



Physical Examination Form

To be completed by your primary care physician and returned to the health office prior to your first day of classes. Athletes must have this completed yearly.

Please Print

Name: _____ Date of Birth _____
LAST FIRST M.I.

Height: _____ Weight: _____ BP: _____ / _____

Corrected Vision:
 Right 20/ _____ Left 20/ _____ Contact Lenses _____ Glasses _____

Abnormalities located below in the following systems:

Please circle any areas of abnormalities		
Head, Ears, Nose or Throat	Hernia	Metabolic/Endocrine
Eyes	Genitourinary	Skin
Respiratory	Musculoskeletal	Other:
Cardiovascular	Neuropsychiatric	
Gastrointestinal		

If any areas are circled, please explain below:

Allergies: Yes or No; If Yes, please list below
 Medications: _____
 Foods: _____
 Environmental: _____

Does the student require a special diet? Yes or No If yes, please list diet: _____

Please list any medications:

List any pertinent surgeries/hospitalizations or injuries:

Clearance for Sports Participation: Participating in _____
 _____ Cleared for full participation
 _____ Cleared after completing the evaluation/rehabilitation for _____
 _____ Not cleared/May not participate
 _____ N/A

Is the patient under any treatment now for medical or emotional conditions? Please list:

Student's Full Name _____ Date of Birth ____/____/____

FOR FIRST YEAR STUDENTS ONLY: Record Immunizations:

Every item on this page must be completed by your primary care provider prior to attending class at Lancaster Bible College. An attached immunization record that include the required immunizations below is acceptable.

REQUIRED: Please provide dates

MMR (Measles, Mumps, Rubella)

First ____/____/____ Second ____/____/____

(Those born before 1957 are considered immune to measles, mumps and rubella)

Polio

First ____/____/____ Second ____/____/____ Third: ____/____/____ Latest Booster ____/____/____

Diphtheria, Tetanus, Pertussis

First ____/____/____ Second ____/____/____ Third: ____/____/____ Latest Booster ____/____/____

Meningococcal Vaccine: MUST BE COMPLETED - Failure to provide a record of meningococcal will result in being delayed in moving into a resident hall per PA Mandate. (www.immunize.org/laws/menin.asp)

Meningococcal Vaccine (Menactra/Menveo) First ____/____/____ Second ____/____/____

Meningitis B First ____/____/____ Second ____/____/____

Meningococcal Vaccine Pennsylvania State law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unit unless the vaccination against meningococcal disease has been received, or a student (parent or guardian for minors) may sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Please review the links below for information and risk for meningitis. www.cdc.gov/meningococcal/about/risk-community.html www.cdc.gov/meningitis/bacterial.html Meningococcal Vaccine Meningitis B Vaccine (Menactra/Menveo) (Bexsero/Trumenba) OR Meningococcalwaiver:

I, (student's name printed) _____, received and reviewed the information provided by the above links regarding meningococcal disease or that the doctor has shared with me. I am fully aware of the risks associated with meningococcal disease and of the availability and effectiveness of the vaccinations against the disease. I wavier the meningococcal disease vaccine at this time.

(student's signature) _____

Other Recommended Vaccines:

Varicella: First ____/____/____ Second ____/____/____ or disease date ____/____/____

Hepatitis B: First ____/____/____ Second ____/____/____ Third: ____/____/____

HPV: First ____/____/____ Second ____/____/____ Third: ____/____/____

Provider's Name (Print) _____

Provider's Signature _____ License number _____

Practice Name _____

Office Address _____

Phone _____ Fax _____ Date _____



AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To be completed by Parent/Guardian and Student-Athlete

I hereby authorize Lancaster Bible College Athletic Staff to release or disclose information to parties in the event of an emergency or in the event that coordinated care is necessary. I understand that protected health information will not be shared with anyone without the consent of the student-athlete, except when necessary. I also understand that my information will be protected from being released through all reasonable means. Lancaster Bible College Athletics' policy is to ensure that information is protected and remains confidential.

Through the course of participation it is necessary for information to be shared between athletic trainer and coach. I acknowledge that this is necessary. I also acknowledge that it is the policy of Lancaster Bible College that information may be shared between medical personnel within Lancaster Bible College.

Signature of Parent/Guardian (if under 18 years of age)

Signature of Student-Athlete

Date

Date



CONSENT AND RELEASE FOR PARTICIPATION IN ATHLETICS

To be completed by Parent/Guardian and Student-Athlete

Lancaster Bible College’s Athletic Program, while voluntary, is an integral part of the curriculum. College personnel have devoted great effort to assure that participating student-athletes are protected in every way possible. However, participation in athletics includes a risk of injury which may range in severity from minor to long-term catastrophic injury, including paralysis and even death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations and report all physical problems to the coach or athletic trainer. They must follow a proper conditioning program and inspect all personal protective equipment daily. Proper execution of skill techniques must be followed for every sport, especially in contact sports. Coaching staff will instruct players concerning skills and rules in their sports.

By initialing each statement below and signing at the bottom, I state that I have read, understand, and approve the above statements.

_____ I consent to (have my son/daughter) represent Lancaster Bible College in approved athletic activities except those activities excluded by the examining doctor.

_____ I grant permission for my son/daughter/self to accompany any college team in which he/she/I participates to out-of-town trips. The athlete will be transported to and from all events in college approved vehicles. Parents/guardians wishing to have their son/daughter traveling with them when returning from an event must make written arrangements with the coach.

_____ In the event of an emergency requiring medical attention, I expect every reasonable attempt to be made to contact parents. In an emergency, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter/self to a qualified medical facility.

_____ Because of the conditions inherent in sport, participating in sports exposes an athlete to many risks of injury. Those injuries include, but are not limited to death; paralysis due to serious neck and back injuries; brain damage; damage to internal organs; serious injuries to the bones, ligaments, joints, and tendons; and general deterioration of health. Such injuries can result not only in temporary loss of function, but also in serious impairment of future physical, psychological, and social abilities, including the ability to earn a living.

_____ I grant permission to the Athletic Training Staff and its medical representatives to render and/or obtain treatment, medical/surgical procedures to the extent of their abilities and training necessary to my (son’s/ daughter’s) health and well being. Also, I grant permission for such established treatments and therapy be employed as may be deemed medically necessary or advisable in the diagnosis and treatment of my (son’s/ daughter’s) illness or injuries sustained through participation in Intercollegiate Athletics.

Signature of Parent/Guardian (if under 18 years of age)

Signature of Student-Athlete

Date

Date



STATEMENT ON INSURANCE COVERAGE

To be completed by Parent/Guardian and Student-Athlete

Sports activities have varying degrees of risk of injury that participants should recognize by the nature of the activity. Students who choose to participate in the intercollegiate sports program are encouraged to have personal insurance coverage. Most students are covered by their parents’ policy. Lancaster Bible College Athletic Department has an excess insurance policy on all sports participants; however, it acts as a secondary carrier for athletic injuries only.

Insurance Claims Policies

1. Any medical or dental services associated with the care of injuries sustained during participation in intercollegiate athletics must be arranged through the athletic trainer. In emergencies, if the athletic trainer is not available, the student should consult the Student Health Services. An athlete who is injured in a practice or a contest should report the injury to the athletic trainer as soon as possible. Delay may result in the insurance declining the claim.
2. All care must be arranged through the athletic trainer. Individuals injured while participating in intercollegiate athletics may not be reimbursed for unauthorized services.
3. Written authorization and all necessary paperwork will be given by the athletic trainer for referral to the appropriate physician or healthcare provider. If this documentation is not on file in the athletic training office, bills for services may not be considered and the athlete may be responsible for payment.
4. If a student-athlete is injured while participating in a game, scrimmage, or practice sanctioned by the athletic department or in transit to or from the event, the policy with regards to insurance coverage as a student is as follows:
 - A. All undergraduate students carrying twelve or more credits are required to have health insurance. Students must prove coverage through parent, spouse, or employer.
 - B. The secondary policy that the college has for each student-athlete requires that the insurance that the student has be applied first to pay for any medical/dental and hospital costs that are covered through the insurance. Procedures for filing a claim through personal insurance must be followed. If not, a delay in payment or denial may result.
 - C. The secondary policy is an “excess coverage plan” over any current insurance coverage by the student or their parents. This policy will pay the remaining eligible charges if there are any limits to personal coverage on the student.
 - D. The athletic trainer will coordinate insurance coverage matters for all student-athletes. The injured athlete is responsible for filling out an insurance claim form with the athletic trainer and submitting any medical paperwork, bills or insurance paperwork immediately upon receipt. All claims must be filed within a specific period of time from the date of initial treatment for the injury.
5. If a serious injury should occur to an athlete while representing Lancaster Bible College in a sanctioned game, scrimmage, meet, or tournament, for which treatment cannot await the return to campus, appropriate medical attention should be sought and the athletic trainer notified immediately.

I, _____, have read and understand the insurance claims policies and know that Lancaster Bible College, the Athletic Department, or any office of Lancaster Bible College is not responsible for medical bills and if guidelines are not followed, I or my parents may be held financially responsible.

Signature of Parent/Guardian (if under 18 years of age)

Signature of Student-Athlete

Date

Date



SICKLE CELL TRAIT FOR NCAA INTERCOLLEGIATE ATHLETICS

To be completed by Parent/Guardian and Student-Athlete

About Sickle Cell Trait

- Sickle cell trait is an inherited condition affecting the oxygen-carrying substance, hemoglobin, in the red blood cells.
- Sickle cell trait is a common condition (> three million Americans)
- Although Sickle cell trait occurs most commonly in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ethnicities may test positive for this condition.
- Unlike persons with actual sickle cell disease, those with sickle cell trait usually have no symptoms or any significant health problems. However, sometimes during very intense, sustained physical activity, as can occur with collegiate sports, certain dangerous conditions can develop in those with sickle cell trait, leading to blood vessel and organ (kidneys, muscles, heart) damage that can cause sudden collapse and death. Some of the settings in which this can occur include timed runs, all out exertion of any type for 2 to 3 continuous minutes without a rest period, intense drills and other bursts of exercise after doing prolonged conditioning training. Extreme heat and dehydration increase the risks.

Sickle Cell Trait Testing

- The NCAA recommends that all student-athletes have knowledge of their sickle cell trait status. Athletes have the following options: 1) show proof of sickle cell testing done at birth; 2) consent to a blood test to check for the sickle cell trait; or 3) sign a waiver declining options 1 and 2. Whichever option is chosen, it must be completed before the student-athlete participates in any intercollegiate athletic event, including strength and conditioning sessions, try-outs, practices, or competitions.
- Athletes who are positive for the trait will not be prohibited from participating in intercollegiate athletics.

1. Copy of student athlete’s newborn sickle cell testing result attached. _____ Date _____

2. Copy of recent sickle cell screening test result attached. _____ Date _____

3. SICKLE CELL TESTING WAIVER:

I, _____, understand and acknowledge that the NCAA recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts and the College policy about sickle cell trait and sickle cell trait testing. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Lancaster Bible College’s Student Health Service Office and Athletics Department. I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify and hold harmless Lancaster Bible College, its officers, employees, agents and their successors and assigns from any and all costs, claims, damages or expenses, including attorneys fees, arising from any loss or personal injury that might result from my refusal to be tested. 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.

Sport: _____

Signature of Student-Athlete	Print Name of Student-Athlete	Date
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Signature of Parent/Guardian (if under 18 years of age)	Print Name of Parent/Guardian	Date
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Signature of Witness	Print Name of Witness	Date
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