

Updated Health Record: Returning Student Athlete

This information is strictly for the use of the WVWC Athletic Training Staff and the WVWC Health and Counseling Center. Information will not be released without your knowledge and written consent or as required by law. Your Health Record will be destroyed 10 years after your last date of attendance.

Student Information: Please Print

Last Name:	First Name:	Middle Name:	Gender:
Address:	City:	State/Province:	Zip/Postal Code
Student email address:		Date of Birth (mm,dd,yyyy)	Student Cell phone:
Parent/Guardian Last Name:	Parent/Guardian First Name:	Home Phone:	Cell Phone:
Alternate Person In Case of Emergency			
Name : _____		Cell Phone: _____	
		Home Phone: _____	

Family History

	Age	State of Health	If deceased, list cause	Have any of your relatives ever had any of the following?	No	Yes	Relationship
Father				Alcohol/Drug Problem			
Mother				Asthmas, Allergies			
Brother				Cancer			
Brother				Depression			
Sister				Diabetes			
Sister				Heart Disease/Stroke			
				Stomach Disease, Ulcer			
				Tuberculosis			

Student's Health History

__ Acne	__ Depression	__ Hernia	__ Murmur
__ ADD/ADHD	__ Diabetes	__ High Blood Pressure	__ Pain in Chest
__ Allergy-Food _____	__ Dizziness/Fainting	__ Insomnia	__ Palpitations
__ Allergy to Penicillin	__ Ear, Nose, Throat Problems	__ Joints, disease/injury	__ Psoriasis
__ Allergy to Sulfa	__ Eating Disorder	__ Learning Disability	__ Sinuistis,frequent
__ Allergy, other _____	__ Epilepsy/Seizures	__ Liver or Kidney Problems	__ Stomach: GERD,ulcer
__ Anxiety	__ Eye Problems	__ Measles	__ Thyroid Disorder
__ Asthma	__ Gallbladder Problems	__ Measles, German	__ Tumor, cancer/cyst
__ Back Problems	__ Headaches	__ Menstrual Problems, female	__ Weight, Recent gain or loss
__ Chicken Pox	__ Headaches, Migraine	__ Mononucleosis	Continued on Back
__ Dental Problems	__ Head Injury/Concussion	__ Mumps	Turn Page Over

Hospitalization History

Please list all medical, surgical, or other hospitalizations including dates and diagnosis.

Dates: Month/Year	Hospitalization History	Diagnosis

Additional Health Information

Please answer the following questions.	Yes	No	Please provide details or list.
Has your physical activity been restricted during the past four years?			
Have you received treatment/counseling for alcohol or other drug abuse, an eating disorder, depression, anxiety, or any other reason?			
Have you had any significant illness or injury other than what you already listed?			
Do you take any medications routinely?			

**In the space below add any recent or significant information about Student's Health you think we need to know.
If necessary, staple an additional page to the form.**

Consent for Medical Treatment/ Emergency Care

A. I consent and authorize WVWC Health and Counseling Center staff to consult with or defer my treatment to other health professionals as deemed necessary or advisable and to contact my parents/ guardians, or other named individuals, in the event of an emergency.

X _____ X _____
 Signature of Student Date Signature of Parent/Guardian (if under 18)

Consent

B. All medical records are confidential and no information is released without written authorization. I authorize the release of medical information to my parents/guardians as deemed necessary for my medical treatment and follow-up care. I understand that I can revoke this authorization in writing at any time.

X _____
 Signature of Student Date

Physical Examination
(to be completed by Physician, CFNP, PAC)

Patient's Name _____

Vitals: TPR _____ B/P _____ WGT _____ HGT _____

	WNL	ABNORMAL (EXPLAIN)
Neurological		
Cardiovascular		
Mouth		
Integumentary		
Respiratory		
Gastrointestinal		
Urinary/Genitalia		
ENT		
Eyes		
Any conditions that prevent living in residence hall or any special accommodations needed?		No ___ Yes ___ Explain:
Any conditions that would prevent normal activity in physical education classes, intramurals, or sports?		No ___ Yes ___ Explain:
If Athletic Training Major Candidate: Does patient have sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical exams using accepted techniques; and accurately, safely, and efficiently use equipment and materials to meet requirements and demands of the program?		Yes ___ No ___ Explain:
Health Care Provider (Print Name) _____ Date: _____ Signature _____ Phone _____ Fax _____		

All WVWC College Athletes Must Complete Form

Name (print) _____ Sport _____

Please answer all of the following questions and sign below. If you answer "yes" explain in the space provided.	Yes	No
1. Have you had an recent illnesses? Explain:		
2. Have you ever been told to give up sports because of a health problem? Explain:		
3. Do you wish to discuss a specific problem with the doctor or Athletic Trainer? Explain:		
4. Has anyone (under the age of 50) in your close family died suddenly? Explain:		
5. Has anyone (under the age of 50) in your close family had a heart attack? Explain:		
6. Has anyone in your immediate family had high blood pressure? Explain:		
7. Do you get chest pain with exercise? Explain:		
8. Do you have faintness or dizziness with exercise? Explain:		
9. Heat trouble or a heart murmur? Explain:		
10. Heat illness (dehydration with exercise)? Explain:		
11. Coughing after strenuous exercise? Explain:		
12. Do you exercise continuously for at least 30 minutes, three or more times a week? Explain:		
13. Do you eat any special foods or follow a special diet during the sports season? Explain:		
14. Is your pregame meal a special part of your game preparation? Explain:		
15. Have you ever taken any supplements or vitamins to help you lose or gain weight or improve performance?		

Consent and Authorization:

I give authorization to the Athletic Training staff and/or medical consultants to evaluate and treat any injuries that occur during my participation in athletics at West Virginia Wesleyan College. I understand the Athletic Trainer has the authority to prohibit me from further participation because of an injury and/or because of undue liability risk to West Virginia Wesleyan College.

Student Athlete's signature _____ Date _____

Parent/Guardian Name (print) _____ Date _____

Parent/Guardian Signature _____

Insurance Information

IMPORTANT: STUDENTS ARE REQUIRED TO HAVE INSURANCE COVERAGE WHILE ATTENDING WVWC. Participation in the **College Student Accident & Sickness Plan** is required unless you complete the online waiver, identifying comparable coverage. **Read “Waiving Student Accident and Sickness Insurance” info at bottom of page.**

The information below will be kept on file at the Health and Counseling Center in the case the student needs medical attention outside the College.

Family Insurance Information

Student's Last Name (Print):	Student's First Name:	Middle Name:	Gender (circle) Male Female
Name of Health Insurance Company		Address	
Phone Number	Policy or Group Number	Policy Holder's Name	
Relationship to Student		Date of Birth	
Policy Holder's Place of Employment:		Employer's Address:	

Contact your medical insurance company to be sure medical providers in our area are in your Network.

Please attach a copy of the FRONT and BACK of your family insurance card HERE

Waiving Student Accident and Sickness Insurance

If you have equivalent medical coverage and prefer to waive the Student Accident and Sickness Insurance, you must complete the online waiver.

The web site is <http://www.eiia.org/wvwc>

1. Click on “Waive Student Insurance” on the left hand navigation bar
2. Review the brochure to make an informed decision

If you choose to waive the coverage, then complete the online form

A few points to consider:

- If you choose to waive the insurance, keep in mind it must be completed each year
- The opportunity to waive will begin June 1
- **The deadline to complete this waiver is September 15,2010**

There will be no refunds for the \$250 cost associated with this coverage after September 15.

See attached STUDENT INSURANCE CLAIM FILING PROCEDURES GUIDE

For questions about Student Accident and Sickness Plan

Visit www.eiia.org/wvwc or Call **1 800-952-4320**