

SAINT LOUIS

SPORTS MEDICINE

Dear Tryout Participant:

On behalf of the Sports Medicine Department, we look forward to working with you during the tryout process. Please review this letter to understand what is required and complete the needed medical documentation. Please submit all of this information to the athletic training staff several days **prior** to your tryout. Physical examinations are required for all tryout participants for intercollegiate athletic teams at Saint Louis University. These physicals must be within 6 months of the tryout date from a licensed physician. Proof of a sickle cell test is also required per NCAA rule. The NCAA recommends that all student-athletes be aware of their sickle cell status. If the student-athlete cannot provide proof of a sickle cell trait; the NCAA recommends that student-athletes undergo testing to determine their status.

Please submit:

- **Physical Exam within 6 months**
- **Sickle Cell test results**
- **Acknowledgment of Insurance Requirements**
- **Provide a copy of your current insurance cards**
- **Student/Family Information Form**
- **Student-Athlete Health History Questionnaire**
- **Authorization for Release of Protected Health Information**

All costs related to pre-participation physicals are the full financial responsibility of the tryout student-athlete, including any additional charges generated from supplemental tests. **THERE ARE NO EXCEPTIONS TO THIS POLICY.**

Saint Louis University Student Health Center provides opportunities to receive a physical examination (or sickle cell test) on campus by our team physician. Please contact the Student Health Center at 314-977-2323, to schedule your appointment. The Student Health Center accepts most insurance plans.

All medical records on file in the athletic training room become confidential property of Saint Louis University Athletics Department and cannot be used for non-athletic purposes. Should you develop a significant injury or illness after your physical examination, but before the tryout practice, you must present to the Saint Louis University athletic training staff a letter from a qualified physician stating you are eligible to be cleared.

Please return all paperwork to the athletic trainer assigned to the sport you are trying out for:

Jonathan Burch

- M. Basketball
- M/W Cross Country

Ben Heimos

- M. Soccer
- Baseball

Tammy Pastor

- Volleyball
- Softball
- M/W Tennis

Lizzy Kienstra

- W. Soccer
- W. Basketball
- M/W Swim & Dive

Petra Knight

- M/W Track & Field
- Field Hockey
- Spirit Groups

Thanks for your time and effort. If you have any questions please feel free to contact me at Jburch7@slu.edu.

Jonathan Burch, ATC
Assistant Athletic Director / Sports Medicine





ACKNOWLEDGMENT OF INSURANCE REQUIREMENTS

I _____ as parent, guardian or legal representative, attest that
(name, please print)
_____ has insurance coverage under a current, in force insurance
(student-athlete name)
policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least \$90,000.

If there is a material change in coverage or expiration of coverage, I agree to notify Saint Louis University of this development and update the insurance information I have on file with Saint Louis University.

I understand and agree that Saint Louis University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses if I/we fail to have this primary insurance coverage.

Signature _____ Date _____
(parent/guardian)

THIS FORM MUST BE PRINTED, SIGNED AND RETURNED TO THE SAINT LOUIS DEPARTMENT OF ATHLETICS BY AUGUST 1ST.

YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD

Return to:

Saint Louis University
3330 Laclede Avenue
St. Louis, MO 63103

Phone: 314-977-3295
Fax: 314-977-3183



STUDENT/FAMILY INFORMATION FORM

IMPORTANT NOTICE: The student accident insurance plan is designed to offer maximum financial protection at minimum cost. In order to maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from other insurance. This provision greatly reduces costs by not duplicating coverage that you already have in effect. Please attach a copy of your insurance card to this form.

School Saint Louis University Address 3330 Laclede Avenue, St. Louis, MO 63103 Phone 314-977-3295

Student Last Name First Name Middle Initial Sport

Banner ID # Sex F M Birth date

School Address City/State/Zip

Home Address City/State/Zip

School Phone Home Phone

EMERGENCY CONTACT
Name Home Phone Cell Phone

ALL SAINT LOUIS UNIVERSITY STUDENTS MUST HAVE PRIMARY HEALTH INSURANCE

Father's Name

Mother's Name

Father's Address (same as above)

Mother's Address (same as above)

City/State/Zip

City/State/Zip

Father's Employer

Mother's Employer

Business Phone

Business Phone

Employer's Address

Employer's Address

City/State/Zip

City/State/Zip

Name and Address of Insurance Company

Name and Address of Insurance Company

City/State/Zip

City/State/Zip

Policy Number

Policy Number

Company Phone

Company Phone

Is the student covered? YES NO

Is the student covered? YES NO

Primary Physician Name

Primary Physician Name

Primary Physician Phone

Primary Physician Phone

Provider Number

Provider Number

Is pre-certification required for treatment? YES NO

Is pre-certification required for treatment? YES NO

Is pre-certification required for hospitalization? YES NO

Is pre-certification required for hospitalization? YES NO

Do you understand that you must furnish, with claims, a statement from your other insurance company indicating their allowable benefits or their reason for refusal to pay? Your claims may be held pending receipt of this information YES NO

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the student's health, to give information to the insurance company. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete claim information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

PARENT/GUARDIAN SIGNATURE IF UNDER 18 YEARS OF AGE

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.



HEALTH HISTORY QUESTIONNAIRE

Name _____ Sex F M Age _____ Birth date _____

Banner ID# _____ Sport _____

Local address _____ Local phone _____

Permanent address:

Street _____ City / State / Zip _____

Phone _____ Cell phone _____

Email address _____

Father's name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Father's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

Mother's Name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Mother's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

IN CASE OF EMERGENCY, CONTACT: Name _____

Relationship _____ Phone (h) _____ Phone (w/c) _____

Personal Physician _____ Physician phone _____

Have any of your relatives had:

	RELATIONSHIP	RELATIONSHIP
• Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Kidney Disease <input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Stomach Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO _____
• Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	• Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO _____



Student-Athlete Name _____

1. CARDIOVASCULAR RISK FACTORS

Have you ever had chest pain, dizziness, fainting and/or shortness of breath during or after exercise / practice? YES NO

• Please describe _____

Have you ever been told that you have a heart murmur? YES NO

• Please describe _____

Does anyone in your family have Marfan Syndrome? YES NO

• Please describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO

• Please describe _____

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? YES NO

• Please describe _____

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? YES NO

• Dates / please describe _____

Do you or anyone in your family have a history of high blood pressure? YES NO

• Please describe _____

Do you or anyone in your family have a history of high blood cholesterol? YES NO

• Please describe _____

2. ALLERGIES

Have you ever been diagnosed with any allergies or had any unfavorable reactions to foods, insects and/or drugs? YES NO

• Please describe _____

Are you presently taking / have you previously taken any allergy medications? YES NO

• Please describe _____

Have you ever had a rash or hives develop during and/or after exercise? YES NO

Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants? YES NO

Have you ever been prescribed an epi pen? YES NO

3. ASTHMA

Have you ever been diagnosed with asthma and/or exercised induced asthma? YES NO

• Please describe (include dates and details) _____

Are you presently taking / have you previously taken any asthma medications / use an inhaler? YES NO

• Date(s)? Type of medication _____

Have you ever been advised not to participate in athletic activities due to asthma or any related condition? YES NO

• Please describe _____



Student-Athlete Name _____

4. HEAD INJURIES / CONCUSSION

Have you ever suffered a head injury / concussion (no matter how minor)? YES NO

• Please describe (include dates and details): _____

Have you ever been evaluated by a doctor for a head injury / concussion? YES NO

• Please describe _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan

Have you ever been hospitalized, knocked out, and/or suffered memory loss to a head injury / concussion? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a head injury / concussion? YES NO

• Please describe _____

5. EYE

Do you have any problems with your vision? YES NO

• Please describe _____

When was your last eye exam? _____

• Findings? _____

Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? YES NO

• List date(s) / time (e.g. practices or games) missed _____

Do you routinely wear glasses and/or contact lenses? YES NO

6. EAR / NOSE / THROAT

Have you ever suffered an injury to your ear(s), nose and/or throat? YES NO

• Please explain and list date(s) / time (e.g. practices or games) missed _____

• Were any diagnostic tests performed? YES NO If yes, please list _____

Have you ever been hospitalized for an ear, nose, and/or throat injury? YES NO

Have you ever been advised not to participate in athletic activities due to an ear, nose, and/or throat injury? YES NO

• Please describe _____

7. DENTAL

When was your last dental exam? _____

• Findings? _____

Have you ever suffered an injury to your mouth, jaw, and/or teeth? YES NO

• Please explain and list date(s) / time (e.g. practices or games) missed _____



Student-Athlete Name _____

8. CERVICAL SPINE / NECK

Have you ever suffered an injury to your cervical spine and/or neck? YES NO

• Please explain and list date(s) / time (e.g. practices or games) missed _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever been hospitalized for a cervical spine / neck injury? YES NO

• Please describe (include location and date): _____

Have you ever had “numbness,” “tingling,” “burners,” “stingers,” or brachial plexus injuries? YES NO

• How many? Date(s)/time missed? _____

Have you ever been advised not to participate in athletic activities due to a cervical spine / neck injury? YES NO

• Please describe _____

9. SHOULDER / ARM / ELBOW / WRIST / HAND

Have you ever suffered an injury to your shoulder / arm / elbow / wrist / hand? YES NO

• Please explain and list date(s) / time (e.g. practices or games) missed _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery of any kind on your shoulder / arm / elbow / wrist / hand? YES NO

• Please describe (include dates and details): _____

Have you ever been advised not to participate in athletic activities due to a shoulder / arm / elbow / wrist / hand injury? YES NO

• Please describe _____

10. SPINE / LOW BACK / SACROILIAC JOINT

Have you ever suffered an injury to your spine / low back / sacroiliac joint? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery of any kind on your spine / low back / sacroiliac joint? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a spine, low back, or SI joint injury? YES NO

• Please describe _____

11. HIP / GROIN

Have you ever suffered an injury to your hip / groin (including hernias and/or sports hernias)? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery for a hip / groin injury? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury? YES NO

• Please describe _____



Student-Athlete Name _____

12. THIGH / HAMSTRING / QUADRICEPS

Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, or quadriceps injury? YES NO

• Please describe _____

13. KNEE / PATELLA

Have you ever suffered an injury to your knee and/or patella (kneecap)? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery for a knee and/or patella injury? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a knee / patella injury? YES NO

• Please describe _____

14. ANKLE / LOWER LEG / FOOT

Have you ever suffered an injury to your ankle / lower leg or foot? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (Check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery for an ankle / lower leg / foot injury? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to an ankle / lower leg / foot injury? YES NO

15. ABDOMEN / RIBS / THORAX / CHEST

Have you ever suffered an injury to your abdomen / rib / thorax / chest? YES NO

• Please describe (include dates and details) _____

• Were any diagnostic tests performed? (Check all that apply) X-Rays MRI CT-Scan Bone Scan

Have you ever had surgery for a rib / thorax / chest injury? YES NO

• Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a ribs, thorax, and/or chest injury? YES NO

• Please describe _____

16. MEDICAL TESTING

Have you ever been diagnosed with a Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? YES NO

• Please describe _____



Student-Athlete Name _____

17. DERMATOLOGICAL (SKIN)

Do you have any skin problems that we should be aware of (e.g. ringworm, herpes, skin infection, itching, rashes, acne, warts, eczema, fungus, etc.)? YES NO

• Please describe _____

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? YES NO

• Please describe _____

Have you ever been under the care of a dermatologist for any condition? YES NO

18. PRESCRIPTION MEDICATIONS

Please list ALL Prescription & Over-the-Counter Medications that you are CURRENTLY taking or have taken in the past 2 years, and for what purpose:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

19. SUPPLEMENTS / ERGOGENIC AIDS

Please list ALL supplements / ergogenic aids that you are CURRENTLY taking or have taken in the PAST 2 years, and for what purpose:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

YES NO I have taken supplements to help me gain or lose weight.

20. HEAT RELATED PROBLEMS

Have you ever suffered from a heat related injury? YES NO

(check all that apply):

YES NO Heat Cramps Date(s) _____

YES NO Heat Syncope (Fainting) Date(s) _____

YES NO Heat Exhaustion Date(s) _____

YES NO Heat Stroke Date(s) _____

Have you ever been hospitalized for a heat-related problem? YES NO

• Date(s)? Where? _____

Have you ever been advised not to participate in athletic activities due to a heat related injury? YES NO

• Please Describe _____



Student-Athlete Name _____

21. DIABETIC HISTORY

Have you ever been diagnosed with Diabetes? YES NO

• Date? _____

Are you presently taking or have you taken any Diabetic medications? YES NO

MEDICATION	FORM	DOSAGE	FREQUENCY

Please list any precautions that you take and/or additional information not mentioned above _____

22. SICKLE CELL ANEMIA

Have you ever been tested for Sickle Cell Anemia that you are aware of? YES NO DON'T KNOW

• Date? Result? _____

The NCAA recommends that all student athletes be aware of their sickle cell status. If you checked "don't know" above, please review the attached Sickle Cell Information Sheet, and arrange for sickle trait testing.

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? YES NO

• Please Describe _____

23. FEMALES ONLY

At what age did you have your first menstrual period? _____ When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of the next? _____

What was the longest time between periods in the past year? _____

YES NO Have you had menstrual periods within the past 12 months? If yes, how many? _____

YES NO Do you take birth control pills? Brand _____

YES NO Do you take any medications during your menstrual periods? If yes, what? _____

Student-Athlete Name _____

24. MENTAL HEALTH

SECTION 1

- I often have trouble sleeping. YES NO
- I wish I had more energy most days of the week. YES NO
- I think about things over and over. YES NO
- I feel anxious and nervous much of the time. YES NO
- I often feel sad or depressed. YES NO
- I struggle with being confident. YES NO
- I don't feel hopeful about the future. YES NO
- I have a hard time managing my emotions (frustration, anger, impatience). YES NO
- I have feelings of hurting myself or others. YES NO

SECTION 2

- Do you make yourself sick because you feel uncomfortably full? YES NO
- Do you worry that you have lost control over how much you eat? YES NO
- Have you recently lost more than 15 pounds in a 3-month period? YES NO
- Do you believe yourself to be fat when others say you are thin? YES NO
- Would you say food dominates your life? YES NO

SECTION 3

- Please answer using the following scale:**
0=None or a little of the time; **1=**Some of the time;
2=Most of the time; **3=**All of the time
- Over the past two weeks, how often have you:**
- Been feeling low in energy, slowed down? 0 1 2 3
 - Blamed yourself for things? 0 1 2 3
 - Had poor appetite? 0 1 2 3
 - Had difficulty falling asleep, staying awake? 0 1 2 3
 - Been feeling hopeless about the future? 0 1 2 3
 - Been feeling blue? 0 1 2 3
 - Had feelings of no interest in things? 0 1 2 3
 - Had feelings of worthlessness? 0 1 2 3
 - Thought about or wanted to commit suicide? 0 1 2 3
 - Had difficulty concentrating or making decisions? 0 1 2 3

SECTION 4

Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by indicating the response option using:
0=not at all; **1=**mildly but it didn't bother me much;
2=moderately – it wasn't pleasant at times;
3=severely – it bothered me a lot

- Numbness or tingling 0 1 2 3
- Feeling hot 0 1 2 3
- Wobbliness in legs 0 1 2 3
- Unable to relax 0 1 2 3
- Fear of worst happening 0 1 2 3
- Dizzy or lightheaded 0 1 2 3
- Heart pounding/racing 0 1 2 3
- Unsteady 0 1 2 3
- Terrified or afraid 0 1 2 3
- Nervous 0 1 2 3
- Feeling of choking 0 1 2 3
- Hands trembling 0 1 2 3
- Shaky/unsteady 0 1 2 3
- Fear of losing control 0 1 2 3
- Difficulty in breathing 0 1 2 3
- Fear of dying 0 1 2 3
- Scared 0 1 2 3
- Indigestion 0 1 2 3
- Faint/lightheaded 0 1 2 3
- Face flushed 0 1 2 3
- Hot/cold sweats 0 1 2 3

SECTION 5

- Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? YES NO
- Do you often feel tired, fatigued, or sleepy during daytime? YES NO
- Has anyone observed you stop breathing during your sleep? YES NO
- Do you have or are you being treated for high blood pressure? YES NO



Student-Athlete Name _____

24. MENTAL HEALTH (CONTINUED)

SECTION 6

Please rate the current (i.e. last 2 weeks) **severity** of your insomnia problem(s).

Difficulty falling asleep	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> very
Difficulty staying asleep	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> very
Problem waking up too early	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> very
How satisfied /disappointed are you with your current sleep pattern?			<input type="checkbox"/> very satisfied	<input type="checkbox"/> very dissatisfied	

To what extent do you consider your sleep problems to **interfere** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?

not at all interfering a little somewhat much very much interfering

How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life?

not at all noticeable a little somewhat much very much noticeable

How **worried**/distressed are you about your current sleep problem?

not at all a little somewhat much very much

SECTION 7

Select the response option that best describes how you have felt and conducted yourself over the past 6 months.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often
3. How often do you have problems remembering appointments or obligations?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often
6. How often do you feel overly active and compelled to do things like you were driven by a motor?	<input type="checkbox"/> never	<input type="checkbox"/> rarely	<input type="checkbox"/> sometimes	<input type="checkbox"/> often	<input type="checkbox"/> very often



Student-Athlete Name _____

25. HEALTH HISTORY

- YES NO Have you had an injury in the last year that has caused you to miss 3 or more consecutive days of practice/competition?
- YES NO Have you ever had any injury or illness other than those already noted?
- YES NO Do you have any ongoing or chronic illnesses?
- YES NO Do you have only one of any paired organs (eyes, kidneys, testicles, ovaries)?
- YES NO Have you ever been hospitalized overnight?
- YES NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
- YES NO Are you currently under a physician's care for any medical conditions?
- YES NO Have you ever been diagnosed or are you currently under physician care for ADHD or ADD?
- YES NO Are you currently taking any medications to treat ADHD or ADD?
- YES NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years? (Circle all that apply.)
- YES NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
- YES NO Have you ever had seizures, convulsions, and/or epilepsy?
- YES NO Do you have frequent, severe (migraine) headaches?
- YES NO Do you have ringing in your ears or trouble hearing?
- YES NO Have you ever had an abnormal chest x-ray and/or pneumonia?
- YES NO Do you require any special equipment (braces, dental, orthotics, hearing aids, etc.)? _____
- YES NO Have you ever had the chickenpox? If yes, when? _____
- YES NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
- YES NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
- YES NO I have tried cigarettes, chewing tobacco, snuff, or dip.
- YES NO In the past 30 days, I have used chewing tobacco, snuff, or dip.
- YES NO Do you have any questions regarding drugs, tobacco, or alcohol?
- YES NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
- YES NO Are you a vegetarian or on a gluten-free diet? If yes, what type? _____
- YES NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
- YES NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?
- YES NO I have taken performance enhancing substances (including anabolic steroids).
- YES NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Saint Louis University at this time? _____
- YES NO Would you like to see the team physician in private, for any reason? (You will not be asked to explain.)

Please explain all "yes" answers:



Student-Athlete Name _____

CONSENT FOR TREATMENT & RELEASE OF MEDICAL INFORMATION

I hereby authorize the members of the Saint Louis University sports medicine department, its physicians and designees to treat any injury or illness that affects my ability to participate in athletic activities at Saint Louis University. I consent to the release of my medical records and related information to Saint Louis University personnel for use in connection with diagnosis, treatment, and/or rehabilitation of such injuries or illness and for determinations of fitness to return to play. This authorization shall expire at the end of the current academic year and/or the end of competitive season, whichever should come later in time.

I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that Saint Louis University is not responsible for expenses related to any previously existing conditions.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name)

DATE

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

PRINT NAME

IF UNDER 18 YEARS OF AGE:

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name)

DATE

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

PRINT NAME

PARENTAL CONSENT

The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors. The following consent form must be signed by the parent or legal guardian, so that medical or emergency procedures can be carried out promptly, reducing unnecessary delay and discomfort. I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

NAME OF STUDENT

DATE

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name)

RELATIONSHIP TO STUDENT

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

PHONE (HOME)

PHONE (WORK/CELL)

ATHLETIC TRAINER SIGNATURE

DATE



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student-Athlete Name _____
First Middle Initial Last

Date of Birth _____ Age _____ Student ID# _____ Sport _____

1. I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
 I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

2. I hereby grant permission to the Sports Medicine Staff of Saint Louis University Department of Athletics to release health information pertaining to my fitness to participate in SLU Intercollegiate Athletic activities to Athletic Department administrators, coaches, and administrative staff responsible for assessing or approving my participation to the extent the information is needed for that purpose.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
 I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

3. I hereby grant permission to SLU Department of Athletics administrators and coaches to release to the news media the nature of any athletic-related injury or illness and my expected rehabilitation period, if any, for purposes of addressing my participation in intercollegiate athletic activities. This information may also be released to my parent or guardian.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
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4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Athletics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that SLU Department of Athletics may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize SLU to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
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EACH AUTHORIZATION EXPIRES ONE CALENDAR YEAR FROM SIGNATURE DATE.



SAINT LOUIS UNIVERSITY SICKLE CELL POSITION STATEMENT

PURPOSE

On June 25, 2009 the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports adopted the recommendation that member colleges and universities test student-athletes to confirm their Sickle Cell Trait status if that information is not already known.

Effective August 1, 2010, the NCAA is mandating under rule that all student-athletes must be tested. The NCAA mandatory medical examination rule states: "... a first time participant shall be required to undergo a medical examination or evaluation administered or supervised by a physician (e.g. family physician, team physician). The examination or evaluation shall include a sickle cell solubility test (SST), unless documented results of a prior test are provided to the institution. To specify the student-athlete is required a medical examination or evaluation that student-athletes who are beginning their initial season of eligibility and students who are trying out for a team must undergo prior to participation in voluntary summer conditioning or voluntary individual workouts pursuant to the safety exception, practice, competition or out of season conditioning activities shall include a Sickle Cell Solubility Test (SST), unless documented results of a prior test are provided to the institution". The examination or evaluation must have been administered within six months prior to participation.

In accordance with NCAA regulations, Saint Louis University Department of Athletics is mandating that all student-athletes must be tested for sickle cell trait or show proof of a prior test. Per NCAA rules Sickle Cell Testing waivers can no longer be accepted.

ABOUT SICKLE CELL DISEASE

Sickle cell disease is a term used for a group of conditions in which the pathology is due to the presence of hemoglobin S. Sickle cell anemia, or homozygous sickle cell disease, results from the inheritance of a sickle cell gene from both parents. Sickle cell disease is characterized by continuous red blood cell hemolysis usually resulting in anemia. This varies from patient to patient from inconsequential to severe; causing the variable presentation of painful vaso-occlusive crises; the potential for serious infections and acute complications involving any of the major organ systems, with progressive, irreversible organ damage. In sickle cell trait (the carrier state) there is always more normal (A) hemoglobin than S hemoglobin. Patients with sickle cell trait do not have symptoms from their sickle hemoglobin except under extraordinary conditions.

Eighty-five percent of people born with the disease now live to age 20, and most patients now survive at least until middle age. Patients are usually able to complete high school; many go on to college and graduate school; and all have the potential to lead productive lives. This greatly improved prognosis over the past generation is the result of comprehensive health maintenance, and the immediate treatment of acute complications, in combination with several therapeutic advances. Each patient with sickle cell disease needs a satisfactory "medical home" tailored to his or her individual needs.

- Sickle cell trait is an inherited disorder that affects red blood cells.
- Sickle cell trait is different from sickle cell disease, (commonly referred to as sickle cell anemia) and carriers of the trait cannot develop sickle cell disease.
- Usually, people with sickle cell trait do not have any medical problems and they can lead normal lives. However, sickle cell trait can change the shape of red blood cells during intense or extensive exertion, causing a blockage in blood vessels and rapid breakdown of muscles, including the heart, which may lead to a collapse or even death.
- More information regarding sickle cell trait and the NCAA's recommendation for sickle cell trait testing can be found at the official website for the NCAA.

REQUIREMENTS FOR STUDENT-ATHLETES

Starting in 2010, all SLU student-athletes will be tested for Sickle Cell unless prior testing and results can be provided. Those student-athletes not wishing to be tested should submit prior test results before they can participate in any intercollegiate athletics event, including strength and conditioning sessions, practices or competitions.

The screening test can be performed at Saint Louis University or with the student-athlete's physician. If the initial screening test is positive for sickle cell, then a follow-up test can be performed to determine if it is Sickle Cell Disease or Sickle Cell Trait. Educational sessions around the topic of sickle cell and the precautions that need to be undertaken due to the serious nature of the condition will be required for those individuals who are sickle cell trait positive.

Student-athletes must send documented results of sickle cell trait testing to:

Jonathan Burch, ATC
Director of Sports Medicine
Saint Louis University
Chaifetz Arena – Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
jburch7@slu.edu