

Athlete Name \_\_\_\_\_ Sport \_\_\_\_\_



Athletic Training Room

**Emergency Contact:**

Parent/Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

*In case your Parent/ Guardian cannot be contacted:*

Notify \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**Athlete Information:**

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Local Address (or Dorm/Room #) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone or other Number ( \_\_\_\_\_ ) \_\_\_\_\_

**Medical Doctor Information**

Local M.D. Name \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Office Address \_\_\_\_\_ Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_  
\_\_\_\_\_

**Medical Insurance:**

Primary Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
Policy Number \_\_\_\_\_ and/or Group Number \_\_\_\_\_

Who does this policy belong to (circle one)?                      MOM/DAD                      SELF

\*If you circled "MOM/DAD" complete the following:

Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

(COPY OF CARD ON BACKSIDE)

Sport \_\_\_\_\_



Returning Athlete Health Questionnaire

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Gender: MALE/FEMALE Eligibility Level: SOPHOMORE/JUNIOR/SENIOR

(All information provided on this form is confidential and will be available only to the Vanguard University Sports Medicine Staff)

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH REGARD TO THE LAST 6 MONTHS.

- 1. Have you sprained or dislocated a joint? Yes No
2. Have you strained (pulled) a muscle? Yes No
3. Have you fractured a bone? Yes No
4. Have you had pain during or after activity? Yes No
5. Have you had surgery to a bone or joint? Yes No
6. Have you had a head or neck injury? Yes No
7. Have you been knocked out or been unconscious? Yes No
8. Have you had a concussion? Yes No
9. Do you have frequent or repeated headaches? Yes No
10. Have you had a burner, stinger, or had one of your limbs feel numb or "fall asleep" during activity? Yes No
11. Have you had unexplained muscle weakness? Yes No
12. Have you experienced pain/discomfort in the chest, neck, jaw or arms during or after sport participation? Yes No
13. Have you experienced dizziness or passed out during or after sport participation? Yes No
14. Have you experienced shortness of breath at rest or with mild exercise? Yes No
15. Have you experienced high or low blood pressure? Yes No
16. Have you noticed rapid heart palpitations or felt like your heart raced? Yes No
17. Have you been told you have a heart murmur, an irregular heartbeat, or any heart disease? Yes No
18. Has anyone in your family died suddenly due to heart related disease? Yes No
19. Have you experienced excessive coughing during or after sport participation? Yes No
20. Have you experienced breathing difficulties or been told you have asthma, bronchitis, or allergies? Yes No
21. Have you been advised that you should not participate in the sport(s) that you intend to participate? Yes No
22. Are you currently seeing a doctor for a medical problem? Yes No
23. Have you been diagnosed with a disease or been hospitalized overnight for a disease? Yes No
24. Have you experienced an epileptic seizure or been informed that you might have epilepsy? Yes No
25. Have you had any general surgery or operation? Yes No
26. Are you currently taking any prescription medications? Yes No
27. Have you had the flu, pneumonia, upper respiratory tract condition or mononucleosis in the past 6 months? Yes No
28. Over the past six months, have you experienced any injury or disorder not covered above? Yes No
29. Do you or any of your family members have the Sickle Cell Trait or Sickle Cell Disease? Yes No
30. Do you have any known allergies (i.e. medication, food, insects, etc)? Yes No

Please use this space for necessary explanations:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

I hereby certify that all answers to the preceding questions are correct and true. I understand that that having passed my physical examination does not mean that I am physically qualified to engage in athletics, but only that the examiner found no medical reason to disqualify me.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



Vanguard University
Department of Athletics-Sports Medicine

STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

I, \_\_\_\_\_, \_\_\_\_\_ acknowledge
Student-Athlete Print Name Sport

that I am currently taking and/or have (within the past 6 months) taken the following ergogenic aids, creatine powder, amino acids, protein supplements or either similar substances, hereinafter referred to as "Supplements." (Use the back of this form if necessary.)

Table with 4 columns: Name, Dosage, Main Ingredients, Comments. The table is currently empty.

I understand and agree:

- a) Vanguard University Department of Intercollegiate Athletics neither approves of nor condones the use of Supplements;
b) I have been informed of the Vanguard University Department of Intercollegiate Athletics, Golden State Athletic Conference, (GSAC), and National Association of Intercollegiate Athletics (NAIA), policies with regards to the use of supplements and have had any of these questions about these policies answered;
c) The use of supplements may result in serious harm to myself, possibly permanent injury and even death;
d) I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NAIA banned substance/drug;
e) I must list all the substances on the chain of custody form at the time of the drug test.

I fully except any and all risk and liability if I have used in the past, continue to use, or use at anytime in the future any form of supplements.

I further understand and agree Vanguard University, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, and/or future use of Supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release Vanguard University, and their officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of Supplements.

I understand the statements in this form, and have had all questions about the information in this form answered to my satisfaction.

Student-Athlete's Signature

Date

Parent or Guardian (if under 18 years old)

Date



Athletic Training Room

Assumption of Risk & Responsibility

I, (print name) \_\_\_\_\_, intend to participate/compete in Vanguard University Athletics in the sport(s) of \_\_\_\_\_.

I understand and accept that activities involved in the above mentioned sport may result in various injury, including but not limited to: Sprains/Strains, Unconsciousness, Fractured Bones, Head/Neck injuries, Loss of Eyesight, Paralysis, Communicable Diseases, and even Death. I understand that the dangers and risks of playing or practicing in the above named sport may result not only in injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

I understand and accept, that the Athletic Treatment Center, the Athletic Department, and Vanguard University employees will uphold their responsibility to me and I hereby assume all the risks associated with participation. I agree to hold Vanguard University, its' employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, cause of action, debts, claims or demands of any kind and nature whatsoever, which may arise by or in connection with my participation in the above named sport at Vanguard University. The terms hereof shall serve as a release and assumption of risk and responsibility for my heirs, estate, executor, administrator, assignees, and for all members of my family.

I understand that if an injury should occur that requires medical treatment beyond the capabilities of the Athletic Treatment Center and Vanguard University, I am financially responsible and liable for any and all medical bills pursuant to that medical treatment. Additionally, should I wish to seek any medical assistance or care outside of what is referred or recommended by the Athletic Treatment Center, I will assume any or all financial responsibility (i.e. chiropractors, massage therapy, physical therapy).

I understand that my participation/competition in Vanguard University Athletics is dependent on my possession of primary insurance, and that participation/competition will not be allowed until proof of primary insurance is provided. I also understand that while I am a student-athlete at Vanguard University, I will be covered under a secondary insurance provided by the institution that will pay the remaining portion of any medical bill once they receive an itemized bill showing that the primary insurance has covered their financial responsibility.

Signature of Student-Athlete \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Student-Athlete \_\_\_\_\_

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If the student-athlete is under 18 years of age at the commencement of sport participation, a parent's signature is required.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

VANGUARD UNIVERSITY  
ATHLETIC DEPARTMENT MEDICAL POLICIES  
Athletic Training Services

The Athletic Training staff is here to assist the student-athlete with the correct procedures for handling and getting their claims paid off in a timely manner. The staff does not handle any receipts or billing problems that may occur. The student-athlete is responsible for keeping their own medical receipts, filing their own insurance claim, and for any follow-up if problems occur.

The Vanguard University Department of Athletics provides outstanding care to our student-athletes in specific NAIA limitations and guidelines. The following is an explanation of the University's procedure concerning athletic injuries and payment of medical expenses. As a student-athlete at VU it is extremely important that you understand the nature of the medical coverage provided for athletic injuries.

1. Only those medical expenses due to injury or illness sustained by the student-athlete as a direct result of practice or participation in intercollegiate athletics at Vanguard University and cleared by the Certified Athletic Training staff can be covered by our insurance. Expenses to treat a student-athlete's injury or illness that is not a result of practice or participation in intercollegiate athletics at VU or is defined as a pre-existing injury **CAN NOT BE COVERED**. This includes off-season non-team related orthopedic injuries, medical procedures such as cardiac testing, appendectomy, tonsillectomy, hernia, etc. Therefore it is recommended that all student-athletes carry health and accident insurance that will cover in the above situations.
2. In all cases involving injury due to competition or organized practice, the Athletic Department's coverage is considered **EXCESS OR SECONDARY** and the student-athlete's personal or parental health insurance is considered **PRIMARY**. This means that the student-athlete or the parents must first submit a claim with their health insurance company. After the primary insurance has paid on the allowable charges, a copy of the Explanation of Benefits (EOB), medical bills and or a statement showing the balance needs to be submitted to the Head Athletic Trainer. The balance will then be paid by VU insurance. We do not want any expenses to be incurred by the student-athlete or parents if the medical problem is due to VU intercollegiate sport(s). Therefore, if there are any deductible expenses not covered by the primary insurance, please contact us and VU will take care of those charges.
3. Student-athletes with HMO (Health Maintenance Organizations) insurance such as: Kaiser, Cigna, Foundation, Maxicare etc. **MUST** visit their HMO physician for primary evaluation, diagnostic testing and surgical procedures (unless cleared by the VU Athletic Director). The VU Athletic Training Staff will assist you in every way to expedite appointments.
4. The VU Athletic Department **WILL NOT** be responsible for costs of medical services except those cleared the VU Athletic Training Staff. Any student-athlete who takes it upon him or her self to seek medical services without authorization from the VU team physician or Athletic Training Staff does so at his or her own expense.
5. Minor injuries, minor illnesses, and or medical concerns are taken care of by the Athletic Training Staff/ VU Student Health Center, and team physicians. The student-athlete should report all injuries and or illnesses to the Athletic Training Staff as soon as possible.
6. The complete summary of benefits for Vanguard University student-athletes is available in the Athletic Training Room.

I confirm that I have read and understand the above information.

**Student-Athlete Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Vanguard University  
Department of Athletics

**CONSENT FOR DRUG TESTING**  
Academic Year 2009-2010

I certify by my signature that I have read the "**POLICY STATEMENT – DRUG EDUCATION AND TESTING PROGRAM FOR VANGUARD UNIVERSITY STUDENT-ATHLETES**" and "**THE VANGUARD UNIVERSITY DRUG PROGRAM PROTOCOL**" and I understand the Policy that is attached to the Policy Statement and Protocol. I have also read the list of banned substances that is a part of the Policy Statement. I recognize that I will be asked to provide urine for drug analysis, and I \_\_\_\_\_ hereby consent to have samples of my urine collected and tested in accordance with the Policy Statement and Protocol.

I agree to fully cooperate with the testing program described in the Policy Statement and the Protocol, and I will not dispute the right of Vanguard University to perform such tests on me. I also agree to inform the University physician, Head Athletic Trainer or Athletic Director whenever I am taking one or more of the listed substances under medical supervision. I recognize that this information is necessary to assist my physician in providing me with the best possible medical care, should such care be needed.

In accordance with the Policy Statement, I specifically authorize the Vanguard University Counseling Center to release to the Vanguard University Sports Medicine Staff, Head Coach and Athletic Director all information and records relating to the testing of my urine samples if I test positive a second time. To the extent permitted by law, information obtained in the operation of the drug education and testing program for Vanguard University student-athletes shall be confidential.

\_\_\_\_\_  
Student Name (Print)

\_\_\_\_\_  
Sport(s)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Signature for minor students

\_\_\_\_\_  
Date