Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

History Form

Returning CLU Athlete Pre-participation Physical Evaluation

Name _____ **Age** _____ **Sport(s)** _____
Date of birth _____ **Sex (circle)** M / F / Other **Student's phone** _____
Personal Physician _____ **Phone** _____
In case of emergency, contact: **Name** _____ **Relationship** _____
Phone (H) _____ **(W)** _____ **(C)** _____

Only since your last athletic clearance at CLU: *check "**Yes**" to any conditions you have had.* **Use a pen**

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify: □ Asthma □ Anemia □ Diabetes □ Infections Other _____		
3. Have you spent the night in the hospital?		
4. Have you had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you passed out or nearly passed out DURING or AFTER exercise?		
6. Have you had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart race or skip beats (irregular beats) during exercise?		
8. Has a doctor told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease Other: _____		
9. Has a doctor 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 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 sudden 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 had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you had any broken or fractured bones or dislocated joints?		
19. Have you had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you had a stress fracture?		
21. Have you 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 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 had a head injury or concussion?		
35. Have you 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 had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you been unable to move your arms or legs after being hit or falling?		
40. Have you 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 had an eating disorder?		
51. Do you have concerns that you would like to discuss?		
MEDICATIONS AND ALLERGIES		
52. List all medications and supplements:		
53. List all allergies (medicines, insects, pollens, food):		
FEMALES ONLY		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

EXPLAIN ALL "Yes" ANSWERS BELOW BY NUMBER OF QUESTION

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct and I agree to update information as needed based on current circumstances. Parent must sign if athlete less than 18 years old.
Signature of athlete _____ Date _____

Clearance Form

Returning CLU Athlete Pre-participation Physical Evaluation

Name _____ **Sex** _____ **Date of birth** _____

Sport(s) _____

**You must attach a copy* of the front and back of your insurance card to these forms.
Athletes must have medical insurance to participate.

TRAINING ROOM

Height _____ **Weight** _____ **Pulse** _____ **Body fat:** Bi_____ Tri_____ Sub _____ IC_____
Vision: R 20/____ L 20/____ **Corrective lenses (circle):** Contacts (Soft/Hard) Glasses None

Date **Trainer's initials**

HEALTH SERVICES

Blood Pressure (left arm, sitting) _____ **Repeat B/P** _____ **Date** _____

Hemoglobin (women) _____ **Repeat Hgb** _____ **Date** _____

History Form reviewed: (check off)
___ No new pertinent illnesses or injuries not previously cleared
___ There was a new illness or injury (note below)
___ Needs Ortho. Reason: _____
_____
___ Discussed with Health Services provider _____
_____

FINAL HEALTH SERVICES CLEARANCE
___ **Cleared**
___ **Provisional clearance.** Reason _____
_____
___ **Not cleared.** Reason _____
_____

Signature _____
Date _____

PRE-CLEARANCE IN SPRING
___ **Cleared;** athlete advised to return in Fall
___ **Provisional clearance;** athlete advised to return in Fall and **needs**: _____
___ **Not cleared, return in Fall.** Reason _____
_____

Signature _____
Date _____

ORTHOPEDIC CLEARANCE

The following is only for a CLU Team Physician if athlete needs Ortho clearance
Notes: _____
_____

(check off)
___ **Cleared without restriction**
___ **Cleared, with recommendations for further evaluation or treatment for:** _____
_____
_____
___ **Not cleared.** Reason _____

Physician (circle one)**:** Dr. Durand Dr. Dahms Dr. Vercillo

Signature of physician _____ **Date** _____

Cal Lutheran Athlete Mental Health and Safety Screening

MH&S Screen Form

Name _____

To be completed by athlete:

Additional questions on more sensitive issues	**Yes**	**No**
1. Do you feel stressed out or under a lot of pressure?		
2. Do you feel unsafe at your home or residence?		
3. Have you ever tried cigarettes, chewing tobacco, snuff, or dip?		
4. Do you drink alcohol or use any other drugs?		
5. Have you ever taken anabolic steroids or used any other performance supplement?		
6. Have you ever taken any supplements to help you gain or lose weight or improve your performance?		
7. Would you say food dominates your life?		
Do you agree with the statements below:	**Yes**	**No**
8. I often have trouble sleeping.		
9. I wish I had more energy most days of the week.		
10. I think about things over and over.		
11. I feel anxious and nervous much of the time.		
12. I often feel sad or depressed.		
13. I struggle with being confident.		
14. I don't feel hopeful about the future.		
15. I have a hard time managing my emotions (frustration, anger, impatience).		
16. I have feelings of hurting myself or others.		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct and I agree to update information as needed based on current circumstances.

Signature of athlete _____ Date _____

Signature of parent/guardian (if athlete is a minor) _____ Date _____

To be completed by California Lutheran University Health Services staff

□ Additional screening <u>not</u> needed.
Notes: _____

□ Additional screening is needed and athlete informed it must take place within 2 weeks or clearance will be pulled. Also:

□ Health Services call reminder made or

□ Appointment made

Notes: _____

_____

Circle:

Dr. Ramos K.Lauchner, PA-C B. Fall, PA-C
S.Sheehan, LVN P.O'Brien, LVN Other_____

_____ Health Services signature

_____ Date

California Lutheran University Department of Athletics
Assumption of Risk Statements

Assumption of Risk Form

Name _____

STATEMENT OF INSURANCE COVERAGE

Sports activities have varying degrees of risk of injury which participants should recognize by the nature of the activity. **Students who participate in the intercollegiate sports program must show proof of personal health insurance that covers intercollegiate athletic injuries.** The student's plan in their name or a plan through a parent's insurance will act as their primary insurance. CLU also has a limited athletic insurance policy with a $500 deductible for all intercollegiate participants that helps to cover some expenses incurred in excess of the student's primary insurance. This policy covers only injuries that occur during official practice or games of the sport in which the athlete is participating and may exclude pre-existing conditions. Should an injury occur, you must report this to a CLU certified athletic trainer. You must have an injury report on file and a claim form completed by a CLU certified athletic trainer. CLU Health Services will discuss your options for medical care on an individual basis and will assist students in accessing appropriate medical care. If there is a remaining balance due after your insurance has paid for your treatment, CLU Health Services will guide students through submitting claims to the athletic insurance carriers. No bills are "paid automatically." It is the student's responsibility to ensure that bills are paid in a timely manner.

Authorization: I have read and understand the information above. I hereby authorize any hospital, physician or other person who had attended or examined or has in his possession records pertaining to my care, to furnish CLU's current athletic insurance company or its representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records and all other information requested. It is agreed that all medical and/or hospital expenses incurred beyond those covered by any applicable insurance policy will be paid directly and promptly by the undersigned student and parents or guardians, and the University will not be responsible thereon. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature:_____ **Date:** _____
Parent/Guardian Signature: (if minor)_____ Print name _____

ASSUMPTION OF RISK

I fully understand that while playing or practicing to play/participate in intercollegiate athletics for CLU, serious injuries can occur, such as head, neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing and practicing to play/participate in intercollegiate athletics may not only result in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social, and recreational activities, and generally to enjoy life. As a participant, I knowingly accept this risk. Because of the dangers of participating in intercollegiate athletics, I recognize the importance to follow the coaches' and trainers' instructions regarding playing techniques, training and other team/game rules, and agree to abide by such instructions.

Signature: _____ **Date:** _____
Parent/Guardian Signature: (if minor)_____ Date: _____

FOOTBALL ONLY: I also understand that while participating in intercollegiate football it is a violation of the NCAA football rules to use the helmet, which I am wearing, to butt, ram, or spear an opposing player, teammate or object, and such use can result in severe head or neck injury, paralysis or death to me as well as possible injury to an opponent or teammate. Also, I understand that no helmet can prevent all head and neck injuries that I might receive while participating in intercollegiate football.

Signature: _____ **Date:** _____
Parent/Guardian Signature: (if minor)_____ Date: _____

EMERGENCY MEDICAL CONSENT

I give CLU athletic coaches and Sports Medicine Staff (i.e., Certified Athletic Trainers, team physician, paramedics, or emergency room physicians) as our agent(s), permission to consent to and administer emergency medical treatment in the event of a serious or life-threatening injury. This consent includes any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is rendered under the general or special supervision of any physician and surgeon licensed hospital, whether such examination, diagnosis, treatment, or hospital care being required and gives our agent(s) the authority and power to give specific consent to any and all such examinations, diagnosis, treatment, or hospital care which the physician in his/her best judgment may deem advisable. This authorization is given pursuant to Section 25.8 of the Civil Code of California. Information collected on this form is used for the purpose of determining medical status. Information on this form, as well as medical information collected throughout the school year pertaining to the practice and play of intercollegiate athletics, will be reviewed by CLU Health Services staff as well as the Athletic Trainers and Team Orthopedist(s). I authorize CLU Athletic training, the Team Orthopedist(s), and Health Services to review and discuss medical information as necessary to establish medical clearance to participate in Intercollegiate Athletics. Medical information not directly related to my medical clearance will not be discussed unless specifically authorized by me. I understand that information will not be shared with individuals not listed above, without my consent.

Signature: _____ **Date:** _____
Parent/Guardian Signature: (if minor)_____ Date: _____