BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Policy and Procedures for New Student-Athletes (Revised May 2019)

Parent(s), Guardian(s), Student-Athlete,

Welcome to Bowling Green State University and participation in Intercollegiate Athletics. It is our goal to provide our student-athletes with the best possible athletic health care. To achieve this, we will need your assistance with a variety of matters. Each student-athlete will be required to complete the necessary paperwork on file before being allowed to participate in any activity. We will also require a completed Medical Packet which includes: Demographics Sheet, Consent Form, Release Form, Nutritional Disclosure Form, Insurance information, Health History/Physical and Mental Health Screen. Please complete these forms with appropriate signatures and dates. This information will be used by providers for billing and also be used to contact individuals in the event of an emergency. The completed Medical Packet can be brought to campus and delivered in person OR may be mailed to: Daniel Fischer M.Ed., AT, Assistant Athletic Director for Sports Medicine, 1610 Stadium Drive, Sebo Athletic Center, Bowling Green OH 43403. In addition, each student-athlete will be evaluated by an approved member of the BGSU Medical Staff upon reporting to campus. This appointment will be scheduled by a member of the BGSU Athletic Training Staff.

Bowling Green State University requires that all students submit valid and current Medical Insurance. It is also required, by the BGSU Athletic Department, that all student-athletes submit current Medical Insurance Information for participation in BGSU Intercollegiate Athletics. If you do not have current medical insurance, you may get information about the BGSU Student Insurance by calling the Falcon Health Center at (419) 372-2271.

In the event of an athletic injury, the athletic department has purchased an Excess Medical Insurance Policy that will help cover medical expenses that are not covered by your personal medical insurance provider. Since the BGSU Athletic Department Insurance Policy is an excess policy, the student-athlete's own primary insurance will be billed first and our policy will cover the expenses beyond the primary policy in accordance with the policy. Our policy will cover expenses for 104 weeks from the date of initial athletically related injury. After this 104-week period has ended, Bowling Green State University will not be financially responsible for any expenses related to any injuries. As a result, it is imperative that all injuries are reported to the appropriate athletic training personnel immediately. The Athletic Department will not be financially responsible for any injury or illness that is not related to direct participation in BGSU athletics.

Bowling Green State University's Athletic Department assumes no financial or legal responsibility for:

- Unreported injuries including concussions
- Unreported illness and medical conditions
- Charges by a healthcare provider to which a student-athlete was not referred by a member of the Sports Medicine Staff or team physician(s)
- Injuries or conditions not occurring during, or as a results of, participation in a scheduled, supervised practice and/or competition including self-inflicted injuries

We have developed the following procedure to assist in processing bills that may occur as a result of an athletic injury:

1) All medical bills incurred as a result of an athletic related injury will be billed to the student-athlete's own primary insurance first.
2) If we do not have complete or accurate insurance information, bills will be sent directly to you or to the student-athlete.

3) If you or the student-athlete receives any statements and/or bills, submit them to your own primary insurance for payment.
   a) The insurance company will send an Explanation of Benefits (EOB) directly to you explaining:
      i) The carrier has honored the claim and paid all or a portion of the bill.
      ii) Deny the claim entirely due to deductible balances, etc.
      iii) Deny the claim requesting additional information from the policyholder. BGSU's excess insurance policy will not pay on a claim if this is the reason for denial. BGSU will not be responsible for missed payments/collection notices for this reason of denial.
   b) If there remains a balance, you must complete the following:
      i) Submit the EOB, itemized bill/statements, or other pertinent paperwork to the athletic training room and it will be submitted to our excess insurance carrier.
      ii) Our insurance carrier is: AmeriBen P.O. Box 6947 Boise, ID 83707.
      iii) They may contact you for additional information that may be needed to process the claim. Please help them so that your claim may be processed as quickly as possible.
   c) Note: All itemized bills/statements/etc. must be submitted to AmeriBen within one year of the date of service. AmeriBen will deny submissions after this time for timely filing. Bowling Green State University will not be responsible for a claim that has not been submitted due to lack of reporting the necessary bills or EOB's.
4) Anytime the student-athlete's insurance information changes, it is your responsibility to notify the Sports Medicine Department immediately of these changes.
   a) Bowling Green State University will not be responsible for a claim that is not processed due to lack of proper, or accurate, primary insurance information.
   b) Bowling Green State University will not be responsible for a claim that has not been submitted due to lack of reporting the necessary bills or EOB's.
5) All medical treatment, evaluation, testing, etc. must be authorized and referred by a BGSU sports medicine staff member.
   a) Authorizations and referrals will be made by completing appropriate paperwork prior to receiving any such services.
   b) If authorization and/or referral for medical services are not obtained, BGSU will not accept any responsibility for payment of services.
   c) If the injury occurs after hours, a member of the sports medicine staff must be notified by telephone as soon as reasonably possible.
   d) If the condition is an emergency or other unusual circumstances exist not permitting prior completion of paperwork, sports medicine personnel must be notified as soon as reasonably possible.
6) All injuries requiring rehabilitation services will be coordinated through a BGSU Certified Athletic Trainer. If services are required at a different location, other than a BGSU Sport Medicine facility, then prior approval for services MUST be obtained. If this procedure is not followed, all bills will be the responsibility of the student-athlete Note: if these services are "out of network" – charges will be the student-athlete's responsibility.
7) BGSU sports medicine will not be liable for any medical expenses related to vision except for replacement/repair of damaged eyeglasses, protective eye wear, or contact lenses or injury to the eye as a result of direct participation in sport related team activities.
8) BGSU sports medicine will not be liable for dental expenses unless resulting from participation in sport related team activities

Failure to return this completed form will cause delays in your Pre-Season Physical Exam and Medical Clearance to participate in athletics at Bowling Green State University. Contact your Athletic Trainer if you have questions Thank you in advance for your prompt attention to the enclosed material.

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Respectfully,

Daniel Fischer, M.Ed., AT
Assistant Athletic Director for Sports Medicine/Insurance Coordinator
Bowling Green State University
dafisch@bgsu.edu

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

STUDENT ATHLETE'S NAME:		SPORT:
DATE OF BIRTH:	BGSU ID#:	Circle One: Fr RSF So RSSo Jr RSJr Sr RSSr

	CELL PHONE:		BGSU EMAIL ADDRESS:	

HOME	FIRST AND LAST NAMES:	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
	HOME MAILING ADDRESS:	Street:	Street:
		City/ State/ Zip:	City/ State/ Zip:
	HOME PHONE #	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
	CELL PHONE #	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
	DATE OF BIRTH	MOTHER: (Or Guardian)	FATHER: (Or Guardian)

EMERGENCY CONTACT	CONTACT'S NAME:	
	RELATIONSHIP:	
	EMERGENCY CONTACT'S #:	

INSURANCE INFO	POLICY HOLDER NAME:			POLICYHOLDER DATE OF BIRTH:	
	NAME OF INSURANCE COMPANY				
	INSURANCE ADDRESS			INSURANCE PHONE NUMBER:	
	POLICY NUMBER:			GROUP NUMBER:	
	RELATIONSHIP OF POLICY HOLDER			MEDICAID? (CIRCLE ONE)	YES NO
	Rx GROUP:		Rx BIN:	Rx PCN:	

1. I hereby verify that I have submitted a front and back copy of my insurance card:

Student-Athlete Signature (Required) Date (Required)

(Parent signature required if S-A is under 18 years old)

2. I hereby verify that I am currently covered under this insurance plan and will inform the Athletic Dept. of any changes:

Student-Athlete Signature (Required) Date (Required)

(Parent signature required if S-A is under 18 years old)

3. I hereby verify that I have read and understand the sports medicine departments policy and procedures rules and regulations:

Student-Athlete Signature (Required) Date (Required)

(Parent signature required if S-A is under 18 years old)

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Student-Athlete Nutritional Supplement Disclosure Form

Student-Athlete Name: _____ **Sport:** _____

I am **NOT** now or do not intend to take any nutritional supplements.

_____

Student-Athlete Signature Date

****

I am taking or intend to take the following nutritional supplements.

I acknowledge the risks to my health and the risk of losing my eligibility to participate I intercollegiate athletics if I take nutritional supplements and test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA or that may be detrimental to my health. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NCAA or Bowling Green State University endorses or approves of its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substances banned by NCAA or that could be harmful. By making this disclosure, I am accepting the risks known and inherent to taking these supplements. By listing these products and their ingredients below they will be reviewed by my institution's sports medicine staff for the purpose of determining whether they are medically safe to use and that they do not contain substances banned by the NCAA. I understand that even with the review by my institution's sports medicine staff the use of these substances can result in injury, including the possibility of death, and could result I a positive NCAA drug test. **I should not take or use these products until their usage has been reviewed by my institution's sports medicine staff, and even then, I use them at my own risk.**

	Brand Name	Listed Ingredients	Banned Substances (Yes or No)
1.			
2.			
3.			
4.			
5.			

_____

Student-Athlete Signature Date

I have reviewed this disclosure and educated the student-athlete about the possible risks and side effects of taking nutritional supplements.

_____

BGSU Sports Medicine Staff Signature Date

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Release, Consent to Treatment, and Indemnification Agreement

Student-Athlete Name: _____ **Sport:** _____

In consideration of being permitted to participate in intercollegiate athletics within the Department of Intercollegiate Athletics ("DIA") at Bowling Green State University, and to use the DIA's facilities and equipment, I understand and acknowledge that:

- Participation in sports requires an acceptance and assumption of risk of serious medical injury.
- Participation in intercollegiate athletics may expose me to hazards that may result in my illness, personal injury, or death. I understand and appreciate the nature of such hazards and risks.
- I am responsible for knowing the risks of injury associated with participation in, and adhering to rules and regulations applicable to my specified sport, including but not limited to those employed to minimize my risk of significant injury while participating in my sport.
- I must refrain from practice and competition during my medical treatment until I am discharged and given permission to resume activities by a BGSU team physician or BGSU sports medicine staff member.
- BGSU is not responsible for any previous or pre-existing medical condition(s) that I may have or injuries and illnesses that are not directly related to an official practice, contest, or conditioning session.
- I have read, fully understand and agree to be bound by the DIA's medical policies and procedures. In the event of illness or injury, BGSU will only be responsible for my care and treatment for one year after the date of such illness or injury and only if I follow the proper procedures I gaining medical treatment as outlined I the DIA's medical policies and procedures.
- I am eighteen years of age or older, under no legal disability, and am fully competent to sign this agreement.

RELEASE

In further consideration of being permitted to participate in intercollegiate athletics, I hereby accept all risks to my health and of my injury or death that may result from such participation. I hereby release and discharged BGSU, its board of trustees, officers, employees, agents and representatives from any liability to me, my personal representatives, heirs, next of kin, and assigns, from any and all claims, causes of action, damages, and costs for any and all illness or injury to myself, including death that may result from or occur during my participation, or loss of or damage to my property, to the full extent allowed by law.

CONSENT TO TREATMENT

In further consideration of being permitted to participate in intercollegiate athletics, I hereby authorize and consent to such diagnostic, medical and/or surgical treatment as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury arising from or sustained by me while engaged in activities related to intercollegiate athletics. The attending physician(s), athletic trainers(s), appropriate staff, and BGSU and its officers, agents, and employees shall not be responsible in any way for ay consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims of causes that may arise, grow out of, or be incident to such diagnosis and treatment, to the full extent allowed by law.

INDEMNITY

In further consideration of being permitted to participate in intercollegiate athletics, I further agree to indemnify and hold harmless the BGSU and its board of trustees, officers, employees, agents and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in my sport.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING I INTERCOLLEGIATE ATHLETICS, AND THAT IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY TO OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION. THIS AUTHORIZATION EXPIRES SIX (6) YEARS FROM THE DATE IT IS SIGNED, UNLESS REVOKED EARLIER IN WRITING.

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

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Authorization for the Release of Medical Information

Initial	_____	**Authorization for the release of medical information to Athletic Training Students and other BGSU Sports Medicine Staff members**
Initial	_____	**Authorization for the release of medical information to BGSU Coaches and other BGSU athletic department staff**
Initial	_____	**Authorization for the release of medical information to Professional Teams and Representatives**
Initial	_____	**Authorization for the release of medical information to parents and/or guardians**
Initial	_____	**Authorization for the release of medical information to BGSU Sports Information Staff and other Media**
Initial	_____	**Authorization for the release of Drug Testing Results to parent(s), legal guardian(s), and/or both**

This authorizes the athletic trainers, team physicians and athletics staff, including coaches representing Bowling Green State University, to release information concerning my medical status, medical conditions, injuries, prognosis, diagnosis and related personally identifiable health information to groups mentioned above. This information includes injuries or illnesses relevant to past, present or future participation in athletics at Bowling Green State University.

The reason for this disclosure is to all such individuals participating in the delivery of athletic training services to assist and participate in the providing of healthcare to me while I am a student-athlete. I understand that the entities that receive this information are not healthcare providers or health plans covered by federal privacy regulations, and that the information described above may be re-disclosed publicly and that the information will no longer be protected by those regulations.

I understand that this information will be shared via mediums including but not limited to: verbal communication, phone calls, text messages, email messages.

I understand that Bowling Green State University 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 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 Director of Sports Medicine, but if I do, it will not have any effect on actions the University took in reliance on this authorization prior to receiving the revocation. **This authorization expires one year from the date it is signed, unless revoked earlier in writing.**

_____ _____

Printed Name of Student-Athlete | Sport

_____

BGSU Student ID number

_____ _____

Student-Athlete Signature | Date

_____ _____

Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age) | Date

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Initial Athletic Health History Form
&Pre-Participation Physical Exam

Name: _____ Date of Birth: _____ Sex: M F

Sport: _____ Class: Frosh Soph JR SR 5th YR BGSU ID: _____

Home Address: _____

Campus Address: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Physician's Name/Address/Phone #:

MEDICAL HISTORY	Y	N
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Were you born without or have you suffered the loss of a lung, kidney, eye, testicle, ovary, or any other organ?	☐	☐
3. Has a doctor ever told you that you have : (Circle, if yes) High Blood Pressure Heart Murmur Heart Problem High Cholesterol Heart Infection	☐	☐
4. Have you ever passed out or nearly passed out **during** exercise?	☐	☐
5. Have you ever passed out or nearly passed out **after** exercise?	☐	☐
6. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
7. Does your heart race or skip beats during exercise?	☐	☐
8. Do you tire more quickly than your teammates?	☐	☐
9. Has a doctor ever treated you for asthma or seasonal allergies?	☐	☐
10. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
11. When exercising in the heat, have you had severe muscle cramping?	☐	☐
12. Have you ever become ill from exercising in the heat?	☐	☐
13. Have you ever been told you have Sickle Cell Anemia or Trait?	☐	☐
DO YOU HAVE OR HAVE YOU EVER HAD:	**Y**	**N**
14. Pneumonia?	☐	☐
15. Mononucleosis?	☐	☐
16. Rheumatic Fever or Scarlet Fever?	☐	☐
17. Diabetes?	☐	☐
18. Epilepsy/ Convulsions/ Seizures?	☐	☐
19. Any bleeding problems or Anemia?	☐	☐
20. An immune system disease?	☐	☐
21. Kidney Disease?	☐	☐
22. A hernia?	☐	☐
23. A stomach disorder or appendicitis?	☐	☐
24. Recurrent headaches?	☐	☐
25. Abdominal pain or nausea?	☐	☐
26. Been hospitalized?	☐	☐
27. Any surgeries?	☐	☐
28. A stress fracture?	☐	☐
29. A screw, pin or plate surgically implanted into your body?	☐	☐
30. Are you taking **ANY** prescription or over-the-counter medicines?	☐	☐
31. Are you taking **ANY** supplements, vitamins or herbs?	☐	☐
32. An allergic reaction to medication, food or insects?	☐	☐
33. Is any doctor presently treating you for any disorder?	☐	☐
34. An MRI, MR-Arthrogram, X-ray, CT scan or Bone Scan?	☐	☐
HEARING HISTORY	**Y**	**N**
35. Do you currently have any problems with your Hearing?	☐	☐
36. Have you experienced an ear ache in the last 12 months?	☐	☐
37. Do you feel that your hearing is good?	☐	☐
38. Do you wear any corrective hearing devices?	☐	☐

VISION HISTORY	Y	N
39. Do you wear glasses or contact lenses?	☐	☐
40. Have you experienced any eye infections in the past 12 months?	☐	☐
41. Do you feel that your vision is good?	☐	☐
DENTAL HISTORY	**Y**	**N**
42. Do you have any chipped, loose or missing teeth?	☐	☐
43. Do you wear any dental appliances? (i.e. Retainer, spacers…)	☐	☐
44. Are you currently experiencing any dental problems?	☐	☐
FAMILY HISTORY	**Y**	**N**
45. Family history of Heart conditions?	☐	☐
46. Family history of High blood pressure?	☐	☐
47. Family history of Sickle cell anemia or trait?	☐	☐
48. Family history of Dying during or following exercise?	☐	☐
49. Family history of Death prior to the age of 50?	☐	☐
50. Family history of Asthma?	☐	☐
51. Family history of Marfan's syndrome?	☐	☐
52. Family history of Eating disorders?	☐	☐
53. Family history of Depression?	☐	☐
FEMALES ONLY SECTION	**Y**	**N**
54. At what age was your first menstrual period? Age:		
55. When did your last menstrual period begin? Date:		
56. What was the longest time between periods in the last year?		
57. Have you even been on birth control pills or injections?	☐	☐
GENERAL QUESTIONS	**Y**	**N**
58. Have you been wearing any type of brace, support, or other special padding for participation in athletic activities?	☐	☐
59. Have you had an illness or injury in the last 12 months that has not been listed previously?	☐	☐
60. Have you used in the past or are you currently using any type of performance enhancing substances or drugs?	☐	☐
61. Are you currently taking medication for Attention-Deficit Hyperactive Disorder?	☐	☐
62. Do you know of any health reason why you should not participate in the BGSU athletic programs at this time?	☐	☐
63. Have you ever been prescribed an inhaler or currently use one?	☐	☐

EXPLAIN ALL "YES" ANSWERS TO THE ABOVE QUESTIONS IN THIS SPACE REFERRING TO THE QUESTIONS BY THEIR NUMBER:	
#	
#	
#	
#	
#	
#	
#	
#	
#	
#	

HAVE YOU HAD AN INJURY OF:	Yes	No	Side		Date	Current Problem?	
64. **HEAD** (concussion- 'knocked out', surgery, hospitalization, other)	☐	☐	LT	RT		Yes	No
65. **FACE** (fracture, eye, ear, nose, surgery, other)	☐	☐	LT	RT		Yes	No
66. **NECK** (strain, fracture, stingers, burners, surgery, other)	☐	☐	LT	RT		Yes	No
67. **SHOULDER** (dislocation, strain, sprain, rotator cuff injury, tendonitis, surgery, other)	☐	☐	LT	RT		Yes	No
68. **ARM/ELBOW** (sprain, strain, tendonitis, fracture, dislocation, surgery, other)	☐	☐	LT	RT		Yes	No
69. **WRIST/THUMB/HAND** (sprain, strain, tendonitis, fracture, dislocation, surgery, other)	☐	☐	LT	RT		Yes	No
70. **FINGERS** (sprain, facture, surgery, other)	☐	☐	LT	RT		Yes	No
71. **CHEST** (pain, lungs, heart, surgery, other)	☐	☐	LT	RT		Yes	No
72. **ABDOMEN** (kidney, spleen, appendix, liver, surgery, other)	☐	☐	LT	RT		Yes	No
73. **GENITALIA** (groin, testicle, ovary, warts, surgery, other)	☐	☐	LT	RT		Yes	No
74. **BACK** (strain, sprain, fracture, chronic pain, disc, surgery, other)	☐	☐	LT	RT		Yes	No
75. **HIP/THIGH** (strain, fracture, surgery, other)	☐	☐	LT	RT		Yes	No
76. **KNEE** (sprain, cartilage, bursitis, tendonitis, patella, surgery, other)	☐	☐	LT	RT		Yes	No
77. **LOWER LEG** (sprain, strain, fracture, tendonitis, shins, surgery, other)	☐	☐	LT	RT		Yes	No
78. **ANKLE** (sprain, strain, fracture, tendonitis, surgery, other)	☐	☐	LT	RT		Yes	No
79. **FOOT** (sprain, fracture, strain, tendonitis, surgery, other)	☐	☐	LT	RT		Yes	No
80. **TOES** (sprain, fracture, surgery, other)	☐	☐	LT	RT		Yes	No
81. **OTHERS:**	☐	☐	LT	RT		Yes	No

EXPLAIN ALL "YES" ANSWERS TO THE ABOVE QUESTIONS (#64-81):	
#	
#	
#	
#	
#	
#	

DIET HISTORY				
DO YOU HAVE or HAVE YOU EVER HAD:	Yes	No	Date	Explain
82. Anorexia, Bulimia, or any other eating disorders?	☐	☐		
83. Do you want to weigh more or less than you do right now?	☐	☐		
84. Have you ever induced vomiting to control your weight?	☐	☐		
85. Have you ever used laxatives, diuretics or diet pills for weight loss?	☐	☐		
86. Are you currently taking any vitamins, minerals, or supplements?	☐	☐		
87. Are there any food groups you choose not to eat (meat, dairy, etc.)?	☐	☐		
88. What is your ideal weight?	Weight:		LBS	
89. What Foods, including supplements, have you eaten in the last 24 hours?				
Breakfast:				
Lunch:				
Dinner:				
Snacks				

THE UNDERSIGNED ATHLETE:

1. Understands that he/she must refrain from practices 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 a Bowling Green State University Team Physician to restart participation despite continuing treatment.
2. Understands that having passed the physical examination does not mean that he/she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him/her at the time of the said evaluation.
3. Certifies that the answers to the above questions are correct and true to the best of his/her knowledge.

ATHLETE's SIGNATURE: _____ DATE: _____

PARENT's SIGNATURE: _____ DATE: _____
(required if athlete is under 18 years of age)

I have reviewed this history with the student-athlete, documented all yes answers, and requested all necessary medical records.
BGSU MEDICAL STAFF SIGNATURE: _____ DATE: _____

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Physical Examination

Name: _____

Height: _____ Weight: _____ % Body Fat (optional): _____

Vision: L 20/____ R 20/____ Corrected Y N Glasses Y N Contacts Y N Pupils: ☐ Equal ☐ Unequal

Pulse: _____ BP: Left arm ____/____ Right Arm ____/____

(PRN BP Recheck or position) Left arm ____/____ Right Arm ____/____

	NORMAL	*Comments regarding Abnormal Findings*	*INITIALS**
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitilia (males only)			
Skin			
MUSCULOSKETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

STATUS

☐ **Cleared**

☐ **Cleared after completing evaluation/rehabilitation for:** _____

☐ **Not Cleared for:** _____ **Reason:** _____

Recommendations: _____

Name of examiner (Print/type): _____ Date: _____

Address of examiner: _____ Phone: _____

Signature of examiner: _____

Modified from the form approved by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine and American Osteopathic Academy of Sport Medicine.

February 2010

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Informed Consent for Sickle Cell Trait Screening

- I consent to have a sample of blood drawn in order to determine if I have Sickle Cell Anemia Trait.
- I understand the results will be made available to BGSU Sports Medicine Personnel, BGSU Coaches, as well as BGSU Health Center Staff.
- I understand the results will not determine eligibility nor influence depth chart decisions.

Print Name

Sign Name

Date

☐ I Refuse the Above Available Testing due to prior knowledge of testing results and I will provide Bowling Green State University with the necessary documentation of my testing results.

Print Name

Sign Name

Date

BOWLING GREEN STATE UNIVERSITY SPORTS MEDICINE

Informed Acknowledgement of Non-Athletically Related Physician Appointment

- I understand that scheduling an appointment with my certified athletic trainer to be seen by a physician (General Practitioner or Orthopedic) for a non-athletically related illness or injury is a courtesy extended to student-athletes.
- I understand that my attendance at this appointment **does not release** me from any and all costs associated to, or generated from, the appointment itself or any subsequent costs such as, but not limited to, insurance co-pay, lab fees, radiology, etc.
- I understand an athletically related injury is considered to be an injury sustained during organized intercollegiate activities. On-campus intramurals, recreational sport leagues, etc are considered non-athletically related and need to be reported to my certified athletic trainer.
- By signing below I acknowledge and accept the responsibility of payment for non-athletically related injury and illness.

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