



Dear Potomac State College Student Athletes and Parents:

We are please to have your son/daughter as a student athlete at Potomac State College of West Virginia University and hope that he/she will achieve academic and athletic success. Enclosed with this letter are the pre-participation physical examination, health insurance and medical forms needed to participate in intercollegiate athletics. Please thoroughly read and complete the enclosed paperwork. Athletes are required to return these completed forms to their coach or the Certified Athletic Trainer or they will **not be permitted to participate in practice or competitions** at Potomac State.

Please acknowledge the following key policy while reviewing this packet:

- Each student athlete is required to have a yearly medical physical examination. This can be completed by your physician, or our team physician will complete the physical the first week of classes in the fall. Student Athletes will not be permitted to participate if they do not have a completed physical. The Potomac State College Team Physician has the final authority to medically clear an athlete for participation.

It is the Athletic Training Department's goal to provide high quality medical care to all student-athletes. Unfortunately accidents and injuries do occur while participating in intercollegiate athletics. Please contact me at 304-788-6880 or by e-mail at Amanda.Cox@mail.wvu.edu if you have any questions or concerns.

Sincerely

Amanda Cox, ATC
Head Athletic Trainer
Potomac State College

Potomac State College of WVU

Pre-Participation Medical History Exam

Name: _____ Birthdate: ___/___/___
Social Security Number: ___-___-____ Sport(s): _____

History:

- 1) Has the student athlete ever:
- | | Yes | No | Explain/Date |
|-------------------------------------|-----|----|--------------|
| Had a concussion? | Yes | No | _____ |
| Had an Operation? | Yes | No | _____ |
| Had heat exhaustion or heat stroke? | Yes | No | _____ |
| Had a head or neck injury? | Yes | No | _____ |
| Had a back or spinal injury? | Yes | No | _____ |
| Had a Knee Injury? | Yes | No | _____ |
| Had a heart murmur? | Yes | No | _____ |
| Had High Blood Pressure? | Yes | No | _____ |
| Had a Heart Problem? | Yes | No | _____ |
| Fainted while exercising? | Yes | No | _____ |
| Had Irregular Menstrual Cycles? | Yes | No | _____ |
| Had any chronic illness? | Yes | No | _____ |
- 2) Does the student athlete:
- Take Medication Regularly? Yes No
If Yes: _____
- Wear glasses or contact lenses? Yes No
Wear Dental Appliances or Hearing aids? No
If Yes: _____
- Have any Allergies? Yes No
If Yes: _____
- Have any chronic illnesses (i.e. asthma, diabetes?) No
If Yes: _____
- 3) Has any physician ever limited the student athlete's athletic participation?
Yes No If Yes: _____
- 4) Has the student athlete injured any of the following? If Yes, explain with date.
- Hand/Wrist? _____
Arm? _____
Shoulder? _____
Foot? _____
Ankle? _____
Leg? _____

This is to certify that the responses to the above questions are correct and that I understand that this examination is designed solely for screening athletes prior to their participation in intercollegiate athletics and should not be considered a complete medical examination.

Signature: _____ Date: _____

This section to be completed by physician

Height: _____ Weight: _____

Pulse: _____ Blood Pressure: _____

Medical Findings:

	Normal	Abnormal	Comments
Neck			
Shoulders			
Arms			
Elbows			
Wrists/Hands			
Hips			
Knees			
Feet/Ankles			

	Normal	Abnormal	Comments
Appearance			
Ears/Eyes/Nose			
Lymph Nodes			
Pulses			
Heart/Lungs			
Abdomen			
Genitalia (male)			
Skin			

Clearance:

Cleared Not Cleared (Reason) _____

Recommendations/Limitations/Comments:

Physician's Signature: _____

Date: _____

Potomac State College of WVU
Athletic Insurance Information

This form must be returned to the Athletic Department **before** the first day of practice.

Student Information:

Name: _____ Birthdate: _____
Social Security Number: ____-____-____ Sport(s): _____
Home Address: _____
Home Phone Number: _____ Cell Number: _____
Local Address: _____

Emergency Contact: (if parent/guardian cannot be reached)

Name: _____ Relation: _____
Home Number: _____ Cell Number: _____

Guardian/Father Information:

Name: _____
Address: _____

Home Phone: _____
Employed: ____ Yes ____ No
Work/Cell Number: _____

Guardian/Mother Information:

Name: _____
Address: _____

Home Phone: _____
Employed: ____ Yes ____ No
Work/Cell Number: _____

Does the Student Athlete have insurance coverage? ____ Yes ____ No
Insurance Company: _____
Address: _____
Phone Number: _____
Group Number: _____
Group Name: _____
PPO? ____ HMO? ____

Please Attach a Copy of front and Back of Insurance Card

**Potomac State College of WVU
Medical Consent and Acceptance of Risk Affidavit**

I hereby grant permission to Potomac State College team physicians and/or their consulting physicians to render any treatment or medical or surgical care that they deem necessary to the health and well-being of the undersigned student athlete.

I also hereby authorize the athletic trainers at Potomac State College, who are under the direction and guidance of the PSC team physicians, to render any preventative, first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to the health or well-being to the undersigned student athlete.

Student Athlete's Name: _____

Student Athlete's Signature: _____

I, _____,

A) understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me.

B) understand that I must refrain from practices or games during medical treatment until I am discharged from treatment by a physician and the Certified Athletic Trainer.

C) understand and accept the risks of injury, permanent disability, and death that are inherent in my sport. By signing below, I pledge to do the best to reduce these risks by keeping in the best possible condition and by following the advice of a physician, Certified Athletic Trainer and coach concerning the prevention, treatment and rehabilitation of athletic injuries.

D) I grant permission to the coaching staff, Athletic Department and Certified Athletic Trainer to hospitalize and secure treatment for myself for any athletic injuries. If the athlete is a minor, the undersigned parent grants permission to the coaching staff, Athletic Department and Certified Athletic Trainer to hospitalize and secure treatment for his/her son/daughter.

Student Athlete's Signature: _____ Date: _____

Parent/Guardian Signature (if athlete is minor): _____