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**Entrance Physical Exam**

**PLEASE FILL OUT ALL FIELDS BELOW:**

|  |  |
| --- | --- |
| Full Name (First, Middle, Last): | Are you a Student Athlete: YES / NO |
| Date of Birth: | Gender: |
| Social Security #: | Year enrolled in: FR SO JR SR 5th |
| Home Address: | D&E Student ID#: |
| D&E Email Address | Cell Phone: |

|  |  |
| --- | --- |
| Emergency Contact: | Secondary Emergency Contact: |
| Relationship: | Relationship: |
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Home/Cell Phone (circle one): | Home/Cell Phone (circle one) |

# Medical History Questionnaire

**Please check the correct box for each question**

|  |  |  |
| --- | --- | --- |
| **Have you ever:** | **Y N** | **Date/Comments** |
| * Had a physician deny or restrict your participation |  |  |
| in sports for any reason? | □ □ |  |
| * Been hospitalized overnight? | □ □ |  |
| * Had any surgery (What & when?) | □ □ |  |
| **Have you ever had, or do you now have:** | **Y N** | **Date/Comments** |
| * A severe viral infection in the last month? * Discomfort, pain, tightness, or pressure in your chest | □ □ |  |
| DURING or AFTER exercise? | □ □ |  |
| * Dizziness DURING or AFTER exercise? | □ □ |  |
| * Passed out DURING or AFTER exercise? | □ □ |  |
| * High blood pressure? | □ □ |  |
| * Racing of the heart/irregular rhythm? | □ □ |  |
| * Heart murmur? | □ □ |  |
| * Heart infection? | □ □ |  |
| * Test for your heart (ECG – echocardiogram)? | □ □ |  |
| * Kawasaki disease? | □ □ |  |
| * Epilepsy/Convulsions/Seizures? | □ □ |  |
| * Diabetes? | □ □ |  |
| * Asthma, wheezing/cough with exercise? | □ □ |  |
| * Hernia, groin pain or bulge in groin? | □ □ |  |

|  |  |  |
| --- | --- | --- |
| * Born without or have absence of any organ? |  | |
| (e.g. appendix, kidney etc. Please list organ) | □ □ |  |
| * Severe headaches or migraines? * Hearing loss or perforated eardrum? | □ □ |  |
| (Which ear?)   * Impaired vision? | □ □ |  |
| (Wear glasses/contacts/both?) | □ □ |  |
| * Unequal pupils? (R or L larger?) | □ □ |  |
| * Heat exhaustion or heat intolerance? | □ □ |  |
| * Herpes or MRSA skin infection? | □ □ |  |
| * Are you satisfied with your eating patterns? * Does your weight affect the way you feel | □ □ |  |
| about yourself? | □ □ |  |
| * Do you worry about not exercising every day? * Use of weight loss meds, laxatives, | □ □ |  |
| self-induced vomiting? | □ □ |  |
| * Little interest or pleasure in doing things? | □ □ |  |
| * Feeling tired or having little energy? | □ □ |  |
| * Feeling bad about yourself or that you’re a failure? | □ □ |  |
| * Thoughts that you would be better off dead or hurting | | |
| yourself in some way? | □ □ |  |
| * I often feel sad or depressed? | □ □ |  |
| * I struggle with being confident? | □ □ |  |
| * Struggle dealing with frustration? | □ □ |  |
| * Have a hard time dealing with emotions? i.e. anger | □ □ |  |
| More days than not, do you feel frustrated | □ □ |  |
| Inability to control worrying about daily activities | □ □ |  |
| * Frequent anxiety, depression, insomnia? | □ □ |  |
| * Been prescribed medications for ADD/ADHD? * Do you have any other concerns that you | □ □ |  |
| would like to discuss with a doctor? | □ □ |  |

**Has anyone in your IMMEDIATE family ever had: Y N Comments**

* Sudden death (age less than 50) □ □
* Heart attack (age less than 50) □ □
* Hypertrophic cardiomyopathy, Marfan syndrome, Long or

Short QT syndrome, ventricular tachycardia? □ □

* A pacemaker or implantable defibrillator? □ □

**Have you ever had: Y N Date/Comments**

* Loss of consciousness? □ □
* Concussion? □ □ How many concussions? (List number) Dates (Month/Year)

|  |  |  |  |
| --- | --- | --- | --- |
|  | A hit or blow to the head that caused confusion, |  | |
|  | prolonged headache, or memory problems? | □ □ |  |
|  | Have you been hospitalized for a head injury?  Numbness, tingling, or weakness in your arms or | □ □ |  |
|  | legs after being hit or falling?  Inability to move your arms or | □ □ |  |
|  | legs after being hit or falling? | □ □ |  |
| **FEMALES ONLY** | | **Y N** | **Comments** |
| Do you have an irregular menstrual cycle? | | □ □ |  |

Longest time between periods in last year? Age at your first period?

**Have you ever sprained/strained, dislocated, fractured (including stress fractures), broken, or had repeated swelling or other injuries to any**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **bones or** | **joints**? | YES □ | NO □ |  | | | |
| Circle: | Head |  | Neck | Face | Chest | Shoulder | Upper arm |
|  | Elbow |  | Forearm | Wrist | Hand | Fingers | Back |
|  | Thigh |  | Knee | Shin/Calf | Ankle | Foot/Toes | Hip |

Please provide dates and explanations for all circled items**:**

**MEDICATION LIST: please list all prescribed medications in the table below:**

**\*Attention Student Athletes: All prescribed medications must be documented with a physician note.**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF MEDICATION: | REASON FOR USE: | DAILY DOSAGE: | TAKEN HOW OFTEN: |
| NAME OF MEDICATION: | REASON FOR USE: | DAILY DOSAGE: | TAKEN HOW OFTEN: |
| NAME OF MEDICATION: | REASON FOR USE: | DAILY DOSAGE: | TAKEN HOW OFTEN: |

Do you have/need an epi-pen? YES NO Do you have/need an inhaler? YES NO

**\*STUDENT ATHLETES ARE REQUIRED TO PROVIDE THE ATHLETIC TRAINING STAFF WITH AN EXTRA INHALER, EPI PEN, DIABETIC**

**MEDICATIONS, OR ANY OTHER LIFE SAVING MEDICATIONS.**

**You must include a photocopy your vaccination record or immunization book.**

\*West Virginia law does not allow for non-medical exemptions for school entry.\*

***Required Immunizations:***

**Measles, mumps, and rubella (MMR):** 2 doses  **Polio (injectable or oral):** 3 or more doses   
 **Tetanus, diphtheria, pertussis (DTap, TDaP):** 4 or more doses. Last dose must be within 10 years of admission.

**Meningococcal A,C,W,Y (Menactra or Menveo):** 2 doses   
 **Hepatitis B (HBV):** 2 doses  
 **Varicella:** 2 doses

***Recommended Immunizations:***

**Meningococcal B Vaccine:** 2 doses (Recommended for those living in the dorms.)

**Most Recent PPD Mantoux Skin Test:** 1- or 2-step

**Human Papillomavirus (HPV):** 2 or 3 doses, depending on age.

**Hepatitis A:** 2 doses (Recommended for international travelers.)

*\*\*Combination vaccines will be accepted if minimum dosage requirements are met. Community Care of WV’s on-campus clinic will be able to administer any missing vaccines to catch up to the college’s requirements. Failure to meet vaccine requirements may result in holds on your account.*

**I confirm that the above information is correct and complete to my knowledge. I give Davis and Elkins College permission to share the medical history, vaccination, and insurance information with Community Care of WV to maintain continuity of care.**

**Signature Date**

**Parent/Guardian (if under 18):**

**Medical Insurance Information**

Name Sport (if athlete)

First, Middle, Last

Permanent Address

**Are you insured: Yes or No Please circle whether insurance is:**

**HMO PPO Medicaid International Travel insurance**

**INSURANCE INFORMATION**

Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Athlete Policy holder DOB \_\_\_\_

Insurance Company Name \_

Insurance Co. address \_

Insurance Co. Phone (for precertification) \_

Policy #/Member ID Group # \_\_

Plan # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Effective Date/Issue Date

**\*Attach a front and back copy of your insurance card(s).**

A red sign with white text

Description automatically generated with medium confidence

**If you are not a Student Athlete you do not need to go any further!!**

**Davis & Elkins College Physical Examination**

**Name: Sport (if athlete):**

**Date of Exam: Blood Pressure: Pulse:**

**Height: Weight: Vision Screening (both): corrected? Y N**

**Medical Examination**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Normal** | **Abnormal Findings** | **Initials** |
| **Neurological** |  |  |  |
| **HEENT** |  |  |  |
| **Lymph Nodes** |  |  |  |
| **Cardiac** |  |  |  |
| **Pulse sounds** |  |  |  |
| **Respiratory** |  |  |  |
| **Abdomen** |  |  |  |
| **Skin** |  |  |  |

**Musculoskeletal Examination**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Normal** | **Abnormal Findings** | **Initials** |
| **Head/ Cervical** |  |  |  |
| **Thoracic / Lumbar** |  |  |  |
| **Shoulder / Arm** |  |  |  |
| **Elbow / Forearm** |  |  |  |
| **Wrist / Hand** |  |  |  |
| **Hip / Thigh** |  |  |  |
| **Knee** |  |  |  |
| **Lower Leg / Ankle** |  |  |  |
| **Foot** |  |  |  |

**Clearance (physician or designee only- please check appropriate box)  
** **Cleared without restrictions.** **Not cleared for participation in athletics (give reason):**

**Recommendations:**

**I certify that I have examined the above student.**

**SIGNATURE OF EXAMINER: (circle one) MD DO PA NP**

# PRINTED NAME OF EXAMINER: DATE: / /

**NCAA Medical Exception Documentation Reporting Form to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Treatment with Banned Stimulant Medication**

* Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
* Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at ([www.ncaa.org/drugtesting).](http://www.ncaa.org/drugtesting))

# To be completed by the Institution:

Institution Name: Davis & Elkins College Institutional Representative Submitting Form:

Name Kerrie Snyder, MS, LAT, ATC Title Head Athletic Trainer \_\_\_\_\_\_\_\_\_\_\_\_\_ Email snyderk@dewv.edu \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone 304-637-1397 \_\_

Student-Athlete Name \_ Student-Athlete Date of Birth \_ Prescribed banned medication

# To be completed by the Student-Athlete’s Physician:

Current Treating Physician (print name):

Specialty:

Office address

Physician signature: Date

Check off that documentation representing each of the items below is attached to this report

* o Diagnosis.
* o Medication(s) and dosage.
* o Blood pressure and pulse readings and comments.
* o Follow-up orders.
* o Date of clinical evaluation:

# o Attach written report summary of comprehensive clinical evaluation. Please note that this includes the original clinical notes of the diagnostic evaluation.

The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD **(required**). Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores **(optional)**.

The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above. **DISCLAIMER**: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.

**Davis & Elkins Travel Information**

**Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M / F**

**DOB \_\_\_/\_\_\_/\_\_\_\_\_ Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Information**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Injuries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Student Athlete Insured Y / N**

**Insurance Information Attached Y / N**