

Dear new student-athlete:

The Sports Medicine Department would like to take this opportunity to welcome you to the College of Mount Saint Vincent. We work to provide all student-athletes with comprehensive health care while placing special emphasis on the prevention, recognition, treatment, and rehabilitation of injuries sustained during athletic competition.

In accordance with guidelines established by the NCAA and the Health Insurance Portability & Accountability Act of 1996 (HIPAA), **all student-athletes are required to have the accompanying pre-season packet documented with the Sports Medicine department before any participation may take place in their chosen sport.** Part of this requirement includes a physical examination and complete documentation of your current immunization record. This requirement is satisfied by the immunization record and physical exam, which you provided to our Student Health Center upon enrollment. Please make sure this requirement has been fulfilled by checking with Student Health Center, prior to participation in any practice or pre-season workout.

Following your arrival here at Mount Saint Vincent, you will receive a specialized orthopedic evaluation performed by the Sports Medicine Department and team physicians. All coaches will be informed of exam dates and times relative to your sport.

All student-athletes must have insurance before participating in intercollegiate athletics. Most are covered by their parents' insurance or have their own personal health insurance. If you do not have insurance, it may be purchased through the school. Proof of insurance is required prior to participation in intercollegiate athletics at Mount Saint Vincent.

The following is a checklist, for your personal use, of all the **forms that must be returned to College of Mount Saint Vincent Sports Medicine by August 11, 2010 for Summer 2010 pre-season teams. All other teams first week of school:**

- Student-Athlete Acknowledgement and Assumption of Risk
- Consent to Treatment Authorization for the Release of Medical Information
- Health Insurance / Authorization
(With **front/back copy of insurance card**)
- Medical History
- Sickle Cell Questionnaire
- NCAA ADD/ADHD Requirements
- Medical Declaration
- Physical exam
(**Return to athletic trainer**)

***** All above documents MUST be returned to the College of Mount Saint Vincent Sports Medicine department before participation in ANY pre-season practices, try-outs, and practices.*****

All documents listed above can be accessed on-line at [MSV Dolphins website](#) . Just click on the Sports Medicine section. Please fax (718-405-3765) or mail the completed forms to:

Barima Yeboah
Head Athletic Trainer
College of Mount Saint Vincent
6301 Riverdale Ave.
Riverdale, NY 10471

Again, welcome and good luck in your career as a Mount Saint Vincent Dolphin. If you have any questions, feel free to call the Athletic Training Room at (718-405-3238).

Printed Name _____ Age _____ Sport _____

College of Mount Saint Vincent – SPORTS MEDICINE
STUDENT-ATHLETE ACKNOWLEDGMENT AND ASSUMPTION OF RISK

The undersigned understands, acknowledges and declares the following:

Athletes generally expect that those who are responsible for the conduct of sport will take reasonable precautions to minimize risk, and that their peers participating in the sport will not intentionally inflict injury upon them. However, I also understand that my participation in sport requires my personal awareness and acceptance of the risk of injury.

I understand that participation in Intercollegiate Athletics at The College of Mount Saint Vincent (CMSV) may result in injury or illness, permanent physical or mental impairment, or even death. Those injuries may be minor or may be career or life threatening. I understand that CMSV cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques which are made known to me by my coaching staff, athletic training staff, by the strength and condition personnel, or which are otherwise known to me from any other source, including but not limited to, the medical personnel of the College.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist; and am willing to assume responsibility for **any and all** such risks while participating in Intercollegiate Athletics at the College of Mount Saint Vincent, and hereby release the College of Mount Saint Vincent from any and all liability arising from my voluntary participate in a sport. I also agree as follows:

- A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics.
- B. I agree that CMSV and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have.
- C. I understand that having passed the physical examination **does not** necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at CMSV, but only that the evaluator did not find a medical reason to disqualify me at the time of the physical examination.
- D. I understand that I must refrain from practice while **injured or ill**, whether or not I am receiving medical care. When under medical care, I may not return to participation until I have been given permission, based on an independent exercise of professional judgment by the attending Team Physician(s) or his/her designate, after review of my condition and fitness for the rigors of my sport. This may occur during or at the conclusion of medical treatment(s).
- E. I understand and agree that if I experience an injury/illness or change in my health status **it is my responsibility** to inform my Head Coach and the Sports Medicine Staff and to adhere to the established injury management guidelines, which include total rehabilitation and reassessment(s) before I am released to return to full participation.
- F. I hereby authorize **any/all** pertinent medical information regarding injury or illness that I may experience, to be freely communicated between CMSV Student Health Services Medical Staff and the CMSV Sports Medicine Staff. I understand that my refusal to authorize this transmittal will result in an automatic **HOLD** on my Athletic Physical.
- G. I understand that I must wear the proper equipment as dictated by the rules of the sport. I may also have to wear padding or braces as indicated by the sports medicine staff or medical personnel. I understand that failure to do so may put me at risk for further injury.
- H. I understand that the Director of Athletics, or designee, may notify in appropriate circumstances, my parent/legal guardian of serious injury or positive drug test results.

I HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

Student-Athlete Signature

Date

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

Date

College of Mount Saint Vincent

CONSENT TO TREATMENT AND AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

This authorizes the athletic trainers, team physicians, and medical staff representing the College of Mount Saint Vincent to gain/release information concerning my medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information to individuals/institutions that may include but are limited to:

- School Administration
- Athletic Staff
- Coaches
- Parents / Guardians
- Student Health Services
- Required Medical Facilities (Hospital, Physical Therapy Clinic, etc)
- Insurance Companies
- Sports Medicine work-study students
- Teammates

I, _____ (print name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team/school/family physician, licensed physical therapists, Certified Athletic Trainers and other practitioners of the healing arts. Also, under the direction of a Certified Athletic Trainer, may include college/university student athletic trainers.

This information to be released is in regards to injuries or illness related to my participation in athletics at the College of Mount Saint Vincent.

The purpose of this disclosure is to advise of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses I have or may have had. This information will be used to make decisions regarding my athletic ability and suitability to compete while I am a student athlete. I understand that the entities that receive the information may not be health care providers or health plans covered by federal privacy regulations and that the information may no longer be protected by those regulations.

I understand that the College of Mount Saint Vincent will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying the Sports Medicine Staff. Doing so will not affect actions that the College of Mount Saint Vincent will take in reliance to this authorization prior to receiving the revocation. This authorization expires six years from the day it is signed.

Printed Name of Student-Athlete

Sport

Student ID #

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian
(If Student-Athlete is under 18 years of age)

Date

I have reviewed the above statements but do not wish to authorize this release. _____
Initials

College of Mount Saint Vincent Sports Medicine

Insurance Information

Have you personally purchased the College of Mount Saint Vincent health insurance? YES NO

Do/Will you need to purchase health insurance from the College of Mount Saint Vincent? YES NO

If you have answered no to the above questions and have insurance through your family, please complete the following information about you Primary Health Insurance Company, and provide a copy of the front and back of your insurance card. If you have the College of Mount Saint Vincent health insurance copy the front and back of your insurance card (look in booklet). You will not be cleared to participate in athletics with out proof of health insurance.

Sport: Date:

Personal Information

Student-Athlete's Name: SS#:
DOB: Student ID#: Age: Sex: M F
Home Address: Campus/Local Address:
Home Phone: Campus/Local Phone:

Parent/Guardian Information

FATHER'S / GUARDIAN'S INFORMATION MOTHER'S / GUARDIAN'S INFORMATION
Name
DOB
Home Address
Home Phone
Employer
Employer Address
Work Phone

Insurance Information

Primary Insurance Policy Secondary Insurance Policy
Insurance Co.:
Address:
Policy / ID #:
Group #:
Insurance Co. Phone #:
Insurance Type: HMO PPO Standard Other:
Primary Care Physician:
Physician Phone #:
Is preauthorization necessary for medical/diagnostic services?
Yes No (If Yes) Phone #:

Emergency Contact Information

Name: Relationship:
Home Phone: Work Phone:

Does your insurance require a referral from your primary care physician? YES NO

Does your insurance require pre-authorization before any medical tests or treatment is preformed? YES NO

I authorize the College of Mount Saint Vincent Sports Medicine Department to share information necessary for treatment with the College of Mount Saint Vincent team physicians, student health services, coaches, and parent(s) / guardian(s). I have been informed that I have the right to revoke this authorization at any time. I understand that my medical records are kept secure and that I have the right to view those records upon request.

Parent's signature _____ (under 18 only) Date _____

Student's signature _____ Date _____

College of Mount Saint Vincent

Medical History

Date: ___/___/___

Name: _____ Gender: ___ Age: ___ D.O.B: ___/___/___

Class Status: _____ Sport(s): _____

Local Phone _____ - _____ Local Address: _____

Cardiac History

YES NO

- 1. Do you know of any family members that have heart disease? [][]
2. Has anyone in your family died of heart problems or sudden death before age 50? [][]
3. Have you ever collapsed, fainted or become dizzy during exercise? [][]
4. Do you have chest pain with exercise? [][]
5. Do you become excessively short of breath during exercise? [][]
6. Do you become excessively fatigued during exercise? [][]
7. Have you ever been diagnosed with a heart murmur or arrhythmia? [][]
8. Do you or anyone in your family have high blood pressure? [][]
9. Do you feel as if your heart flutters or races abnormally during exercise? [][]

General Medical History

YES NO

- 10. Have you ever been hospitalized before? [][]
11. Have you had surgery before? [][]
12. Are you presently taking any medications, nutritional or herbal supplements? [][]
13. Do you have any known allergies to medications, foods, bees etc? [][]
14. Have you ever had a concussion? [][]
If yes, how many? _____, and when was the most recent? _____
15. Have you ever had a seizure or been diagnosed with epilepsy? [][]
16. Do you have either chronic or exercised induced asthma? [][]
17. Do you have any other medical conditions not mentioned above? (diabetes, hemophilia, migraine, eating disorder, etc) [][]

- 18. Do you feel you are - overweight, - underweight or at an - appropriate weight? (circle one)
19. Do you or have you ever had an eating disorder? [][]
20. Have you ever had a muscle strain, joint sprain, dislocation, stress fracture or complete fracture? [][]
If yes check locations below.
___ Head ___ Arm/Forearm ___ Hand ___ Knee ___ Foot
___ Neck ___ Elbow ___ Hip ___ Lower leg ___ Chest
___ Shoulder ___ Wrist ___ Thigh ___ Ankle ___ Back
21. Do you or have you had any chronic injuries that do not seem to heal? [][]

Gynecological History

YES NO

- 22. Have you ever missed more than 1 consecutive menstrual cycle? [][]
23. What is the longest time you have experienced between menstrual cycles? _____
24. Do you have irregular menstrual cycles? [][]

If you have answered yes to any of the above items please list the number of the question and explain.

Previous History of Injuries

Do you have or have you had in the past, problems with:

Date	Condition	Description	Are you currently affected by this?
_____	Concussion(s)	_____	_____
_____	Skull fractures	_____	_____
_____	Neck injuries	_____	_____
_____	Shoulder injuries	_____	_____
_____	Elbow injuries	_____	_____
_____	Arm/Wrist/Hand	_____	_____
_____	Rib cage injuries	_____	_____
_____	Back injuries	_____	_____
_____	Hip injuries	_____	_____
_____	Thigh injuries	_____	_____
_____	Knee injuries	_____	_____
_____	Lower leg injuries	_____	_____
_____	Ankle/Foot	_____	_____
_____	Frequent headaches	_____	_____
_____	Fainting spells/Dizziness	_____	_____
_____	Heat exhaustion/Heat stroke	_____	_____
_____	Epilepsy or convulsions	_____	_____
_____	Numbness or Tingling	_____	_____
_____	Nosebleeds	_____	_____
_____	Difficulty hearing	_____	_____
_____	Frequent colds	_____	_____
_____	Pneumonia	_____	_____
_____	Heart murmur	_____	_____
_____	High blood pressure	_____	_____
_____	Diabetes	_____	_____
_____	Anemia	_____	_____
_____	Thyroid disorders	_____	_____
_____	Skin disorders	_____	_____
_____	Loss or impairment of an organ	_____	_____
_____	Frequent indigestion or heart burn	_____	_____
_____	Stomach ulcer	_____	_____
_____	Kidney/Bladder problems	_____	_____
_____	Menstrual problems	_____	_____
_____	Chicken pox	_____	_____
_____	Measles	_____	_____
_____	German measles	_____	_____
_____	Mumps	_____	_____
_____	Tuberculosis	_____	_____
_____	Scarlet/Rheumatic fever	_____	_____
_____	Polio	_____	_____
_____	Mononucleosis	_____	_____
_____	Hepatitis	_____	_____
_____	Diphtheria or Tetanus	_____	_____
_____	Other	_____	_____

The undersigned, herewith,

A. Understands that he/she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he/she is discharged from treatment or is given permission by the clinical practitioner to resume participation despite continued treatment.

B. Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics but only that the examiner did not find a medical reason to disqualify him/her at the time of said exam.

C. Certifies that the answers to the questions above are correct and true.

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

Signature of Athlete: _____ Date: _____

Signature of Parent if athlete is a minor: _____ Date: _____

Dear Parents and Student –Athlete,

The National Collegiate Athletic Association (NCAA) has enacted new regulations in helping the health care providers at Mount Saint Vincent; provide better medical care for all Student- Athletes. These new regulations apply a stricter application of the **NCAA’s Banned Drugs and Medical Exceptions Policy**. These new regulations go into effect August 2009. With that target date in mind the Sports Medicine Department at the College of Mount Saint Vincent would like to immediately implement new guidelines so that Mount Saint Vincent will be in compliance with this new regulation prior to August 2009.

The following is an excerpt from the **NCAA’s Banned Drugs and Medical Exceptions Policy**:

The NCAA list of banned drug classes is composed of substances that are generally reported to be performance enhancing. The NCAA bans performance enhancing drugs to protect student-athlete health and safety and ensure a level playing field, and it also recognizes that some of these substances may be legitimately used as medications to treat student-athletes with learning disabilities and other medical conditions.

Accordingly, the NCAA allows exceptions to be made for those student-athletes with a documented medical history demonstrating the need for regular use of such a drug. The benefit of a medical exception procedure is that in most cases the student-athlete’s eligibility remains intact during the process.

Exceptions may be granted for substances included in the following classes of banned drugs: stimulants, beta blockers, diuretics, anti-estrogens, anabolic agents (steroids), and peptide hormones* (Bylaw 31.2.3). (*anabolic agents and peptide hormones must be approved by the NCAA before the athlete is allowed to participate while taking these medications. The institution, through its director of athletics, may request an exception for use of an anabolic agent or peptide hormone by submitting to The National Center for Drug Free Sport (Drug Free Sport) any medical documentation it wishes to have considered.)*

In all cases, a student-athlete, in conjunction with his or her physician, must document that other non-banned alternatives have been considered prior to requesting the medical exception for the use of a medication containing a banned substance. It is the responsibility of the institution to educate student-athletes about this policy, and to follow-up with any student- athlete who identifies the use of a banned medication to determine if standard non-banned medications have been pursued and documented.

In order for a student-athlete to be granted a medical exception for the use of a medication that contains a banned substance, the student-athlete must:

- 1. Have declared the use of the substance to his or her athletics administrator responsible for keeping medical records;*
- 2. Present documentation of the diagnosis of the condition; and*
- 3. Provide documentation from the prescribing physician explaining the course of treatment and the current prescription.*

Requests for medical exceptions will be reviewed by physicians who are members of the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports. Medical exceptions will be granted if the student-athlete has presented adequate documentation noted above. Unless requesting a review for the medical use of an anabolic agent or peptide hormone, a student-athlete's medical records or physicians' letters should not be sent to the NCAA unless requested by the NCAA. Also, the use of the substance need not be reported at the time of NCAA drug testing. Following are three treatment issues to help illustrate the medical exception procedure:

Attention Deficit/Hyperactivity Disorder (ADHD) – is one of the most common neurobehavioral disorders of childhood and can persist through adolescence and into adulthood. ADHD is generally diagnosed in childhood, but sometimes not until college or later. The most common medications used to treat ADHD are methylphenidate (Ritalin) and amphetamine (Adderall), which are banned under the NCAA class of stimulants. In order for a medical exception to be granted for the use of these stimulant medications, the student-athlete must show that he or she has undergone standard assessment to identify ADHD. Frequently a student-athlete may find that the demands of college present difficult learning challenges. They may realize that some of their teammates are benefitting from the use of these medications, and figure they should ask their team physician or family doctor to prescribe the same for them. **If they do not undergo a standard assessment to diagnose ADHD, they have not met the requirements for an NCAA medical exception.** Most colleges provide these types of assessment through their student support services or counseling and testing centers. The student-athlete should either provide documentation of an earlier assessment, or undergo an assessment prior to using stimulant medication for ADHD. If the diagnosis is ADHD, the student-athlete may then pursue treatment with the team physician or family physician for a prescription for stimulant medication, and provide all documentation to the appropriate athletics administrator to keep in the file in the event the student-athlete is selected for drug testing and tests positive. At that point, the athletics administrator will be instructed to provide the documentation for review by the medical panel, and if all is in order, the student-athlete's medical exception is granted.

Male-Pattern Baldness – Androgenic alopecia is a common form of hair loss in both men and women. In men, this condition is also known as male-pattern baldness. Hair is lost in a well-defined pattern, beginning above both temples. Over time, the hairline recedes to form a characteristic "M" shape. Hair also thins at the crown of the head, often progressing to partial or complete baldness. Non-banned medications are available to treat this condition. Finasteride (trade name Propecia), which is prescribed in some cases to treat male-pattern baldness, is a banned substance under the class of masking agents, as it interferes with the ability to identify steroid use. Before using Finasteride, a student-athlete must exhaust other standard medications and document this effort. All documentation should be submitted to the sports medicine staff to review and maintain in the student-athlete's record. In the event a student-athlete tests positive for the use of Finasteride, the institution will then submit the full record for a medical exception review.

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In order to comply with these regulations, the Sports Medicine Department request that all Student-Athletes diagnosed with these or any other illnesses that require the use of banned substances, follow the following guidelines as set forth by the NCAA.

The institution should maintain documentation that supports the use of medication in the student-athlete's medical record on campus. The documentation can be a letter or copies of medical notes from the prescribing physician that documents how the diagnosis was reached, and that the student-athlete has a medical history demonstrating the need for regular use of such a drug. The letter should contain information as to the diagnosis (including appropriate verification of the diagnosis), medical history and dosage information.

These documents should be sent to the Sports Medicine Department at Mount Saint Vincent, where it will be placed in your personal file and kept confidential. If you have any questions please feel free to contact the Head Athletic Trainer Barima Yeboah @ (718) 405-3238.

Sincerely,

Barima Yeboah
Head Athletic Trainer

College of Mount Saint Vincent Sports Medicine
MEDICATION DECLARATION FORM

Use prescription label to complete this form.

Please include all over-the-counter medications and supplements.

NAME: _____ SSN: _____ DOB: _____ TEAM: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

PHYSICIAN: _____ TELEPHONE: _____

MEDICATION NAME: _____

DOSAGE: INSTRUCTIONS: _____

PHARMACY: _____ TELEPHONE: _____ RX NO.: _____

DATE FILLED: _____

COLLEGE OF MOUNT SAINT VINCENT SPORTS MEDICINE

On June 25, 2009, The NCAA adopted the recommendation that Division III athletic departments confirm Sickle Cell Trait status in all student-athletes, if it is not already known, during their required medical examinations.

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 condition (> three million Americans)
- Although Sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central America ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent, or 'sickle' shape), which can accumulate in bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starved for blood.

Participation in athletics is allowed as long as proper precautions are followed to prevent such instances from occurring.

All 50 states screen for Sickle Cell Trait at birth and the information should be available to you by your physician as part of your health information. If you are unsure if you were tested, or if you do not know the results of the test, please contact your physician prior to answering the following question. If necessary you may need to obtain blood test to ascertain your status, two most commonly used test are Hemoglobin Solubility test or Hemoglobin Electrophoresis test.

Name_____ Sport_____ College ID#_____

YES NO Have you ever been tested for Sickle Cell Anemia that you are aware of?

Date? _____ Result_____

YES NO Have you ever been advised that you carry the Sickle Cell Trait or have Sickle Cell Anemia?

Please Describe_____

Yes NO Does any member of your family carry the Sickle Cell Trait or have Sickle Cell Anemia ?

For more information on Sickle Cell Trait: <http://www.nata.org/statements/consensus/sicklecell.pdf>