



UFV PRE-PARTICIPATION MEDICAL INFORMATION 2011-2012

PLEASE PRINT LEGIBLY IN INK; Take your time and answer thoroughly.

This must be completed prior to ANY participation in a UFV Cascades Athletics practice, game, or event. Submit fully completed form to Sarah Eckert UFV Head Athletic Therapist.

Name: _____ Student ID: _____

Sport: _____ Year of Participation: _____

Date of Birth: ____/____/____ Age: _____ Gender: M / F
Month Day Year

Health Care Card #: _____ Province: _____

All students are part of the Student Union Health and Dental plan that covers medications, braces, orthotics, athletic / physiotherapy, chiropractic and much more. It is strongly recommended that Cascade athletes do not "opt out" of this insurance plan as it can supplement any other medical coverage you may have.

If you have "opted out" or if you are an international student please complete the following:

Insurance Company Name: _____

Group Plan #: _____ Policy #: _____

Address During the School Year: (if in residence, or living away from home)

Building: _____ Room #: _____

City: _____ Postal Code: _____

Cell Phone #: () _____ Email Address: _____

Permanent Address:

Address: _____ City _____ Postal Code: _____

Home Phone #: () _____ Email Address: _____

Family Physician's Name: _____ Phone #: () _____ City: _____

In case of injury or illness, please notify: (parent / spouse / guardian):

Name: _____ Relationship To You: _____

Address: _____ City: _____ Postal Code: _____

Phone: Home: () _____ Work: () _____ Cell: () _____

Name: _____ Relationship To You: _____

Address: _____ City: _____ Postal Code: _____

Phone: Home: () _____ Work: () _____ Cell: () _____

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MEDICAL HISTORY

- Y N Do you have any allergies? (ie: medications, food, insects)
If yes, elaborate: _____
- Y N Do any major illnesses/diseases run in your family?
If yes, elaborate: _____
- Y N Other than accidents and injury, has any member died suddenly <50 years of age (ie: heart attack)
If yes, elaborate: _____
- Y N Do you take any prescription or non-prescription medication? (ie: herbal remedies, Advil/ibuprofen, creatine, anabolic steroids, laxatives, water pills, birth control, protein powder)
If yes, elaborate: _____
- Y N Are you currently under a doctor's care for any medical conditions?
If yes, elaborate: _____
- Y N Have you ever been advised, for medical or injury reasons, not to participate in certain sports?
If yes, elaborate: _____
- Y N Have you ever been hospitalized overnight or longer?
When? How? _____

Please read carefully and answer fully. Respond to the following with 'P' (previous), 'C' (current), or 'N' (no).

Do you have or have you ever had: (please elaborate in the space provided below)

HEAD	P/C/N
1 Frequent Headaches	
2 Concussion	
3 Dizziness with exertion	
4 Migraines	
5 Balance problems	
6 Coordination problems	
7 Ringing in the ears	
8 Loss of smell or taste	
9 Recurring earaches	
10 Loss of memory	
11 Fainting with exercise	
12 Recurring blackouts	
13 Double/blurred vision	
14 Wear glasses	
15 Wear contact lenses	

HEAD	P/C/N
16 Use dental appliances	
17 Sinus problems	
18 Frequent nosebleeds	
19 Meningitis	
20 Convulsions/seizures	
CARDIOVASCULAR	
21 Heart murmur	
22 High blood pressure	
23 Low blood pressure	
24 Sickle cell disease	
25 Chest pain with exercise	
26 Poor circulation	
27 Heart disease	
28 Heart palpitations	
29 Anemia	

	P/C/N
30 Phlebitis	
RESPIRATORY	
31 Cough with exercise	
32 Shortness of breath	
33 Asthmas/wheezing	
34 Collapsed lung	
35 Pneumonia	
36 Tuberculosis	
37 Smoking	
38 bronchitis	
39 Emphysema	
HEAT DISORDERS	
40 Dehydration problems	
41 Heat stroke/exhaustion	
42 Excessive thirst	
43 Frequent muscle cramps	

Please read carefully and answer fully. Respond to the following with 'P' (previous), 'C' (current), or 'N' (no). Do you have or have you ever had: (please elaborate in the space provided below)

DIGESTIVE/ORGANS	P/C/N
44 Frequent abdominal pain	
45 Diarrhea w/ travel/sports	
46 Constipation w/ travel	
47 Indigestion/heart burn	
48 Abnormal bowel mov'ts	
49 Hernia	
50 Blood in urine	
51 Blood in stool	
52 Ulcers	
53 Liver/gall bladder issues	
54 Hepatitis	
55 Kidney/bladder issues	
56 Painful urination	
57 Enlarged/ruptured spleen	
58 Single/missing organs	
SKIN	
59 Skin allergies	
60 Herpes	
61 Rashes	
62 Athlete's foot and/or warts	

OTHER CONDITIONS	P/C/N
63 Rheumatic fever	
64 Chicken pox	
65 Measles/pumps	
66 Infectious mononucleosis	
67 Diabetes	
68 Arthritis	
69 Cancer	
70 Thyroid problem	
71 Depression	
72 Anxiety/panic attacks	
73 Insomnia	
74 Unintended weight loss	
75 Severe menstrual cramps	
76 Irregular menstruation	
77 Los of menstruation (6+ months)	
78 HIV/AIDS positive	
79 Eating disorders	
80 Mental implants	
81 Transmissible diseases	
82 Bleeding disorder	

INJURIES	P/C/N
83 Fracture/broken bone	
84 Stress fracture	
85 Neck injury/problems	
86 Burner/stinger	
87 Low back problems	
88 Face, jaw, nose	
89 Surgery	
90 Shoulder	
91 Elbow/wrist	
92 Hand/fingers	
93 Hip	
94 Thigh	
95 Knew	
96 Lower leg	
97 Ankle	
98 Foot/toes	
99 Had 'bell rung'	

Please elaborate on any condition that you marked with a 'P' or a 'C'. Attached separate sheet if more space is needed.

Condition #	Date(s) Month/Year	Comments – include the severity, duration, treatment provided	Resolved YES/NO

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CONCUSSIONS

Date Month/Year	Symptoms	Duration of symptoms (min., hours, days, weeks...)	Interventions SCAT, MRI, CT, Neuropsych

I, _____, certify that the above information is true, and I have made a full and complete disclosure concerning any and all illnesses, allergies, injuries, physical characteristics and conditions regarding any medical information and history.

UFV Medical Staff reserves the right, in its absolute discretion, to withhold any athlete from participating in intercollegiate sports. I give the UFV Medical Staff consent to inform my Emergency Contact(s) should I be involved in a medical emergency. I consent to the release of all information from this medical history and exam to the UFV Medical Staff, Team Coaches, Emergency Medical Personnel and other relevant persons who may require this information.

Student-Athlete Signature

Date

Signature of Guardian (IF under 18 years of age)

Date

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UFV PRE-PARTICIPATION PHYSICIAN'S EXAMINATION

Name: _____ D.O.B. / /
(last) (first) (initial) dd / mm / yyyy

Local phone: () _____ Home phone: _____

Citizenship: _____

Home Address:

Address: _____ City _____ Postal Code: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Medical Insurance Company: _____ Policy #: _____

The following is to be completed by your FAMILY PHYSICIAN – if this is not possible, you will need to have this completed by the UFV team physician. Contact head athletic therapist to schedule this. Any costs associated with the physician exam are the sole responsibility of the athlete and not UFV athletics.

ATTENTION EXAMINING PHYSICIAN: Please review the medical history form completed by the student and elaborate if needed in the space below. Then complete the physical exam and summary section. The intent is not solely to disqualify athletes from participation that would be at significant risk, but also to identify athletes who may need follow up care or intervention to maximize their safety and performance.

MEDICAL HISTORY: Review any significant points from the student's medical form

PHYSICAL EXAM:

Height: _____ Weight: _____ Marfanoid features? _____

Vision: RT. _____ Lt. _____ Pupils _____ Fundi _____

Neurological: DTR: _____ Balance: _____ CNS _____

Head and neck: _____ Hearing: _____

BP: _____ Heart Sounds _____ Murmurs: _____ Pulse: _____

Respiratory: _____ Abdomen: _____ Hernia: Y N

Skin: _____ Lymphatics: _____

Musculoskeletal system: Right Left Right Left

Wrist/Hand _____ Knee _____

Elbow _____ Ankle _____

Shoulder _____ Back _____

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EXAMINATION SUMMARY:

Based on review of the medical history and physical exam I find this athlete to be:

- Fit for play in the designated sport.
- Fit with the reservations below.
- Unfit for the reasons below.

Information the coach or therapist should be aware of (i.e. Asthma, MSK rehabilitation advised, etc.)

Physicians Signature: _____ MD Date: _____

Please stamp or type name, address and phone number of physician.

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SPORTS MEDICINE TREATMENT CONSENT

ATHLETE'S NAME: _____ **SPORT:** _____

I hereby grant permission to the team physician(s) at the University of the Fraser Valley and those professional personnel designated by them, including athletic therapy staff, athletic therapy students, emergency medical personnel and other relevant persons to treat me for the duration of my participation in Cascade Sports. This permission includes emergency surgery and admission to the hospital as deemed necessary in addition to drugs, therapeutic modalities, and rehabilitation exercises used as part of treatment.

I understand that failure to provide an accurate health history or report injuries to the University of the Fraser Valley Sports Medicine personnel may void the University of the Fraser Valley's responsibility. The University of the Fraser Valley reserves the right, in its absolute discretion, to withhold any athlete from participating in intercollegiate sports.

I recognize that participation in an intercollegiate sport is highly competitive, demanding physically, AND THAT A RISK OF INJURY IS PRESENT. The University of the Fraser Valley will take reasonable precautions to safeguard health and safety, but I realize that serious and potentially debilitating or fatal injuries can and do occur.

ATHLETE'S SIGNATURE

DATE

GUARDIAN SIGNATURE (IF UNDER 18 YEARS)

DATE

MEDICAL RELEASE

I, _____, as a member of the University of the Fraser Valley _____
Athlete's full name **sport**

Team, authorize the UFV Athletics Health Care staff of the Team physician, Athletic Therapists, Physiotherapists, and other Health care professionals to release to each other, coaches, and/or administration of the athletic department, information pertaining to my health and physical condition, including injuries and their treatment progress, as it relates to my participation as a member of the team and for the duration of my participation with UFV Cascades Sports. All information obtained will remain confidential and only be utilized in the manner and with the personnel described above.

ATHLETE'S SIGNATURE

DATE

GUARDIAN SIGNATURE (IF UNDER 18 YEARS)

DATE

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RELEASE AND INDEMNIFICATION

WHEREAS I wish to participate in certain activities with Cascade Athletics (hereinafter, referred to as the “Activities”);

IN CONSIDERATION of The University of the Fraser Valley (the “University”) arranging for me to have the opportunity to participate in the Activities of the University:

1. I ACKNOWLEDGE and agree as follows:
 - a. I am familiar with, and understand the rules governing, the Activities; and
 - b. prior to participating in the Activities, I will inspect the playing field, equipment, facilities and if I believe anything is unsafe or beyond my capability, I will immediately advise the coach or supervisor or such conditions and refuse to participate.
2. I FURTHER ACKNOWLEDGE and accept that there are potential risks associated with my participating in the Activities, including, but not limited to:
 - a. bodily-injury risks and personal safety risks, and
 - b. miscellaneous risks that would result from the Activities and which might not be foreseeable to me at this time.
3. I AGREE to participate in the Activities notwithstanding the above-stated risks and further agree:
 - a. To assume all related health risks of participating in the Activities;
 - b. That, to the best of my knowledge, I am healthy and fit and I am able to participate in the said Activities;
 - c. That I have disclosed any pre-existing medical conditions which may impact my ability to participate in the Activities, and have made appropriate arrangements with the University to accommodate those conditions; and
 - d. That I will advise the University of any Medical conditions which arise subsequent to signing this Release, and make appropriate arrangements to accommodate such conditions, or cease my participating in the Activities.
4. I, my heirs, executors, administrators, successors or assigns, RELEASE the University, its respective servants, agents or employees from any claims for personal injury (including death), damages, losses or other proceedings while I am engaged in the Activities or thereafter.
5. I FURTHER AGREE TO INDEMNIFY the University, its servants, agents or employees from any damages which may result or claims or demands which may be made against the University arising out of or in consequence of the Activities and/or my actions.
6. I FURTHER STATE that I am of lawful age and legally competent to sign this Release.
7. The executed Release may be delivered by facsimile transmission and shall be deemed an original.

In signing this Release, I am not relying upon any oral or written representations or statements made by the University other than what is set forth in this Release.

I HAVE READ AND UNDERSTOOD THIS RELEASE AND I AM AWARE THAT BY SIGNING THIS RELEASE I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, EXECUTORS, ADMINISTRATORS AND ASSIGNS MAY HAVE AGAINST THE UNIVERSITY.

IN WITNESS WHEREOF I have set my hand on the date sets out below:

Signature

Please print your name here

Date

Witness Signature

Please print witness name here

Date