

Roosevelt University 2011-2012		Name:	
Intercollegiate Athletics		RU ID#	Sport:
NCAA Student Health History – Initial Form		Year in School Fall 2011 1 2 3 4 5 Transfer	
HAVE YOU EVER HAD ANY OF THE FOLLOWING?		SPORTS MEDICINE STAFF USE ONLY	
YES	NO	Any case of Asthma related problems?	Type: (circle one) Ongoing Illness Related Exercise Induced Allergy Related
			Diagnosed by: _____ How long have you had it? _____
			Usual peak flow (if measured): _____
			Have you been hospitalized for asthma or ER? Y / N When? _____
			Have you taken oral steroids (prednisone)? Y / N
			Family history of asthma? Y / N Who? _____
			How controlled are symptoms? Good Bad Depends
			Trouble sleeping or wake up with shortness of breath? Y / N
			Do you use an inhaler? Y / N
			Ever had pulmonary function testing (spirometry)? Y / N
			Do you have frequent respiratory infections (bronchitis, pneumonia)? Y / N
YES	NO	Seasonal allergies that require medical attention?	Have you ever had skin testing for allergies? Y / N
			Do you need an inhaler or nasal steroid spray for your allergies? Y / N
			Ever needed a steroid shot or oral (prednisone) for allergies? Y / N
			During exercise/exertion, do allergies cause: Wheezing Coughing Shortness of Breath
YES	NO	Head injury, concussion, been knocked out, or lost your memory for any period of time? (Circle appropriate choice)	How many times has it happened? _____ How long ago? _____
			Describe incidence(s): _____
			What symptoms: nausea/vomiting headache dizziness cramps passed out
YES	NO	Heat exhaustion, heat stroke, or been restricted from participation due to heat illness? (Circle appropriate choice)	How many times has it happened? _____ How long ago? _____
			Describe incidence(s): _____
			What symptoms: nausea/vomiting headache dizziness cramps passed out
			What did a coach or athletic trainer do to help?
			ER or Hospitalized? Y / N Family history of thyroid problem? Y / N
			How do you hydrate for practice or competition?
YES	NO	Do you or a member of your family have a history of Marfan's Syndrome?	Appearance suggestive of Marfan's: Height: Men > 6'(72") Women > 5'10" (70") Greater arm span than height?
			Height of parents: _____ Height of siblings: _____

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HAVE YOU EVER HAD ANY OF THE FOLLOWING?			SPORTS MEDICINE STAFF USE ONLY	
YES	NO	During or after exercise, (other than heat or asthma related) do you cough, wheeze or have trouble breathing, get chest pain, get tired more quickly than your friends, have unusual racing of your heart or skipped heartbeats, or ever pass out? (Circle appropriate choice/s)	Describe when you get this/these issues:	
			How long does it last?	
			What makes it go away?	
			Describe chest pain: Dull Sharp Crushing Pressure N/A	
			Pain occurs in: Neck Jaw Arm N/A	
			Dizziness is: Lightheaded Spinning N/A	
			Does shortness of breath cause coughing or wheezing? Y / N	
			Do you have trouble with non-athletic activities (walking, climbing stairs)? Y / N	
			Have you been diagnosed or treated by a physician for this? Y / N	
			Do you or have you taken: Energy drinks Diet pills N/A What kind?	
YES	NO	Heart condition or heart murmur, high blood pressure or high cholesterol? (Circle appropriate choice – if you circle heart condition, please indicate type in this box)	When was it diagnosed? By whom?	
			Do you still have it? Y / N	
			Current symptoms: Headaches Chest pain Racing heart Feeling flushed Dizziness Shortness of breath Passing out or tiredness Frequent muscle cramps N/A Other (explain):	
			If you have high blood pressure or cholesterol, did you have a change in diet? Y / N N/A	
			Did you see: Nutritionist Cardiologist N/A	
			Have you ever been restricted or denied participation in sports due to this heart problem? Y / N	
			Do you have mitral valve prolapsed? Y / N	
			Do you need to take antibiotics before seeing a dentist or surgery? Y / N	
			Was a murmur diagnosed as a baby?	
			Family history? Y / N Who? Which condition?	
YES	NO	In the past 12 months did you have any injury or illness that required medical attention?	Describe illness or injury?	
			Are you undergoing any rehabilitation? Y / N	
			Were you treated by an Orthopedist? Y / N	
			Are you still under MD care? Y / N Are you fully recovered? Y / N	
YES	NO	Currently taking medications for any reason? (excluding oral contraceptives)	Describe type and purpose of medication:	
YES	NO	Are you currently taking any supplements or vitamins?	Describe type and purpose:	
YES	NO	Have you had a severe viral infection diabetes or hypoglycemia?	Explain:	
YES	NO	Have you had a severe viral infection within the last month?	Indicate which: Mono Pneumonia Flu Myocarditis	
YES	NO	Has any family member or close relative died of heart problems or sudden unexpected death before age 50?	Describe incidence(s):	
YES	NO	Do you, or have you had an eating disorder?	Explain:	

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HAVE YOU EVER HAD ANY OF THE FOLLOWING?			SPORTS MEDICINE STAFF USE ONLY	
YES	NO	Do you want to weigh more than you do now?	Goal Weight:	lbs.
YES	NO	Do you want to weigh less than you do now?	Goal Weight:	lbs.
YES	NO	Do you want to speak to a dietitian or athletic trainer regarding weight issues?		
YES	NO	Do you feel more stressed out or depressed than you think you should?	Explain which and why:	
YES	NO	Are you missing an eye, kidney or ovary?	Explain:	
YES	NO	Allergies to: (circle) Drugs, Food, or Bee Stings	Explain:	
YES	NO	Have you ever had: (circle) 2-D Echo or Echo Cardiogram / EKG	When?	For what purpose?
YES	NO	Do you have any medical conditions not listed above	Explain:	
<u>FEMALES ONLY</u>				
YES	NO	Menstrual irregularity?	Loss of periods? Y / N	Number of periods in the last year:
YES	NO	Taking oral contraceptives?	What kind?	
YES	NO	History of stress fractures?	When?	Where?
YES	NO	Do you roughly consume 1200mg of Calcium daily?	(Once cup skim milk, yogurt, or orange juice = 300mg)	
YES	NO	Significant weight changes or weight concerns?	Explain:	
<u>Males ONLY</u>				
YES	NO	Have you ever had a hernia?	Explain:	
YES	NO	Are you missing a testicle or do you have any testicular dysfunction?	Explain:	
Additional Notes:				
Student-Athlete Signature:			Date:	
Review By:			Date:	

**ROOSEVELT UNIVERSITY
INTERCOLLEGIATE ATHLETICS
STUDENT-ATHLETE'S ACKNOWLEDGEMENT AND
ASSUMPTION OF ATHLETIC RISK AND RESPONSIBILITY**

Name _____

RU ID # _____

The undersigned herewith formally acknowledges and declares the following:

I understand that training, traveling and participation in athletics will require a personal acceptance of risk for serious injury. Athletes generally expect that those who are responsible for the training, travel and conduct of sport take reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict wrongful injury upon them.

Periodic analysis of injury patterns leads to refinement in the training methods, sport rules and other safety decisions. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself. To rely on officials to enforce compliance with a set of rules can be as practically insufficient as reliance on warning labels to always avoid or prevent injuries or sickness. Chance and risk of injury are an inescapable part of physical athletic training and competition.

I understand that training, traveling and participation in Intercollegiate Athletics at Roosevelt University may involve accidents resulting in injury/illness, permanent physical or mental impairment or even death. These injuries may be minor or may be career or life threatening. I understand that Roosevelt University cannot be held responsible for any injuries or conditions which may be caused by the actions of third parties, other student-athletes, other teams, or me. I further understand that I may have personal physical conditions that may appear during my training, conditioning or participation in competition that my coaches, athletic trainers and medical support providers may not know about that can cause me unanticipated injury/illness, permanent physical or mental impairment, or even death. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques that are made known to me by my coaching staff or athletic training staff are otherwise known to me from any other source including but not limited to medical personnel of the University.

I have read the above risks statement. I understand that there are certain inherent risks involved in training, traveling and participating in an intercollegiate athletics program. I acknowledge the fact that these various risks exist and I am voluntarily willing to personally assume responsibility for any and all such risks while participating in Intercollegiate Athletics at Roosevelt University. As inducements to my being permitted to participate, I also agree as follows:

- A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics as administered by Roosevelt University.
- B. I accept that Roosevelt University and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have.
- C. I understand that having pass the physical examination **does not** necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at Roosevelt University, but only that the evaluator did not find a medical reason to disqualify me at the time of physical examination.
- D. I understand that I must refrain from practice while injured or ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission, based on independent exercise of professional judgment, by the attending Physician after review of my condition and fitness for the rigors of my sport. This may occur during or at the conclusion of medical treatment.
- E. I understand and agree that if I experience an injury/illness or change in my health status **it is my responsibility** to inform my Head Coach and the Athletic Trainer and to adhere to the established injury management guidelines which includes total rehabilitation and reassessments before I am released to return to full participation
- F. **Governing Law and Jurisdiction.** *The laws of the State of Illinois shall govern the validity, construction and enforceability of this Agreement, without giving effect to its conflict of laws principles. All suits, actions, claims and causes of action relating to the construction, validity, performance and enforcement of this Agreement shall be in the State of Illinois Court of Claims.*

I HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS

Name (Print): _____ Signed: _____

Witness: _____ Date: _____



Roosevelt University

Intercollegiate Athletics

Injury and Illness Reporting Acknowledgement Form

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 athletic training staff of Roosevelt University. 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 athletic training staff at Roosevelt University.

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 athletic training staff.

By signing below, I acknowledge that Roosevelt University 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.

I, _____, have read the above and agree that the statements are accurate.
Student-athlete's name

Signature of student-athlete

Date

Name of person obtaining consent

Signature of person consenting

The following is educational information to help the student-athlete better understand what a concussion is and recognize the signs and symptoms associated.

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 athletics 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 ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell the athletic training staff and coach. Never ignore a blow to the head. Also, tell the athletic training staff 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 in a safe manner.

Get checked out. The team physician or athletic training staff 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.



Roosevelt University, Intercollegiate Athletics
Physical Examination (2011)

Student-Athlete: _____ Year in School Fall '11 (circle): 1 2 3 4 5
Sport _____ RU ID# _____ Date: _____

Vision: Corrected / Uncorrected L _____ R _____ **Height:** _____ **Weight:** _____
B/P: Auto / Manual _____ **Pulse:** _____ **Pupils Equal:** YES / NO

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIAL
Neck/Back/Head			
Upper Extremity			
Lower Extremity			

Comments or Assessment: _____

ORTHO CLEARANCE: 1.) Without restriction
2.) Pending due to _____
3.) Other _____

Signed: _____ ATC Date: _____

MD Use Only

Last Tetanus Shot: _____ Sickle Cell Date and Result: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIAL
E/E/N/T			
Lymph Nodes			
Heart			
Pulse			
Lungs			
Abdomen			
Genitalia (Males Only)			
Skin			
Other			

Comments or Assessment: _____

Additional Orders: _____

CLEARANCE IS:

- 1.) Without Restriction
- 2.) Pending due to _____
- 3.) Deferred due to _____

PRACTICE STATUS:

- 1.) Full Participation
- 2.) Non Contact: Strenuous OR Non-Strenuous
- 3.) Participate As Able
- 4.) No Practice

Signed: _____ Physician Date: _____

Have you formally declined RU Student Insurance for 2011-2012?	YES	NO
<u>I verify that the above statement of insurance is true, complete and correct to the best of my knowledge</u>		
Parent or Guardian Signature: _____	Date: _____	
Signature : _____	Date: _____	

INFORMED CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, give the Roosevelt University Athletic Training Staff permission to share medical and insurance information with the team physicians and or other medical professionals regarding injuries, illness, or other medical /psychological/personal conditions that may affect my participation in any way with Roosevelt University Intercollegiate Athletics sanctioned practices, contests, team functions, and events. I understand that this information will be shared for referrals and correspondence with physicians and medical professionals who are directly involved with my care. Furthermore, I understand that in order for medical insurance companies to process claims they must be provided with injury reports, dictation's and follow-up notes which are provided through the Certified Athletic Trainer.

Signature of student-athlete: _____ Date: _____

PLEASE ATTACH COPIES OF YOUR PRIMARY INSURANCE CARD

FRONT

BACK

*(Secure All Edges with
Glue or Tape Only)*

*(Secure All Edges with
Glue or Tape Only)*

SECONDARY INSURANCE CARD (if Applicable)

FRONT

BACK

*(Secure All Edges with
Glue or Tape Only)*

*(Secure All Edges with
Glue or Tape Only)*

(RETURN THIS PAGE WITH YOUR SIGNATURE TO THE RU ATHLETIC DEPARTMENT)

SIGNATURE PAGE

THE 2011-2012 ROOSEVELT UNIVERSITY ATHLETIC DEPARTMENT

SUBSTANCE ABUSE POLICY

The acceptance of membership on an athletic team constitutes an agreement to comply with all the regulations of Roosevelt University and the athletic department and a voluntarily consent to undergo and cooperate in the drug testing program as summarized in the student-athlete handbook, Substance Abuse Policy.

In addition, I (print your name here) _____ SPORT _____

understand that I may be temporarily or permanently suspended from a team and will participate in substance abuse counseling, if applicable, for violation of the substance abuse policy.

I fully understand the penalties for a positive drug test and that TERMINATION of team membership WILL occur on the THIRD POSITIVE TEST.

I certify that I have carefully read the preceding Roosevelt University substance abuse policies regarding testing frequency, collection methods and penalties, and that I have been given an opportunity to have them explained to me.

I do understand and agree to comply with the Roosevelt University Athletic Department substance abuse policy.

SIGNED: _____ DATE: _____

PARENT (if needed): _____ DATE: _____

Roosevelt University

Intercollegiate Athletics

Athletic Training

430 S Michigan Ave.

Chicago, Illinois 60605

Authorization For Release Of
Confidential Health Information
For NAIA Athletes

Name: (Last) _____ (First) _____

RU ID # _____ Date of Birth: _____

I authorize Roosevelt University and RU Intercollegiate Athletic Training Staff to share confidential health information regarding services related to NAIA clearance and participation. This release could include information contained in my medical record from RU Intercollegiate Athletic Training records.

Diagnosis of Mental Health and/or Alcohol and Substance abuse are NOT included in this general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require a separate, specific release form signed for any Diagnosis of Mental Health and/or Alcohol and Substance Abuse.

This information is to be used for the purpose of continuity of health care and treatment. I understand that I have the right to inspect and/or obtain a copy, (for an appropriate fee) of the information prior to disclosure. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to Roosevelt University. If I refuse to sign this authorization, my medical record/information will not be released. If this is for the purposes of third party payment, the refusal to authorize could result in the assignment of financial responsibility to me, the patient, for services. This authorization will be considered valid for 1 academic year following the date of signature unless otherwise specified here: I absolve the individual or agency identified above and the Board of Trustees of Roosevelt University together with its officers and employees from any legal liability which may arise from the disclosure of this information.

Athlete Signature: _____ Date: _____

If athlete is under 18 must be signed by parent or guardian

Witness by: _____