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:  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:

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<td>Feet/Ankles</td>
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<td>Skin</td>
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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:                       Guardian/Mother Information:

Name: _______________________________ Name: _______________________________
Address: _____________________________ Address: _____________________________
_______________________________________ ________________________________
Home Phone: _______________________ Home Phone: ______________________
Employed: _____ Yes _____ No Employed: _____ Yes ____ No
Work/Cell Number: _________________ 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*
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): _____________________________