UFV First Year Medical Form 2016-17

PLEASE PRINT LEGIBLY IN INK; Take your time and answer thoroughly.

This must be completed prior to ANY participation in a UFV Cascades Athletics practice, game, or event by anyone who has not completed this form previously. Submit fully completed form to Tyne Campbell, UFV Head Athletic Therapist.

General Information

Name: _____ Sport/ Year of eligibility _____

Date of birth: ___/___/___ Age: _____ Gender : M / F Student ID #: _____
Month Day year

Care Card #: _____ Province: _____

All students are part of the Student Union Health and Dental plan that covers medications, braces, orthotics, athletic/physiotherapy, chiropractic and more. It Is strongly recommended that Cascade athletes do not 'opt out' of this insurance plan as it can supplement any other medical coverage you may have.

If you have 'opted out' or if you are an international student please complete the following:
Policy Holder Name (ex. Parent who this plan is through):_____
Insurance Company Name:_____Group Plan Number_____
Policy Number:_____

Address during school year (if in res., provide bldg . name and room #):_____ ___

_____ _____ ( ) _____ _____
City Postal code Cell Phone # e-mail address

Permanent address: _____ _____
City; Province / State

_____ ( ) _____ _____
Postal code Home Phone# e-mail address (if different from above)

Family Physician's Name: _____ Phone #: ( ) _____ City: _____

Emergency Contacts

In case of injury or illness, please notify (parent / spouse / guardian):
Name: _____ Relationship to you: _____
Address: _____
Phone: home ( ) _____ work ( ) _____ cell ( ) _____

Name: _____ Relationship to you: _____
Address: _____
Phone: home ( ) _____ work ( ) _____ cell ( ) _____

Medical History

[ ]Y [ ]N Allergies: medications, food, insects _____

[ ]Y [ ]N Do any major illnesses/diseases (cancer, heart disease) run in your family? Who? What?

_____

[ ]Y [ ]N Other than accidents and injury, has any member died suddenly <50 years of age (ie: heart attack)
If yes, elaborate: _____

[ ]Y [ ]N Do you take any prescription or non-prescription medication? (ie: herbal remedies, advil/ibuprofen, creatine, anabolic steroids, laxatives, water pills, birth control, protein poweder)
If yes, elaborate: _____

[ ]Y [ ]N Are you currently under a doctor's care for any medical conditions?
If yes, elaborate: _____

[ ]Y [ ]N Have you ever been advised, for medical or injury reasons, not to participate in certain sports?
If yes, elaborate: _____

[ ]Y [ ]N Have you ever been hospitalized overnight or longer? When? Why?

_____

_____

Please read carefully and answer fully. Respond to the following with a '**P**' (previous), '**C**' (current), or '**N**' (no).
Do you or have you ever had: (please elaborate in the space provided below)

	HEAD		26 poor circulation		50 blood in urine		75 severe menstrual cramp
	1 frequent headaches		27 heart disease		51 blood in stool		76 irregular menstruation
	2 concussion		28 heart palpitations		52 ulcers		77 loss of menstruation
	3 dizziness with exertion		29 anemia		53 liver / gall bladder issue		- longer than 6 months
	4 migraines		30 phlebitis		54 hepatitis		78 HIV/AIDS positive
	5 balance problems		**RESPIRATORY**		55 kidney / bladder issue		79 eating disorders
	6 coordination problems		31 cough with exercise		56 painful urination		80 metal implants
	7 ringing in the ears		32 shortness of breath		57 enlarged/ruptured spleen		81 Transmissible diseases
	8 loss of smell or taste		33 asthma / wheezing		58 single / missing organs		82 bleeding disorder
	9 recurring earaches		34 collapsed lung		**SKIN**		**INJURIES**
	10 loss of memory		35 pneumonia		59 skin allergies		83 fracture/broken bone
	11 fainting with exercise		36 tuberculosis		60 herpes		84 stress fracture
	12 recurring blackouts		37 smoking		61 rashes		85 neck injury / problems
	13 double / blurred vision		38 bronchitis		62 athlete's foot &/or warts		86 burner / stinger
	14 wear glasses		39 emphysema		**OTHER CONDITIONS**		87 low back problems
	15 wear contact lenses		**HEAT DISORDERS**		63 rheumatic fever		88 face, jaw, nose
	16 use dental appliances		40 dehydration problems		64 chicken pox		89 Surgery
	17 sinus problems		41 heat stroke / exhaustion		65 measles / mumps		90 shoulder
	18 frequent nosebleeds		42 excessive thirst		66 infectious mononucleosis		91 elbow/wrist
	19 meningitis		43 frequent muscle cramps		67 diabetes		92 hand / fingers
	20 convulsions / seizures		**DIGESTIVE / ORGANS**		68 arthritis		93 hip
	CARDIOVASCULAR		44 frequent abdominal pain		69 cancer		94 thigh
	21 heart murmur		45 diarrhoea w/ travel/sports		70 thyroid problem		95 knee
	22 high blood pressure		46 constipation w/ travel		71 depression		96 lower leg
	23 low blood pressure		47 indigestion / heart burn		72 anxiety / panic attacks		97 ankle
	24 sickle cell disease		48 abnormal bowel mov'ts		73 insomnia		98 foot / toes
	25 chest pain with exercise		49 hernia		74 unintended weight loss		99 Had 'bell rung'

Please elaborate on any condition that you marked with a '**P**' (previous) or a '**C**' (current). Attach separate sheet if more space is needed.

Condition #	**Date(s)** month/year	**Comments**-include severity, duration, treatment provided	**Resolved** Yes / No

Concussions – describe any time you had symptoms such as dizziness, headache or nausea after having a hard hit (ex bell rung)

Date(s) month/year	**Symptoms**	**Duration of symptoms** (min., hours, days, weeks…)	**Interventions** SCAT, MRI, CT, Neuropsych

Medical Information Consent

I _____, certify that the above information is true, and I have made a full and complete disclosure concerning any and all illnesses, allergies, injuries, physical characteristics and conditions regarding my medical information and history. UFV Medical Staff reserves the right, in its absolute discretion, to withhold any athlete from participating in intercollegiate sports. I give the UFV Medical Staff consent to inform my Emergency Contact(s) should I be involved in a medical emergency. UFV Medical staff will keep this information confidential and will only be released as needed to Team Physicians, Coaches, Emergency Medical Personnel, associated allied health professionals and other relevant persons who may require this information. I consent to the release of all information from this medical history and exam to the UFV Medical Staff, Team Coaches, Emergency Medical Personnel and other relevant persons who may require this information.

_____ _____
Student-Athlete Signature Date

_____ _____
Signature of Guardian (IF Under 18) Date

Sports Medicine Treatment Consent and Medical Release

Athlete's Name: _____ **Sport:** _____

I hereby grant permission to the team physician(s) at the University of the Fraser Valley and those professional personnel designated by them, including athletic therapy staff, athletic therapy students, emergency medical personnel and other relevant persons to treat me for the duration of my participation in Cascade Sports. This permission includes emergency surgery and admission to the hospital as deemed necessary in addition to drugs, therapeutic modalities, and rehabilitation exercises used as part of treatment.

I understand that failure to provide an accurate health history or report injuries to the University of the Fraser Valley Sports Medicine personnel may void the University of the Fraser Valley's responsibility. The University of the Fraser Valley reserves the right, in its absolute discretion, to withhold any athlete from participating in intercollegiate sports.

I recognize that participation in an intercollegiate sport is highly competitive, demanding physically, AND THAT A RISK OF INJURY IS PRESENT. The University of the Fraser Valley will take reasonable precautions to safeguard health and safety, but I realize that serious and potentially debilitating or fatal injuries can and do occur.

I, _____, as a member of the University of the Fraser Valley _____
Athlete's full name **sport**

Team, authorize the UFV Athletics Health Care staff of the Team physician, Athletic Therapists, Physiotherapists, and other Health care professionals to release to each other, coaches, and/or administration of the athletic department, information pertaining to my health and physical condition, including injuries and their treatment progress, as it relates to my participation as a member of the team and for the duration of my participation with UFV Cascades Sports. All information obtained will remain confidential and only be utilized in the manner and with the personnel described above.

_____ _____
Athlete's Signature **Date**

_____ _____
Guardian Signature (if under 18 years) **Date**

RELEASE AND INDEMNIFICATION

WHEREAS I wish to participate in certain activities with Cascade Athletics (hereinafter, referred to as the "Activities");

IN CONSIDERATION of The University of the Fraser Valley (the "University") arranging for me to have the opportunity to participate in the Activities at the University:

1. I ACKNOWLEDGE and agree as follows:
   (a) I am familiar with, and understand the rules governing, the Activities; and

   (b) prior to participating in the Activities, I will inspect the playing field, equipment, facilities and if I believe anything is unsafe or beyond my capability, I will immediately advise the coach or supervisor of such conditions and refuse to participate.

2. I FURTHER ACKNOWLEDGE and accept that there are potential risks associated with my participating in the Activities, including, but not limited to:
   (a) bodily-injury risks and personal safety risks, including death; and

   (b) miscellaneous risks that would result from the Activities and which might not be foreseeable to me at this time.

3. I AGREE to participate in the Activities notwithstanding the above-stated risks and further agree:
   (a) to assume all related health risks of participating in the Activities;

   (b) that, to the best of my knowledge, I am healthy and fit and I am able to participate in the said Activities;

   (c) that I have disclosed any pre-existing medical conditions which may impact my ability to participate in the Activities, and have made appropriate arrangements with the University to accommodate those conditions; and

   (d) that I will advise the University of any medical conditions which arise subsequent to signing this Release, and make appropriate arrangements to accommodate such conditions, or cease my participation in the Activities.

4. I, my heirs, executors, administrators, successors and assigns, RELEASE the University, its respective servants, agents or employees from any claims for personal injury (including death), damages, losses or other proceedings while I am engaged in the Activities or thereafter.

5. I FURTHER AGREE TO INDEMNIFY the University, its servants, agents or employees from any damages which may result or claims or demands which may be made against the University arising out of or in consequence of the Activities and/or my actions.

6. I FURTHER STATE that I am of lawful age and legally competent to sign this Release.

7. The executed Release may be delivered by facsimile transmission and shall be deemed an original.

In signing this Release, I am not relying upon any oral or written representations or statements made by the University other than what is set forth in this Release.

I HAVE READ AND UNDERSTOOD THIS RELEASE AND I AM AWARE THAT BY SIGNING THIS RELEASE I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, EXECUTORS, ADMINISTRATORS AND ASSIGNS MAY HAVE AGAINST THE UNIVERSITY.

IN WITNESS WHEREOF I have set my hand on the date set out below:

_____	_____
Signature	Witness Signature (Guardian if under 18)
_____	_____
Print Name	Print Name
_____	_____
Date	Date

UFV PRE-PARTICIPATION PHYSICIAN'S EXAMINATION

NAME: _____ D.O.B____/____/____
(last) (first) (initial) dd/ mm /yyyy
Local Phone_____ Home Phone_____
Citizenship_____
Home Address: _____
(Street) (City) (Province/state) (Postal Code/zip)
Emergency contact person: _____
(Relationship) (Phone #)
Medical Insurance Company: _____Policy # _____

The following is to be completed by your FAMILY PHYSICIAN (bring the whole medical information form with you)- if this is not possible you will need to have this completed by the UFV team physician Contact head athletic therapist to schedule this. Any costs associated with the physician exam is the sole responsibility of the athlete and not UFV athletics.

ATTENTION EXAMINING PHYSICIAN: Please review the medical history form completed by the student and elaborate if needed in the space below. Then complete the physical exam and summary section. The intent is not solely to disqualify athletes from participation that would be at significant risk, but also to identify athletes who may need follow up care or intervention to maximize their safety and performance.

MEDICAL HISTORY: Review any significant points from the student's medical form_____

_____

_____

PHYSICAL EXAM:
Height: _____ Weight: _____ Marfanoid features? _____
Vision: Rt. _____ Lt._____ Pupils _____ Fundi _____
Neurological: DTR: _____ Balance: _____ CNS _____
Head and neck: _____ Hearing _____
BP: _____ Heart sounds _____ Murmurs: _____ Pulse: _____
Respiratory: _____ Abdomen _____ Hernia: Y _____ N _____
Skin: _____ Lymphatics: _____

Musculoskeletal system:	Right	Left		Right	Left
Wrist/hand	_____		Knee	_____	
Elbow	_____		Ankle	_____	
Shoulder	_____		Back	_____	

SUMMARY: Based on review of the medical history and physical exam I find this athlete to be:

- Fit for play in the designated sport.
- Fit with the reservations listed below.
- Unfit for the reasons below.

Information the coach or therapist should be aware of (i.e. Asthma, MSK rehabilitation advised, etc.)

_____

_____

_____

Physicians Signature: _____MD Date: _____

Please stamp or type name, address and phone number of physician.