ _____ Left 20/ _____
Both: 20/ _____ Glasses/Contacts _____

Heart: Heart Inspection _____ Palpation _____
 Rhythm _____ Sounds & Murmurs _____

Genitalia: _____ Not Examined _____

	Satisfactory		Physician's Comments	Follow-up	
	Y	N		Y	N
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thorax and Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal:

General Posture/ Deformities/ Scars: _____

Neck/ Cervical-Spine/ Back: _____

Lower Extremities:

Hip	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Shin	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Calf	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Toes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Upper Extremities:

Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Wrist, Hand, Fingers	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Athletic Participation Approved: Yes _____ No _____

Additional Comments/ Limitations: _____

Physician's Signature: _____ Date: _____

Physician's Office Phone Number completing physical: _____