



Warner University Sports Medicine ATHLETIC PARTICIPATION MEDICAL CLEARANCE PACKET

Dear Student-Athletes and Parents,

Welcome to Warner University Athletics. We hope that you are looking forward to competing for Warner University in the upcoming year. The purpose of this letter is to inform you of some very important information for the school year.

All student-athletes are required, by law, to possess primary health insurance coverage prior to participating in any athletic event (workouts, conditioning, practices, games, etc.) sponsored by Warner University. The insurance policy must cover injuries that occur during an athletic event.

Warner University has purchased an "excess" policy to assist student-athletes with medical bills that are a direct result of an injury suffered during a school sponsored athletic event. It is important that you understand that this insurance policy will only become active after the student athlete's primary insurance has fulfilled its responsibility. At that point, the excess policy will pick up the balance at 100% of usual and customary charges within the terms of the policy. The excess policy will not pay for co-pays or deductibles as they are the responsibility of the primary policy holder (parent/guardian/student-athlete).

All injuries that occur from a direct result of an intercollegiate athletic event must be reported to the Athletic Training staff immediately. This allows the staff to perform an evaluation and referral, if necessary, to the appropriate physician. The Athletic Training staff is responsible to report all injuries with the school's insurance company. Costs pertaining to an injury that are not reported in a timely manner may be the responsibility of the student-athlete and/or the student-athlete's parent/guardian. Any financial obligation from medical treatments received *without* an Athletic Trainer's authorization will be the responsibility of the student-athlete.

All student-athletes must have the following forms filled out completely and turned into the Athletic Training Department before he/she will be cleared to participate in any Warner University athletic event:

- Athletic Participation Medical Clearance Packet (this form)
- Personal Information/Emergency Contact form
- Health Insurance Information/Authorization form
- **Copy (front and back) of primary health insurance card**
- HIPAA Release form
- Pre-Participation Physical Evaluation – History form (completed by student-athlete and parent if student-athlete is a minor)
- Pre-Participation Physical Evaluation – Physical form (completed by MD or DO office ONLY)
- Warner University Athletics Drug Testing form
- NAIA Drug Testing form
- Assumption of Risk form
- Athletic Pre-Participation Eligibility Statement
- Completion Checklist

Sincerely,

Nathan Arambula, MS, ATC, EMT, CES
Warner University
Head Athletic Trainer

Please sign and date below that you read and understand this letter.

Student-Athlete _____ **Date** ____/____/____

Parent/Guardian _____ **Date** ____/____/____
(If student-athlete is under 18)



Warner University Sports Medicine
PERSONAL INFORMATION/EMERGENCY CONTACT FORM

PERSONAL INFORMATION

Athlete's Name _____
First Last Middle Initial

Social Security # _____ - _____ - _____

Year (check) _____ Freshman _____ Sophomore _____ Junior _____ Senior

Date of Birth _____ / _____ / _____ Sex (check) _____ Male _____ Female

Sport(s) _____

Permanent Address _____
Street

City State Zip

Local Address (Check one)

Same as permanent address

Campus housing

Dorm Name and Room # _____

Different from permanent address

Street

City State Zip

Cell phone # _____

Preferred email (if different from school email) _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Cell phone # _____

Address _____
Street

City State Zip



Warner University Sports Medicine HEALTH INSURANCE INFORMATION/AUTHORIZATION

Athlete's Name _____ SS# _____

Sex (circle) Male Female Date of Birth ___/___/___ Sport _____

Home Address _____
 Street City State/Zip

Insurance Policy Holder's Name _____
 First Last Middle Initial

Insurance Policy Holder's Date of Birth ___/___/___ SS# _____

Insurance Policy Holder's Phone # _____

Insurance Policy Holder's Address _____
 Street

City _____ State _____ Zip _____

Insurance Company _____

Insurance Company Claims Address _____
 Street

City _____ State _____ Zip _____

Insurance Company Member Services Phone# _____

Policy # _____ Group # _____

Plan _____ Type (circle) HMO PPO Other _____

Primary Care Physician _____ Phone # _____
 Name

»»»»» Copy front AND back of insurance card and attach to this form «««««

- I/We hereby authorize Warner University, hospitals, and physicians connected with or provided services to furnish information to insurance carriers concerning any illness, injury and treatment and I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I/We agree to supply any and all information requested by my primary insurance, Warner University and their excess insurance company in a timely manner.
- I/We hereby authorize Warner University and their excess insurance company to secure and inspect copies of case history records, lab reports, diagnoses, X-rays and any other data pertaining to the injury/illness the aforementioned athlete is receiving care for or previous confinements or disabilities relevant to the care of the injury/illness.
- I/We agree to notify Warner University Athletic Training staff immediately upon any change in the above health insurance information. If I/We fail to do so, I/We fully understand that I/We may be responsible for any and all changes incurred.
- I/We hereby authorize Warner University's Athletic Trainers and/or coaches, to hospitalize and secure treatment for the aforementioned athlete for any athletic injury/illness and/or medical emergencies.
- A photocopy of this authorization shall be deemed as effective and valid as the original.

Policy Holder's Signature _____ **Date** ___/___/___

Student-Athlete's Signature _____ **Date** ___/___/___



Warner University Sports Medicine HIPAA RELEASE FORM

HIPAA stands for Health Insurance Portability and Accountability Act and was created to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, certified athletic trainers (ATC's) will not be able to speak to anyone in regard to an injury or condition unless a release is signed.

By signing below I, _____ **(print student-athlete's name)**, am allowing FULL disclosure of my personal health information in regard to any athletic injury I may sustain while participating in intercollegiate athletics at Warner University.

Any athletic injury may be disclosed to the following individuals/companies:

- Warner University Certified Athletic Trainers
- Warner University Team Physicians
- Warner University Coaches
- Warner University Faculty when applicable
- Warner University Administration/Student Services
- Warner University's insurance company
- Student-athlete's personal primary insurance company
- Student-athletes personal physician(s) and their office staff
- Student-athlete's parent/guardian

A photo-static copy of this consent form shall be deemed as effective and valid as the original. This release form shall remain effective unless revoked by me in writing.

Student-Athlete's Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____
(If student-athlete is under 18)

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

****Please wait until July to complete your physical**
**** Physicals must be done by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA) or a Nurse Practitioner (NP/APRN)**

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / / (/)	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. ^bConsider GU exam if in private setting. Having third party present is recommended. ^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
-
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of physician _____, MD or DO



Warner University Sports Medicine ATHLETICS DRUG TESTING POLICY

Warner University is committed to the best-interests of its student-athletes. A part of this commitment is a desire to ensure that athletes compete fairly and avoid making decisions that could lead to unnecessary physical, emotional, or spiritual harm to themselves. This is the reason for the drug testing policy.

All student-athletes participating as an active member in a Warner University athletic program are subject to random drug testing. The test will be administered by Warner University's Sports Medicine staff and must be completed within 24 hours of notification. Failure to report for testing will be considered a positive result. A result that is "non-negative" will be shipped to a lab for verification. Once the test is completed and the lab results returned, they will be forwarded to Warner University Administration. The student-athlete will then be notified of the results. A positive result is defined as a finding of a drug that is not prescribed by a physician*. Positive results will be reported to the following personnel: the student-athlete, the Head Coach, the Athletic Director and the Dean of Students.

By accepting admission to Warner University, a student-athlete agrees to the terms of this drug testing policy and consents to any tests conducted pursuant to this policy. If a student-athlete withdraws that consent by refusing to take a random drug test, such refusal could result in an immediate termination of athletic participation.

THE UNDEERSIGNED STUDENT-ATHLETE ACKNOWLEDGES AS FOLLOWS:

I have received a copy and understand this drug testing policy.

As a condition of participation in an athletic program, I give my consent to any random drug testing done in pursuant to this policy.

Print Name _____

Student-Athlete Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____
(If student-athlete is 18 or under)

**Students taking prescribed Medical Marijuana, while welcome to attend Warner University, may not participate in Intercollegiate Athletics. More information on Medical Marijuana can be found in the Student Handbook.*



NAIA Official Student Consent Form

A. Requirement to Sign Drug-Testing Consent Form

1. Name of Institution: _____
2. Name of student-athlete: _____ Sport(s): _____
3. You must sign this form to participate in any NAIA National Championship competition. This includes but is not limited to Opening Rounds and Final Sites. If you have any questions, you should discuss them with your director of athletics.

B. Consent to Testing

1. You agree to allow the NAIA to test you in relation to any participation by you in any NAIA national championship or invitational competition. Examples of drugs in each class can be found at www.naia.org/wellness. Note: There is no complete list of banned substances. Check the NAIA Drug Free Sport AXIS for questions about supplements, medications and banned drugs.

C. Consequences for a Positive Drug Test

1. By signing this form, you affirm that you are aware of the NAIA drug-testing program, which provides:
2. A student-athlete who tests positive for use of a banned substance as defined by the NAIA banned-drug classes list, shall be sanctioned as outlined below:
 - a. A student-athlete's first offense for testing positive for the use of any banned drug shall be immediately suspended from further competition in any sport; and
 - b. The period of suspension will be for a minimum of 365 days from the date of the specimen collection that lead to the positive test result; and
 - c. The student-athlete shall be charged one season of competition in all sports because of the positive test result.
 - d. A student-athlete testing positive a second time for the use of any banned drug shall lose all remaining NAIA regular season and post-season eligibility in all sports.
 - e. Individual placings and honors earned at the national championship at which the positive test occurred shall be vacated.
 - f. Team championships will be determined by the National Drug Testing and Education Committee.

D. Signatures

1. By signing below, I consent:
 - a. To be tested by the NAIA in accordance with NAIA drug-testing policy, which provides among other things that I will be notified of selection to be tested;
 - b. I must appear for NAIA testing or be sanctioned for a positive drug test; and my urine sample collection will be observed by a person of my same gender;
 - c. To accept the consequences of a positive drug test;
 - d. To allow my drug-test sample to be used by the NAIA drug-testing laboratories for research purposes to improve drug-testing detection; and
 - e. To allow disclosure of my drug-testing results only for purposes related to eligibility for participation in NAIA competition.

I understand that if I sign this statement falsely or erroneously, I violate NAIA legislation on ethical conduct and will jeopardize my eligibility.

Date	Signature of student-athlete

Date	Signature of parent (if student-athlete is a minor)

Name (please print)	Date of birth	Age

Home address (street, city, state and zip code) _____

Sport(s) _____



Warner University Sports Medicine ATHLETIC ASSUMPTION OF RISK

Athletic Participation Release and Waiver of Liability and Hold Harmless Agreement

Please Read Carefully

I wish to participate in intercollegiate sports through Warner University's athletics' program. I understand that Warner University is not obligated to permit me to participate in intercollegiate sports. I understand that my participation in intercollegiate sports at Warner University will include participation in intercollegiate contests/games, practices, in-season and off-season training and rehabilitation (including weight lifting, running, therapy sessions with athletic trainers, and other forms of physical training), receiving suggestions on nutrition and travel to practices, games or competitions, training sessions and meetings. All of the above activities collectively shall be referred to herein as "Intercollegiate Sports."

I am aware that participating in Intercollegiate Sports, including, but not limited to _____ **(sport)** is a dangerous activity involving MANY RISKS OF INJURY, SICKNESS AND ILLNESS that are both inherent to the sport and not inherent to the Intercollegiate Sports activities. I understand that among the risk are catastrophic injury, illness, sickness, infection and death. Further, I voluntarily and knowingly accept the dangers and risks of participating in Intercollegiate Sports, including, but not limited to, death, head injuries, serious neck and spinal injuries, orthopedic injuries, and illness or sickness as a result of contracting a virus, bacteria or other communicable disease, which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury, impairment, illness, sickness or infection to other aspects of my body, general health and well-being. Furthermore, I understand and accept the risk of injury, catastrophic injury, illness, sickness, infection and/or death. Additionally, I also understand and accept the risks associated with traveling and other related activities connected with or related to my participation in Intercollegiate Sports. Finally, in addition to accepting the risks inherent in participating in my chosen sport, I also agree to release and hold harmless Warner University from its own past and future negligence that may cause me damage in the future as more specifically set forth below.

In consideration for Warner University permitting me to participate in Intercollegiate Sports and to engage in all related activities and travel related to Intercollegiate Sports, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, I, on behalf of myself and my successors, assigns, dependents, personal representatives, and survivors, hereby agree **(a) that I hereby voluntarily and knowingly assume all risks associated with participation in Intercollegiate Sports; and (b) that I, for myself and my heirs and survivors, hereby release, waive and discharge Warner University, and its agents, servants, volunteers, employees, contractors, coaches, faculty members, staff members, trainers, security personnel, trustees, donors and sponsors from and of any and all liability, all claims, causes of action, lawsuits, remedies, damages, and/or demands**

of any kind and nature whatsoever, known or unknown, matured or unmatured, that have been asserted, or could be asserted in the future, including, but not limited to, specifically any claims arising from the past and/or future negligence or negligent acts or omissions of Warner University and its agents, servants, volunteers, employees, contractors, coaches, faculty members, staff members, trainers, trustees, donors and sponsors, which have arisen or may arise in the future in connection with or related in any way to my participation in any Intercollegiate Sports, including, without limitation any injury, sickness, illness, infection or death that may arise or be related to my participation in Intercollegiate Sports. I also covenant that I and my heirs, survivors or personal representatives shall not sue or bring any cause of action against Warner University, and its agents, servants, volunteers, employees, contractors, coaches, faculty members, staff members, trainers, security personnel, trustees, donors and sponsors related to any injury, damage, sickness, illness, infection or death that occurs as a result of or related to participating in Intercollegiate Sports, including any claim for the future acts of negligence or negligent omission by Warner University, and its agents, servants, volunteers, employees, contractors, coaches, faculty members, staff members, trainers, security personnel, trustees, donors and sponsors.

Further, I and my heirs, survivors and personal representatives agree to exonerate, save harmless, and release Warner University and their agents, servants, volunteers, employees, contractors, coaches, faculty members, staff members, trainers, trustees, donors and sponsors from any medical expenses and other categories of damages (including pain and suffering and lost wages) not covered by my medical insurance or Warner University's medical insurance coverage.

The terms hereof shall serve as a complete release and waiver of liability for myself, my heirs, my estate, personal representative, executor, administrator, assignees, survivors under any wrongful death act, and all members of my family.

The terms of this agreement shall extend to all of my activities in participating in Intercollegiate Sports from the date of my execution of this release and hold harmless agreement forward in time through the time that I am no longer participating in Intercollegiate Sports as a student athlete associated with Warner University. My agreement to release past and future negligent conduct of Warner University shall not be revocable, and if I ever seek to revoke such prospective release and waiver of claims, I will no longer be eligible to participate in Intercollegiate Sports associated with Warner University.

I hereby attest that I have read, fully understand, and agree to the terms of the Warner University's Athletic Participation Release and Waiver of Liability and Hold Harmless Agreement.

Student-Athlete Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____
(If student-athlete is under 18)



Warner University Sports Medicine
ATHLETIC PRE-PARTICIPATION ELIGIBILITY STATEMENT

Athlete's Name _____ **DOB** ____/____/____

STUDENT AGREEMENT (regarding conditions for participation):

I state that I have completed all parts of the Pre-Participation Physical Evaluation – History form which requires me to list all previous injuries or additional conditions known to me which may affect my performance or participation in conditioning, training, or treatment and I certify that it is correct and complete.

I understand that participation in interscholastic athletics is a privilege and not a right. As a student-athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of the University and laws of my community, state, and country.
- I will show respect to those who are responsible for enforcing the rules at the University and the laws of my community, state, and country.
- I agree to notify University authorities of any injury resulting from my athletic participation and activities while a student-athlete.

By signing below, I affirm that I have read, completed, signed where required, and understand all of the Athletic Participation Medical Clearance forms.

Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____
(If student-athlete is 18 or under)



Warner University Sports Medicine COMPLETION CHECKLIST

ATHLETIC PARTICIPATION MEDICAL CLEARANCE PACKET COMPLETION CHECKLIST:

- Read and signed Athletic Participation Medical Clearance Letter to parents and student-athletes
- Completed the Personal Information/Emergency Contact form
- Completed Health Insurance Information/Authorization form
- Included a copy **(front and back)** of primary health insurance card
 - OR I have sent a picture and/or scanned a copy of my primary health insurance card to the Athletic Training department via email to athletictrainer@warner.edu
 - OR I do not have primary health insurance
- Read and signed the HIPAA Release form
- Completed the Pre-Participation Physical Evaluation – History form
- Included the Pre-Participation Physical Evaluation – Physical form (completed by MD or DO office only)
- Read and signed the Warner University Drug testing form
- Read and signed the NAIA Drug testing form
- Read and signed the Assumption of Risk form
- Read and signed the Pre-Participation eligibility Statement
- Read and signed the Completion Checklist (this form)

I, _____ **(Print Name)**, have completed the above paperwork, I have read, understood and signed all forms and have my parent/legal guardian's signature if under the age of 18. I confirm that all information is accurate and up-to-date. If any information (contact information, address, phone number, insurance coverage, etc.) changes during the school year, I am responsible for turning the information into the Athletic Training Department personally. I also understand that any misrepresentation of the above information can result in disqualification or revocation of scholarship funds and releases Warner University from any financial obligations even if I am injured during a school sponsored athletic event.

Student-Athlete Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____
(If student-athlete is under 18)

ELECTROCARDIOGRAM SCREEN (ECG) CONSENT FORM AND RELEASE OF LIABILITY

An ECG screen (also referred to as an EKG) can help identify young athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An ECG screening may assist in diagnosing several different heart conditions that may contribute to sudden cardiac death.

By signing below, I am electing an ECG screen provided by Warner University. By electing to receive an ECG screen, I acknowledge the limitations of an ECG screen and that sudden cardiac death or other cardiac events may still occur, despite this screening. I further acknowledge that students with an abnormal ECG screen will be required to undergo further testing (e.g. an echo or ultrasound) and/or a medical consultation prior to being released to resume participation in Warner University athletics. By my signature below, I hereby release and forever discharge, and waive, any and all claims against Warner University for, its employees, sponsors, trustees, consultants, volunteers and contractors that relate to my election to participate in this ECG screening project. I authorize medical personnel to review the ECG results, and interpret and use the same for diagnostic and aggregated statistical purposes in accordance with the Family Education Rights and Privacy Act and Health Insurance Portability and Accountability Act of 1996.

I DO HEREBY CONSENT to participation in the ECG screening

Name Printed

Date

Email address

Signature

Phone number

PARTICIPANT INFORMATION

Ethnicity: Afro American/ Black _____ Asian _____ Caucasian/ White _____ Hispanic _____ Other _____
(Mark all that apply)

Age: _____ Gender: Male _____ Female _____ Birthdate ____/____/____ Height: _____ Weight: _____

Previous Cardiac Issues (if any): _____

Family Cardiac History (if any): _____

Do you currently take any of the following medications? (circle any that apply):
ADD/ADHD Beta Blockers Asthma medication/inhaler Cardiac Medications





Sickle Cell Trait Testing/Waiver Form

Facts About Sickle Cell Trait:

- **Sickle cell trait** is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- **Sickle cell trait** is a common medical condition most predominant in those of African, Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, but people of all races and backgrounds may test positive.
- **Sickle cell trait** is generally benign, and almost all of the 3 million Americans with sickle cell trait live healthy normal lives. However, during maximal exercise the oxygen levels in muscles can decrease sufficiently to cause some of the red cells to change from the normal disk shape to a crescent or sickle shape. These sickled red blood cells can block blood vessels in muscles, kidneys, and other organs resulting in severe damage to the involved tissues or elsewhere in the body and/or death.
- **Identification of sickle cell trait** is not, by itself, a limiting or disqualifying finding with regards to athletic participation.
- For more information on Sickle Cell Trait please visit https://ncaaorg.s3.amazonaws.com/ssi/other/SSI_NCAASickleCellTraitforSA.pdf

Sickle Cell Trait Testing Protocol:

- Warner University recommends that all student-athletes have acknowledged their sickle cell trait status. Sickle cell trait testing in the form of a blood test can be done by the student-athletes primary care physician or by Warner University.
- Warner University recommends that all student-athletes who are unable to confirm their sickle cell trait status undergo sickle cell trait testing prior to participation in any intercollegiate athlete activity.
- **Warner University will cover the cost of the Sickle Cell Screening test. Any further testing required will be at the expense of the student-athlete.**

Testing Results or Testing Waiver

- After reviewing the above information, I have elected to: (Please check one of the boxes below and sign and date the appropriate lines).

- I want to be tested for sickle cell trait

- I will provide documented proof of my Sickle Cell Trait status from previous testing to Warner University’s athletic trainers

- I, _____, understand and acknowledge that the Warner University Sports Medicine department recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally I have read and fully understand the aforementioned facts about sickle cell trait testing.

By checking this box and signing this waiver it shows that I do not wish to undergo sickle cell trait testing. I voluntarily agree to release, discharge, indemnify, and hold harmless Warner University, its board, employees and any one affiliated with its Sports Medicine Department from any and all cost liabilities expenses, claim demands, or any loss or personal injury that might result from my noncompliance with the recommendation of Warner University.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student-Athlete Signature

Date

Sport(s)

Parent/guardian signature (if under 18)

Date