Davis&Elkins College™

Student Health Services
& Sports Medicine
Entrance / Pre-Participation Physical Exam

Full Name (First, Middle, Last):	If Student Athlete what sport?
Date of Birth:	Gender:
Social Security #:	Year enrolled: FR SO JR SR 5th
Home Address:	D&E Student ID#:
D&E Email Address	Cell Phone:

Emergency Contact: Relationship:	Secondary Emergency Contact: 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 medications (prescribed & over the counter) in the list below

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

***Attention: ADHD medications (Adderall, Ritalin, etc.) require further documentation per NCAA regulations. Your physician must complete the attached documentation of this medication.**

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:
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.**

(Freshman and Transfer Students Only): Please Fill out or attach a copy of your Immunizations

Required Immunizations:

MMR (Measles, Mumps, Rubella) – two doses required

Dose #1: ____/____/____ (given @ 12-15 months)

Dose #2: ____/____/____ (given at least 1 month after first dose)

Tetanus-Diptheria-Pertussis (DTaP, Tdap, DT, and TD)

Dose #1: ____/____/____ Dose #2: ____/____/____

Dose #3: ____/____/____ Dose #4: ____/____/____

Booster: ___/___/___ TD or Tdap (circle one)

Polio – three doses required

Dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____

Hepatitis B (HBV) Dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____

Meningococcal Vaccine ____/____/____ **Menomune or Menactra (circle one)** required if living in dorms

Recommended Immunizations:

Most Recent PPD Mantoux Skin Test: Date: ____/____/____ result: ________

Varicella (Nursing Students) ____/____/____

Human Papillomavirus (HPV) Vaccine – Gardasil

Dose#1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____

Hepatitis A Vaccine – recommended for international travelers

Dose #1: ____/____/____ Dose #2: ____/____/____ (can be combined with the HBV series)

I confirm that the above information is correct and complete to my knowledge.

Signature ____________________________________ **Date** ______________________

Parent/Guardian (if under 18):____

Davis & Elkins College Pre-participation Physical Examination

Name:____**Sport(s):**_______________________________________

Date of Exam:___________ **Blood Pressure:**_______________ **Pulse:**_________

Height:_________ **Weight:**____________

Medical Examination

	Normal	Abnormal Findings	Initials
Neurological			
HEENT			
Lymph Nodes			
Cardiac			
Pulse sounds			
Respiratory			
Abdomen			
Genitalia (males only)			
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 for participation in athletics

◯ Cleared for participation only after completing further rehabilitation / evaluation for: ______________________
____

◯ 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).

To be completed by the Institution:

Institution Name:__Davis & Elkins College______________________________________
Institutional Representative Submitting Form:
Name__Brian Reyes MHs, LAT, ATC-R____
Title___Head Athletic Trainer____
Email______Reyesb@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.

Insurance Information 2018-2019

Name ____ Sport (if athlete) _________________________

First, Middle, Last

Permanent Address ____

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 ____

IT IS YOUR RESPONSIBILITY TO UPDATE YOUR INSURANCE

INFORMATION IF ANY CHANGES OCCUR.