Gardner-Webb University
Intercollegiate Student-Athlete Insurance Program

All Student-Athletes entering Gardner-Webb University who are first-year participants are **REQUIRED** to have **primary** health care insurance in the State of North Carolina that will cover the student-athlete while participating in intercollegiate athletics. Primary health care insurance is the health insurance that will pay first on medical claims. This primary health care insurance policy must have a minimum coverage limit of $10,000. A photocopy of your primary insurance card (front and back side of the card) must be submitted to the Gardner-Webb University Athletic Training Department. Failure to comply will keep the student-athlete from participating in their respective sports until primary health care insurance is obtained and on file with the Gardner-Webb University Athletic Training Department. In addition to the primary health care insurance coverage you provide, Gardner-Webb University will provide **secondary** insurance for injuries sustained while participating in intercollegiate athletics for Gardner-Webb University. The secondary insurance coverage provided by Gardner-Webb University will pay medical expenses that are reasonable and customary after the primary health care insurance pays their portion including up to $1,000.00 of any deductible on your primary coverage. NO pre-existing injuries or congenital disorders will be covered under the secondary insurance policy. It is the responsibility of the student-athlete and his or her parent/legal guardian to notify the University **IMMEDIATELY** upon any change in your primary health care insurance coverage. Failure to notify the University within 30 days of any changes in the student-athlete's medical insurance coverage may nullify Gardner-Webb University from responsibility regarding any medical bills.

We strongly recommend that you research and understand your primary health care insurance benefits prior to your arrival on campus to make sure that your son/daughter is covered in the State of North Carolina and while participating in intercollegiate athletics. It is recommended that if you have a HMO/PPO plan, you call your carrier to inquire about coverage in the Cleveland County Area and secure "guest privileges" for a local provider. Also, it would be advisable to look into your out-of-network coverage in the Cleveland County area. Tricare, Medicare/Medicaid, or any government sponsored insurance does not cover you while you are participating in intercollegiate athletics and will **NOT** be accepted as primary health care insurance coverage. If you participate in any government sponsored insurance or have no primary health care insurance coverage you MUST purchase a primary health care insurance policy that will cover you while participating in intercollegiate athletics. If you are not using your parent or guardian's insurance and need a recommendation for coverage to purchase, please contact the Gardner-Webb University Athletic Training Department. Please note that the University accepts no responsibility based on any recommendations made concerning primary health care insurance coverage available for you to purchase as these are only recommendations.

When a student-athlete is injured, all medical insurance claims will be filed with your primary health care insurance company. The following information is required from the student-athlete in order to process a claim with the secondary insurance company:

1) Itemized bills from all medical providers
2) Explanations of Benefits (EOB's) from your medical insurance company
3) Receipts from payments made to medical providers

The Gardner-Webb University Athletic Training staff will assist in expediting the dissemination of this information to the secondary insurance company and process the remaining portion of the claim for you. **Please be advised that if a balance still exists after both primary and secondary insurance have paid, this will be the responsibility of the student-athlete.**

Your signature on this letter indicates that you have read, understood, and will comply with all that is stated above. Any false information will nullify Gardner-Webb University from responsibility regarding any medical bills.

"I, ____ have read the above letter and understand that Gardner-Webb University is responsible on a secondary basis only for injuries which occur while representing Gardner-Webb University in an athletic practice or competition. I also verify that all the insurance information that I have provided is correct and complete.**"**

_______________________________________	____________	__________/________
Student-Athlete's Signature	Date	Date of Birth/Current Age

_______________________________________	____________
Parent's Signature	Date

GARDNER-WEBB UNIVERSITY ATHLETIC TRAINING
Acknowledgment of Insurance Policy

Name:______________________________

Date:_______________________________

Sport:______________________________

As a student-athlete participating in athletics at Gardner-Webb University you are insured under a secondary insurance policy. Secondary insurance coverage pays the remaining portions of medical bills after the student-athlete's Primary Insurance carrier has made its payment.

As a student-athlete at Gardner-Webb University, it is your responsibility to inform the Athletic Training Staff of any changes in your Primary Insurance status when it happens. Failure to report any change in your Primary Insurance coverage could result in non-payment of any injuries that might occur while representing Gardner-Webb University as a student-athlete.

Gardner-Webb University is not responsible for any injury occurred while not representing Gardner-Webb University. It is also not responsible for any pre-existing injury. It is the student-athlete's responsibility to reveal all pre-existing injuries with the Gardner-Webb University Athletic Training Staff.

The undersigned, by signing this release, hereby certifies that the undersigned has read and fully understands the conditions herein provided, and has disclosed all pre-existing injuries.

Signature:___________________________

Date:_______________________________

Witness:_____________________________

Updated: 05-13-03

PARENT INFORMATION FORM

M09/10

PARENTS/GUARDIAN TO COMPLETE AND RETURN TO:
FAX- (704) 406-3503
Attn: Jon Mitchell, Service Program Director

Gardner-Webb University
Athletic Training
P.O. Box 877
Boiling Springs, NC 28017

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: ______________________ Sport: ______________

Social Security #: ______________________ Date of Birth: ______________

GWU Campus Box: ______________________ Phone: ______________

Home Address: ______________________ Phone: ______________

City: ______________ State: ______________ Zip: ______________

II. Father/Guardian: ______________________ Mother/Guardian: ______________________

Social Security #: ______________________ Social Security #: ______________________

Date of Birth: ______________________ Date of Birth: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

III. Employer: ______________________ Employer: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Telephone: ______________________ Telephone: ______________________

IV. Medical Insurance Company or Plan ______________________ Medical Insurance Company or Plan ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Policy Number: ______________________ Policy Number: ______________________

Policy Effective Dates: ______________________ Policy Effective Dates: ______________________

Policy Deductibles/Co-insurance: ______________ Policy Deductibles/Co-insurance: ______________

Phone Number: ______________________ Phone Number: ______________________

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? ☐ Yes ☐ No
If yes, please circle which type of Plan you have: HMO PPO

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Does your insurance or plan require a second opinion before surgery? ☐ Yes ☐ No

Does your insurance or plan cover athletic injuries? ☐ Yes ☐ No

Does your insurance or plan provide out-of-state or out-of-network benefits? ☐ Yes ☐ No

I hereby authorize Gardner-Webb University to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize that the university or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the university.

Policy Holder's Signature: ______________________ Student's Signature: ______________________

HOSPITAL EMERGENCY INFORMATION
GARDNER-WEBB UNIVERSITY
ATHLETIC TRAINING

Name: First:____________________Middle:____________Last:____________________

Home Address: ____
____
____

Home Phone Number:____

Cell Phone Number:____

Date of Birth:____

Social Security Number:____

Parent's Name: Father:________________________ Mother:________________________

Parent's Address: ____
____
____

Parent's Home Phone Number:____

Any Existing Medical Conditions: Yes:________ No:_________
If yes please list: ____
____
____

Any Known Allergies: Yes:________ No:_________
If yes please list: ____
____
____

Family Physician/Primary Care Physician: ______________________________________
(Name/Address/Phone Number) ______________________________________
____

If you are 18 or older Gardner-Webb University Athletic Training Staff and Team Physicians needs your permission to inform your parents about any injuries/illness that might require emergency medical attention. Do you give Gardner-Webb University permission, circle one:
Yes No
Signature:_____________________________ Date:___________________________

If you are 17 or younger your parents will be notified of any injury/illness that happens to you that requires emergency medical attention.

Gardner-Webb University Athletic Training
Medical History

I. This question is part of your physical examination for participation in college athletics. This is part of you medical record and will be treated confidentially.
II. Please fill in all blanks to the best of your knowledge. This will be screened by our team physician.
III. Answer all questions.

Do Not Write In This Space

What sport?__________________ Year at GWU 1st ____ 2nd ______ 3rd ______ 4th ______ 5th ______

Name____ Date______________________

Social Security Number___________________________ Age______________ Birth Date__________

GWU Campus Box_______________________ GWU Phone Number ___________________________

Home Address____

City_____________________________________ State_______________ Zip__________________________

Parent or Guardian_________________________________ Phone___________________________________

Parent or Guardian's Address____

In Case of Injury, Notify____________________________ Phone___________________________________

Family Doctor___________________________ Address____

City_____________________________________ State_______________ Zip__________________________

Family History	Age	State of Health If Living	Cause of Death	Age at Death
Father				
Mother				
Brothers				
Sister				
Wife				
Husband				

Who in Your Family Has Had: Goiter__________________________ Diabetes______________________

Cancer______________ Tuberculosis__________________ Allergies________________________________

Asthma________________________ Heart Attacks Before at 60_____________________________________

High Blood Pressure____________ Gout________________ Strokes Before Age 60____________________

Mental Disorder__________________________ Convulsion/Epilepsy_______________________________

Migraine Headache____

MARITAL HISTORY:
Married________________________ Single__________________________ Children______________________

Wife's Address____ Phone______________________

Husband's Address____ Phone______________________

HEALTH HISTORY

Please check the correct answer following each question:

Do Not Write In This Space

A. HEAD INJURY

1. Did you ever have spasms or convulsions as an infant? Yes___ No___

2. Have you ever had a seizure, convulsion fit or epileptic attack? Yes___ No___

3. Have you ever had, or has it been suggested that you should have, a brain wave test (EEG or Electroencephalogram)? Yes___ No___

4. Have you ever had, or has it been suggested that you have, a skull X-Ray or brain scan? Yes___ No___

5. Have you ever been unconscious? If yes, check the following: Yes___ No___

   1. Knocked out _________ If yes, how many times_____________

   2. Passed out fainted, or blacked out ________________

   3. Were you hospitalized for this? Yes___ No___

      A. Did this occur while participating in athletics? Yes___ No___

      If yes, which sports:___________________________

      B. How long were you unconscious? Less than 5 minutes ______________

      Less than 15 minutes_________ Over 15 minutes _________________

      C. Were you seen by a physician? Yes___ No___

      D. Were you admitted to a hospital or infirmary? Yes___ No___

      E. Were X-Rays made? Yes___ No___

      F. Were you given a brain wave test (EEG)? Yes___ No___

      G. How long after being unconscious before you were allowed to participate in athletics again?

      Less than 2 days ______ Less than 1 week______ Over 1 week

6. Have you ever had a skull fracture? Yes___ No___

7. Have you ever had amnesia (loss of memory) following a head injury? Yes___ No___

8. Do you now, or have you ever, suffered from frequent headaches? Yes___ No___

9. Have you ever had blurred or double vision? Yes___ No___

10. Have you ever had a concussion without being unconscious? Yes___ No___

    How many times? ____________

    How long to make a complete recovery? ____________

    How many games missed following concussion?_________

    When was your last concussion?____________

B. EYES

1. Have you ever been told you had a lazy eye? Yes___ No___

2. Do you have an absence of one eye? Yes___ No___

3. Do you have diminished or abnormal vision? Yes___ No___

4. Do you normally wear glasses? Yes___ No___

5. Do you wear contact lenses? Yes___ No___

   If yes, hard or soft? _________________

   Contacts fitted by: ______________________

7. Last seen by doctor for vision check?_____________

8. Have you ever had an eye injury? Yes___ No___

9. Have you ever had eye surgery? Yes___ No__

Do Not Write In This Space

C. EARS

1. Do you have any defect of hearing? Yes___ No___

2. Do you have any drainage? Yes___ No___

3. Do you have any ringing in your ears? Yes___ No___

4. Have you ever had ear injury or ear surgery? Yes___ No___

D. NOSE

1. Do you have frequent nose bleeds? Yes___ No___

2. Have you ever broken your nose? Yes___ No___

3. If broken, did you have surgery? Yes___ No___

4. Have you had difficulty breathing through your nose? Yes___ No___

E. DENTAL AND THROAT

1. Do you have any false teeth or plates? Yes___ No___

2. Have you fractured a tooth? Yes___ No___

3. Have you had a tooth knocked out? Yes___ No___

4. Have you had more than one tooth knocked out? Yes___ No___

5. Did you miss practice because of the injury? Yes___ No___

6. Dentist last seen: Name___________________ Month___________Year ___________

7. Wisdom teeth? In________ Out ________

F. NECK

1. Have you ever had a neck injury? Yes___ No___

2. Have you ever had a fractured neck or spine? Yes___ No___

3. Have you ever sustained a neck injury while playing organized sports? Yes___ No___

4. Did you have numbness, burning, or sharp pain in your arms or hands? Yes___ No___

5. Did you see a physician? Yes___ No___

6. Were X-Rays made? Yes___ No___

7. Were you in a hospital or infirmary? Yes___ No___

8. How long did you miss practice following injury?

Less than 2 days________ Less than 1 week ________ More than 1 week________

9. Have you ever had a pinched nerve? Yes___ No___

10. Have you ever worn a "horse collar" because of neck injury? Yes___ No___

11. Did the collar reduce the incidence of neck injury? Yes___ No___

12. Have you ever been taught to "spear" with your head when you tackle and block? Yes___ No___

G. MUSCULOSKELETAL

a. Dislocations

1. Have you ever dislocated a joint? Yes___ No___

Do Not Write In This Space

2. If answer is yes, please check involved area or areas:

Shoulder (L)______ (R)______ Ankle (L)______ (R)______

Knee-cap (Patella) (L)______ (R) _____ Finger (L)______ (R)______

Knee (L)______ (R)______ A-C Separation (L)______(R)______

Elbow (L)______(R)______ Collar bone separation from shoulder (L)______(R)______

3. Has the dislocation occurred more than once? Yes___ No___

How many times________ Last occurrence_______________

4. Did you see a physician with initial dislocation? Yes___ No___

5. Were X-Rays made? Yes___ No___

6. Was the involved area immobilized (put in cast splint or other immobilization?) Yes___ No___

7. Did you have surgery? Yes___ No___

8. Were you given specific exercises following the injury or surgery? Yes___ No___

b. Spine

1. Have you ever injured your back? Yes___ No___

2. Have you injured your back more than once? Yes___ No___

3. When did you first have back trouble?

Before high school________ During high school________ During college________

4. Did you see a physician? Yes___ No___

5. Were X-Rays made? Yes___ No___

6. How long did you miss practice?

Less than 2 days________ Less than 1 week________More than 1 week________

7. Were you ever told that you have a spinal defect that has been present since birth? Yes___ No___

8. Were you ever instructed in special exercises for your back? Yes___ No___

9. Do you have frequent back pain? Yes___ No___

c. Knee

1. Do you have occasional swelling of the knee? Yes___ No___

Does your knee ever lock up? Yes___ No___

Does your knee ever give away? Yes___ No___

Does your knee feel unstable? Yes___ No___

Does your knee hurt following activity? Yes___ No___

2. Have you had a significant knee injury? (L)________ (R)________ Yes___ No___

3. When did you first injure your knee?

Before high school________During high school________ During college________

4. Did you see a physician? Yes___ No___

5. Did you have X-rays taken? Yes___ No___

6. Did you have surgery? Date____________ Yes___ No___

7. Name of surgeon _________________________________

Address of surgeon _________________________________

8. If you had surgery, what was repaired?___________________________________

9. Were you given specific knee exercises following surgery or injury? Yes___ No___

10. How long did you miss practice?

Less than two days______Less than one week______ More than one week______

11. Have you had significant injuries to both knees? Yes___ No___

12. Have you had surgery on either knee more than once? Yes___ No___

13. If you had a knee injury in college, did this represent a re-injury from high school? Yes___ No___

14. If you had a knee injury in high school, do you think it was properly treated? Yes___ No___

If no, please explain on a separate sheet of paper.

d. Shoulder

1. Does your shoulder ever give away? Yes___ No___

Does your shoulder feel unstable? Yes___ No___

Does your shoulder hurt following activity? Yes___ No___

2. Have you had a significant shoulder injury? (L)________ (R)________ Yes___ No___

3. When did you first injure your shoulder?

Before high school_________During high school________ During college________

4. Did you see a physician? Yes___ No___

5. Did you have X-rays or an MRI done? Yes___ No___

6. Did you have surgery? Date____________ Yes___ No___

7. Name of surgeon _________________________________

Address of surgeon _________________________________

8. If you had surgery, what was repaired?___________________________________

9. Were you given specific shoulder exercises following surgery or injury? Yes___ No___

10. How long did you miss practice?

Less than two days______Less than one week______ More than one week______

11. Have you had significant injuries to both shoulders? Yes___ No___

12. Have you had surgery on either shoulder more than once? Yes___ No___

13. If you had a shoulder injury in college, did this represent a re-injury from high school? Yes___ No___

14. If you had a shoulder injury in high school, do you think it was properly treated? Yes___ No___

If no, please explain on a separate sheet of paper

e. Fractures

1. Have you ever had a broken bone? Yes___ No___

2. If # 1 was yes, check involved area:

Nose________ Forearm (R or L)__________ Ribs (R or L)___________

Face_________ Hand (R or L)____________ Leg (R or L)___________

Neck_________ Pelvis_________________ Foot (R or L)___________

Do Not Write In This Space

Thigh (R or L)____________ Clavicle (R or L)________

Skull_________ Arm (R or L)______________ Ankle (R or L)__________

3. Was the fracture a result of organized participation in athletics? Yes___ No___

What sport?_______________________

4. Was your athletic performance altered following injury? Yes___ No___

5. Do you have any residual defect as a result of the fracture? Yes___ No___

f. Myositis Ossificans Traumatic

1. Have you ever had calcium to form in your thigh or arm following a bad bruise? Yes___ No___

Right ______ Left______

2. How much time did you miss from practice?___________________________

3. Was the calcium surgically removed? Yes___ No___

4. Do you still have trouble as the result of this injury? Yes___ No___

g. Muscle Strain

1. Have you ever had a bad "muscle pull" or strain? Yes___ No___

2. How much time did you miss from practice?
Less than 2 days______ Less than 1 week______ More than 1 week______

3. Did the injury re-occur? Yes___ No___

4. More than once? Yes___ No___

5. Did the muscle pull occur initially:

Before high school______ During high school______ During college______

h. Ankle Sprain

1. Have you ever sprained your ankle? (R)______ (L)______ Yes___ No___

2. If yes, when did you first sprain your ankle?

Before high school______ During high school______ During college_______

3. When first sprained, was your ankle taped? Yes___ No___

4. Did you see a physician? Yes___ No___

5. Was an X-Ray made? Yes___ No___

6. Did you have surgery? Yes___ No___

7. Did you have any immobilization? Yes___ No___

8. Have you had recurrent sprains of the ankle? Yes___ No___

9. At present, do you always tape or wrap your ankles? Yes___ No___

i. Foot or Toe Injuries:

1. Have you ever had a foot problem? (R)______(L)______ Yes___ No___

2. What type of problem?____

3. Did you see a physician? Yes___ No___

Was surgery required? Yes___ No___

4. Do you wear arch supports? Yes___ No___

What type:_______________________________________

5. Have you ever had a toe problem? Yes___ No___

Please describe:____

Do Not Write In This Space

H. CARDIAC
Do you have or have you ever had?

1. High blood pressure Yes___ No___
2. Any disease of the valves of the heart Yes___ No___
3. Any congenital heart disease present since birth Yes___ No___
4. Abnormal heart rate Yes___ No___
5. Palpitation or flutter of heart Yes___ No___
6. Heart Murmur Yes___ No___
7. Shortness of breath at rest Yes___ No___
8. Frequent cough Yes___ No___
9. Chest pressure with exertion Yes___ No___

Do Not Write In This Space

I. GENITOURINARY

1. Absence of one kidney Yes___ No___
2. Frequent urinary infection Yes___ No___
3. Kidney stone Yes___ No___
4. Blood in urine Yes___ No___
5. Sexually Transmitted Disease Yes___ No___

For Males Only:

A. Do you have absence of either testicle? Yes___ No___

B. Is one testicle much smaller than the other? Yes___ No___

For Females Only:

A. Have you ever had an injury to your breasts? Yes___ No___

B. Have you ever had surgery on your breasts? Yes___ No___

C. Have you ever had surgery on the ovaries or uterus (womb)? Yes___ No___

F. How long do your periods typically last? _________ days

G. How often do you have a period? Every________days

H. Are your periods painful or do you notice any clotting? Yes___ No___

I. Do you use any contraceptives (Birth control)? Yes___ No___

For Females Only (continued)

D. Do you have both of your ovaries? Yes___ No___

E. When was your last menstrual period?_______________

J. Do you have any recurrent gynecological infections? Yes___ No___

J. GASTROINTESTINAL

1. Frequent diarrhea Yes___ No___
2. Frequent nausea Yes___ No___
3. Frequent constipation Yes___ No___
4. Ulcer disease Yes___ No___
5. Pre-game stress (Nausea, vomiting) Yes___ No___
6. Liver infection (hepatitis) Yes___ No___
7. Jaundice Yes___ No___
8. Enlarged spleen Yes___ No___
9. Ruptured spleen Yes___ No___
10. Hernia Yes___ No___
11. Hemorrhoids Yes___ No___

K. SKIN

1. Frequent boils Yes___ No___
2. Severe acne Yes___ No___
3. Athletes' foot Yes___ No___
4. "Jock itch" Yes___ No___
5. Herpes Yes___ No___

L. MISCELLANEOUS DISEASE

1. Diabetes Yes___ No___
2. Frequent sinus infection Yes___ No___
3. Polio Yes___ No___
4. Measles Yes___ No___
5. Frequent strep throat Yes___ No___
6. Seasonal allergy Yes___ No___
9. Hepatitis Yes___ No___
10. Asthma Yes___ No___
11. Infectious mononucleosis Yes___ No___
12. Scarlet fever Yes___ No___
13. Tuberculosis Yes___ No___
14. Epilepsy Yes___ No___

7. Abnormal bruising Yes___ No___
8. Drug allergy Yes___ No___
List drug(s)____ ___________________________

15. Food allergy Yes___ No__
16. Abnormal bleeding tendency Yes___ No__
17. Sickle Cell Yes___ No__

Do Not Write In This Space

M. SURGERY

1. Appendectomy Yes___ No___
2. Tonsillectomy Yes___ No___
3. Hernia repair Yes___ No___

Other surgery Yes___ No__
If yes what type?_________________________

N. HEAT DISORDER

1. Have you ever had trouble with dehydration (excess loss of salt or water)? Yes___ No__
2. Have you ever had heat exhaustion? Yes___ No__
3. Have you ever had a heat stroke? Yes___ No__
4. Were you hospitalized? Yes___ No__
5. How long did you miss practice?

Less than 2 days______ Less than 1 week______ More than 1 week______

O. IMMUNIZATIONS

1. Have you been immunized against tetanus? month/year______________ Yes___ No__
2. Have you been immunized against the flu? month/year______________ Yes___ No__
3. Have you been immunized against Hepatitis B? month/year___________ Yes___ No__

P. DRUG, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS

Check the appropriate space according to your use of the following items:

	Never	Rarely	Occasionally	Frequently
1. Vitamin	_____	_____	_____	_____
2. Wheat Germ	_____	_____	_____	_____
3. Bone Meal	_____	_____	_____	_____
4. Stimulants (Benzedrine, amphetamine)	_____	_____	_____	_____
5. Cigarettes	_____	_____	_____	_____
6. Sleeping pills	_____	_____	_____	_____
7. Alcoholic Beverages	_____	_____	_____	_____
8. Anabolic agents (Growth stimulants or hormones)	_____	_____	_____	_____
9. Weight loss products	_____	_____	_____	_____
10. Nutritional supplements	_____	_____	_____	_____

If #10 is yes, what supplements?____

____

____

____

Q. TRAINING AND CONDITIONING
Check appropriate space which most clearly resembles your own training and conditioning program:

Do Not Write In This Space

1. LENGTH OF TRAINING

Some form of training year-round Yes___ No___ Training 6 months per year Yes___ No___

Training 4 months per year Yes___ No___ Training 9 months per year Yes___ No___

2. TRAINING TERMS

Weight lifting Yes___ No___ Specific exercises for knees Yes___ No___

Isometrics Yes___ No___ Specific exercises for back Yes___ No___

Nautilus Yes___ No___ Reaction training Yes___ No___

Flexibility exercises Yes___ No___ Endurance training Yes___ No___

Specific exercises for shoulders Yes___ No___

R. MENTAL FITNESS
1. Have you ever been treated for:

A) psychosis (hearing voices) Yes___ No___ C) anorexia or bulimia Yes___ No___

B) depression or attempted suicide Yes___ No___ D) drug/ alcohol addiction Yes___ No___

2. Are you currently on medications for any mental illness? Yes___ No___

If yes, please list medications: ____

3. Do you see any possibility of any need for counseling in the future? Yes___ No___

S. Miscellaneous
1. Do you currently have any condition which would affect your participation in athletics at Gardner-Webb University? If yes, please explain:_________________________ Yes___ No___

____

To the best of my knowledge the answers to the questions in this questionnaire are true.

Signature____ Date ____________

FEMALE STUDENT-ATHLETE'S ONLY

Dear Student- Athlete,

The intent of this form is to inform you of the medical recommendations should you become pregnant while participating in intercollegiate athletics.

Shelby Women's Clinic presently provides health care to Gardner-Webb University's female student-athletes. The following statement is the recommendation to all female student-athletes from Shelby Women's Clinic along with the athletic training staff at GWU. After the twelfth week of gestation (pregnancy), the uterus begins to enlarge above the pelvic brim, leaving the fetus vulnerable to trauma. Because of this risk, it is our recommendation that the student-athlete no longer participate in sports after this time until after delivery. If you have a signed statement from your personal physician stating otherwise, please present this to the athletic training department and/or team physician.

GWU will not be held liable for any problems occurring during pregnancy in regards to athletic participation. If you have any questions or problems, please feel free to contact the athletic training office or Shelby Women's Clinic (704-487-5258).

I have read and understand the above statement.

______________________________________ ________________________
Student Name / Parents Name Date

______________________________________ ________________________
Witness Date

IF YOU ARE UNDER 18 PARENTS MUST SIGN

______________________________________ ________________________
Parent Signature Date

Updated: 06-11-09

[Appendix A]

2009-2010 DRUG TESTING ACKNOWLEDGMENT AND CONSENT FORM

I have read the description of the Gardner-Webb University Intercollegiate Athletics Drug Education/ Screening Program. I understand the program, and freely consent to participate in it, undergo all required test and cooperate in its administration. In consideration of participation in the athletic program, I release Gardner-Webb University from any and all liability and waive any and all claims against the University arising out of the Drug Education/Screening Program, unless such claim is based on negligent or wrongful conduct by the University.

IF YOU ARE UNDER EIGHTEEN YEARS OF AGE, THIS WAIVER MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN.

____
Print Students Name | GWU ID Number | Social Security Number

____
Student's Signature | Date

____
Witness

____
I/We Agree

____
Parent/Guardian's Signature | Date

____
Witness

____
Parent/Guardian's Signature | Date

____
Witness

Please Print Your Home Address

Please Print your current age: ________

____
____
____

Gardner-Webb University
Athletic Training

Consent to Participate and Acknowledgment of Risk

Participation in ___________________(sport) requires an acceptance of the risk of injury. Although the risk of catastrophic injury may be remote, you should be aware that serious injury, including paralysis and even death can occur as a result of participation in intercollegiate athletics.

By your signature(s), below, you acknowledge that you accept the risk of participation in the sport of ______________________ , and give your consent to participation.

This is the____ day of _____________. 200___ .

Student-Athlete's Name:_________________________________ Date of Birth______________

Student-Athlete's Signature_____________________________Date:_______________,200___

Parent's Signature:____________________________________Date:_______________,200___

(Needed if student-athlete is under 18 years of age.)

Medical Consent

I hereby grant permission to the Gardner-Webb University team physicians and/or their consulting physicians to render any treatment or medical or surgical care that they deem necessary to the health and well-being of the undersigned student-athlete.

I also hereby authorize the athletic trainers of Gardner-Webb University, who are under the direction and guidance of the Gardner-Webb University team physicians, to render any preventative, first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to health or well-being of the undersigned student-athlete.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

Student-Athlete's Name: ___________________________________Date of Birth:____________

Student-Athlete's Signature______________________________________Date:_______________

Student-Athlete's Social Security #________-_________-_________

Parent's
Signature____Date:_______________

(Needed if student-athlete is under 18 years of age.)

Parent's Social Security #__________-__________-__________

Updated: 05-13-03

Gardner-Webb University
Athletic Training

FOOTBALL ONLY

Helmet Warning Statement

Do not strike an opponent with any part of this helmet or face mask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death.

Severe brain or neck injury may also occur accidentally while playing football. **NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.**

I have read and fully understand this statement above.

______________________________ ______________________

Signature

Date

____

Print Full Name

Gardner-Webb Baseline Head Injury Symptom Scale

Name: ______________________ Date: _________________ Sport:__________________

Below are 25 symptoms that are common with concussion. Please read each symptom carefully and report how you would experience each of them during a normal "AVERAGE DAY" (24 hour period). If you would not normally experience the symptom, circle "0" and move on to the next symptom. If you would normally experience the symptom during an "AVERAGE DAY" please rate how long "DURATION" that symptom would be present during the 24 hour period (using the "1-5" scale). If you do experience the symptom please use the next scale to rate how bad the symptom is for you on your "AVERAGE DAY" (SEVERITY) ("0" = not severe at all, "5" = as severe as possible).

	SYMPTOM DURATION never---------------------------------------always						SYMPTOM SEVERITY not severe at all--------------------as severe as possible					
Headache	0	1	2	3	4	5	0	1	2	3	4	5
Nausea (sick to stomach)	0	1	2	3	4	5	0	1	2	3	4	5
Difficulty balancing	0	1	2	3	4	5	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5	0	1	2	3	4	5
Neck Pain	0	1	2	3	4	5	0	1	2	3	4	5
Drowsiness	0	1	2	3	4	5	0	1	2	3	4	5
Sensitive to light	0	1	2	3	4	5	0	1	2	3	4	5
Sensitive to noise	0	1	2	3	4	5	0	1	2	3	4	5
Feel "in a fog"	0	1	2	3	4	5	0	1	2	3	4	5
Feel "slowed down"	0	1	2	3	4	5	0	1	2	3	4	5
Difficulty Remembering	0	1	2	3	4	5	0	1	2	3	4	5
Irritability	0	1	2	3	4	5	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5	0	1	2	3	4	5
Sadness	0	1	2	3	4	5	0	1	2	3	4	5
Sleep more than usual	0	1	2	3	4	5	0	1	2	3	4	5
Nervousness	0	1	2	3	4	5	0	1	2	3	4	5
Numbness	0	1	2	3	4	5	0	1	2	3	4	5
Difficulty concentrating	0	1	2	3	4	5	0	1	2	3	4	5
Depression	0	1	2	3	4	5	0	1	2	3	4	5
Tingling	0	1	2	3	4	5	0	1	2	3	4	5
Problems with vision	0	1	2	3	4	5	0	1	2	3	4	5
Unusually emotional	0	1	2	3	4	5	0	1	2	3	4	5
Vomiting (throwing up)	0	1	2	3	4	5	0	1	2	3	4	5
Blurred vision	0	1	2	3	4	5	0	1	2	3	4	5

Updated: 06-11-09

Gardner-Webb University Athletic Training

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your therapist will use and disclose your protected health information described in **Section 1**. Your protected health information may be used and disclosed by your therapist, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and support the operation of Gardner-Webb University Athletic Training.

Following are examples of the types of uses and disclosures of your protected health information that our office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office, once you have provided consent.

- We will use and disclose your protected health information to team physicians and other health care professionals to provide, coordinate or manage your health care and any related services.
- Your protected health information will be used, as needed, to coordinate payment for your health care services.
- We may disclose your protected health information to Athletic Training Students participating in clinical education with the Athletic Training Educational Program and work study student performing clerical duties in support of the Athletic Training department.
- We will use and disclose your protected health information in cooperation with Gardner-Webb University's drug education and testing program.
- We may disclose your protected health information in support of the NCAA and its regulations.

I have read and understand the uses of my protected health information. I also understand that I may access my protected health information upon written request to my staff athletic trainer.

Student Athlete Name ____

Student Athlete Signature ____ Date:________

Witness ____ Date:________

Gardner-Webb University Athletic Training

Student-Athlete Nutritional Supplement Disclosure Form

Student Athlete's Printed Name:________________________Sport:_______________

By completing this form I am disclosing any and all nutritional supplements that I am taking or intend to take. 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 also 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 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 am taking, I am 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. I acknowledge and understand that I can inquire about products by contacting the Center for Drug-Free Sport's Resource Exchange Center. I understand that this is a free service and all inquiries are kept confidential. (www.drugfreesport.com/rec with the password: ncaa1)

Supplement / Product Name	**Manufacturer**	**Where Purchased**
1.__________________	__________________	_________________
2. __________________	__________________	_________________
3. __________________	__________________	_________________
4. __________________	__________________	_________________
5. __________________	__________________	_________________

Please initial if not currently taking any nutritional supplements: __________

Comments:

Signature:

____

Student-Athlete Date

Gardner-Webb University Athletic Training
Student-Athlete Prescription Disclosure Form

Student-Athlete's Printed Name:_________________________________

By completing this form I am disclosing any and all prescription medications that I am currently taking. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I take a prescription medication not prescribed to me, regardless of the reason or purpose for taking the prescription medication.

The NCAA does not accept ignorance as an excuse following a positive drug test for a banned substance. Gardner-Webb University Athletic Training is requiring you to disclose any prescription medications that you have are currently taking in the table below. Depending on what medication you are prescribed, you might need to acquire additional information from your physician to justify the need for that particular medication. Upon receipt of this document, the Athletic Training staff may be in touch with you to acquire additional supporting documentation.

Date	Medication	Prescribing Physician	Diagnosis
1.			
2.			
3.			
4.			
5.			

Please initial if not currently taking any prescription medications:_____________

Prescribing Physician's Name, Address, and Phone Number:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

I understand the statements in this form, and have had all questions about the information in this form answered to my satisfaction.

____ ____________________
Student-Athlete's Signature Date

____ ____________________
Parent/Guardian Signature (if under 18 years old) Date