Calvin College Sports Medicine
Returning Athlete Pre-Participating Exam Form

NAME	SPORT	DATE

The NCAA requires on-site documentation at Calvin College re: ADHD diagnosis and medication prescription. Please Provide

PERTINENT HEALTH HISTORY

TO BE COMPLETED BY ATHLETE		
QUESTIONS	**YES**	**NO**
1. In the last year, have you been placed under a doctor's care for any reason?	☐	☐
EXPLAIN IF YES :		
2. In the last year, have you undergone any surgical procedures?	☐	☐
EXPLAIN IF YES :		
3. Have you been hospitilized in the last year for any reason?	☐	☐
EXPLAIN IF YES :		
4. Have you suffered any injuries in the last year?	☐	☐
EXPLAIN IF YES :		
5. Are you taking any prescribed medications?	☐	☐
EXPLAIN IF YES :		
6. Do you have any complaints that you would like to speak to the doctor about?	☐	☐
EXPLAIN IF YES :		
7. Are you happy with your current weight?	☐	☐
EXPLAIN IF NO :		

8. (MALES ONLY)	What is the date of your last testicular examination?	
9. (FEMALES ONLY)	How many periods have you had in the past year?	
	How much time do you usually have between between periods?	
	What was the longest time between periods?	
ATHLETE'S SIGNATURE		**DATE**

TO BE COMPLETED BY ATHLETIC TRAINER				
DATE				
HEIGHT				
WEIGHT				
BLOOD PRESSURE				
PULSE				

SIGNATURE OF ATHLETIC TRAINER			**PRINTED NAME**	**DATE**
FOLLOW-UP REQUIRED	**YES**	**NO**	**EXPLAIN**	
SIGNATURE OF EXAMINER			**PRINTED NAME**	**DATE**

Calvin College Sports Medicine
Incoming Student-Athlete Baseline Concussion Testing Form

The NCAA requires that "Institutions should record a baseline assessment for each student-athlete prior to the first practice in the sports of **Baseball**, **Basketball**, **Diving**, equestrian, field hockey, football, gymnastics, **Ice Hockey, Lacrosse, Pole Vaulting**, rugby, **Soccer**, **Softball**, water polo, and wrestling, at a minimum. The same baseline assessment tools should be used post-injury at appropriate time intervals." -NCAA Memorandum, April 29, 2010

Part I - To be completed by Student-Athlete

Athlete's Name	Date of Birth

Baseline Symptom Scale (Circle/Check how you normally feel)

	None					Moderate					Severe	
Dizziness	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sleeping More Than Usual	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
More Emotional Than Usual	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Numbness or Tingling	0	1	2	3	4	5	6
Feeling as if "In a Fog"	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Headache	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Trouble Falling Asleep	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
Feeling "Slowed Down"	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Other	0	1	2	3	4	5	6

I, _____, agree to and accept the responsibility for reporting my injuries and illnesses to the Calvin College Sports Medicine Staff, including the signs and symptoms of concussions. These symptoms include, but are not limited to: Amnesia, Confusion, Loss of Consciousness, Disorientation, Inability to Focus, Headache, Nausea/Vomiting, Excessive Drowsiness, Visual Disturbances, Feeling "In a Fog," Dizziness, and Slurred/Incoherent Speech. I understand that while concussions are most commonly caused by a direct blow to the head, they can also be caused indirectly by other trauma to the body that is then translated to the head. Furthermore, I understand that there are many serious complications that can come about as a result of sustaining a concussion, including second impact syndrome, post-concussive syndrome, post-traumatic encephalopathy, or even death.

Signature of Athlete	Signature of Parent/Guardian (If <18 yrs)	Date

Part II - To be completed by Sports Medicine Staff during Pre-Participation Exam

Balance Error Scoring System (BESS)

BESS Types of Errors	**SCORE CARD**	FIRM Surface	FOAM Pad
1. Hands lifted off iliac crest	Double Leg Stance (Feet together)		
2. Opening eyes	Single Leg Stance (Non-dominant foot)		
3. Step, stumble, or fall	Tandem Stance (Non-dom foot in back)		
4. Moving hip into more than 30 degrees abduction	**Total Scores**		
5. Lifting forefoot or heel	**BESS TOTAL**		
6. Out of testing position more than 5 seconds			
BESS Score is calculated by adding one error point for each error during the six 20-second tests. (Maximum 10)	Which Foot is Non-Dominant? (circle)	Left	Right

ImPACT Testing

Date of Baseline Test	ATC Signature	Date

Calvin College Sports Medicine | 3195 Knight Way SE | Grand Rapids, MI 49546 | Phone: 616-526-7630 | Fax: 616-526-8478

Calvin College Athletics
Acknowledgement of Insurance Requirements and Coverage Form

Note: If the student-athlete receives their medical insurance coverage through a parent/guardian, that parent/guardian must also sign this form.

We, _____ and _____,
(Parent/Guardian's Name, Please Print) (Student-athlete's Name, Please Print)

attest that _____ has insurance coverage under a currently effective medical insurance
(Student-athlete's Name, Please Print)

policy. We have read the policy summary regarding Calvin College's secondary athletic accident coverage and agree to its terms and conditions. Information regarding this policy can be found at: www.calvinknights.com/athletics/sports_med/policies

If there is a material change in coverage or expiration of coverage, we agree to notify the Calvin College Athletic Training Staff of this development and update the insurance information which is on file.

We understand and agree that Calvin College will assume no responsibility for payment of, or authorization to pay, medical expenses that are not the direct result of an accident suffered during an approved intercollegiate practice or competition. Furthermore, although student-athletes have the right to choose any medical provider, Calvin College will only assume financial responsibility for those services pre-approved by the Athletic Training Staff or Team Physician, and then only to the extent covered by any Calvin College secondary/excess insurance program.

_____ _____
(Parent/Guardian's Signature) (Date)

_____ _____
(Student-athlete's Signature) (Date)

Tape Copy of the Front Side of Your Insurance Card Here

Tape Copy of the Back Side of Your Insurance Card Here

Calvin College
Returning Athlete Waiver

Assumption of Risk

I understand that there are certain inherent risks involved in participating in intercollegiate athletics. Even though Calvin College takes all reasonable precautions to minimize these risks, injury and illness do sometimes occur.

I understand that participation in athletics at Calvin College may result in injury/illness, permanent physical or mental impairment, or even death. These injuries may be minor or career or life-threatening. I understand that Calvin College cannot be held responsible for injuries or conditions caused by the actions of another athlete or my own failure to follow the safety procedures established by my coaching staff, sports medicine staff, or other athletic department staff.

I understand and accept that Calvin College and its sports medicine staff will uphold their responsibility to minimize injury risks associated with athletic participation. I acknowledge that these risks may still exist and I hereby assume responsibility for any and all such risks while participating in intercollegiate athletics at Calvin College. Additionally, I agree to the following:

a. I accept that Calvin College and its personnel are not to be held responsible for any pre-existing medical conditions or any medical conditions I **fail** to disclose on my Health History. Any medical expense paid by Calvin College will be limited to that covered under a secondary/excess insurance program listed in section "e" below.

b. I understand that having passed the pre-participation physical exam does not necessarily mean I am physically qualified to participate in athletics at Calvin College, but only that the evaluator did not find a medical reason to disqualify me at the time of the exam.

c. I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission by the Team Physician, his/her delegate, or Certified Athletic Trainer (after consultation with the team physician). This may occur during or at the conclusion of medical treatment.

d. I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.

e. I understand that while I am a student-athlete at Calvin College I will be covered under a secondary insurance program provided by the athletic department. This policy will pay towards the remaining balances only after the student-athletes' primary insurance has covered their financial responsibility. Only injuries/illness occurring as the result of an accident during participation in supervised and approved intercollegiate athletic activities are covered by this plan.

_____ _____

Student-Athlete Signature Date

_____

Student-Athlete Printed Name

_____ _____

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

MICHIGAN INTERCOLLEGIATE ATHLETIC ASSOCIATION
INDIVIDUAL CERTIFICATION OF ELIGIBILITY

Student ID #:_____ First & Last Name: _____

Calvin Email (@students.calvin.edu):_____

Cell Phone (include area code):_____

Campus/Local Address: _____
Dorm/Street Address, City, State, Zip

Home Address:_____
Street Address City, State, Zip

High School Graduated From:_____ HS Graduation Year:_____

1. Have you ever accepted money or awards (other than school awards) for participation in athletics?
Yes ☐ No ☐

2. Have you ever participated in professional athletics or signed a professional contract?
Yes ☐ No ☐

3. Year in school: freshman ☐ sophomore ☐ junior ☐ senior ☐ 5th year ☐

4. **AFTER graduating from high school,** have you ever attended any other college or university?
Yes ☐ No ☐

If "no", OMIT items a, b, & c

a) Institution(s) previously attended: _____

b) Semester & years attended there (ex.: Fall '14 & Spring '15):_____

c) Did you participate in Intercollegiate athletics there? Yes ☐ No ☐
If "yes", indicate sport(s) and year/season your eligibility was used (ex.: XC, Fall '14; Outdoor Track, Spring '15):

_____

5. This 2015-2016 season will be which year for you, playing this sport **at Calvin** (list each sport separately & indicate season for each, ex.: XC, 3rd; Indoor Track, 2nd; Outdoor Track, 3rd)?

Fall Sport: ___	1st ☐	2nd ☐	3rd ☐	4th ☐
Winter Sport:	1st ☐	2nd ☐	3rd ☐	4th ☐
Spring Sport:	1st ☐	2nd ☐	3rd ☐	4th ☐

I certify that the above information is correct and that I have, to the best of my knowledge, violated none of the rules of eligibility. I believe that I am eligible to compete in MIAA/NCAA sports for the season of 2015–16.

Signed:_____ Date:_____

OVER

CALVIN COLLEGE SPORTS QUESTIONNAIRE

This form will be used in writing news releases for hometown papers, high schools and parents. Please try to be as complete and accurate as possible. THANKS!

Name & year at Calvin College _____

Local address & phone _____

_____

Height _____

Birthdate & place _____

Hometown _____

High school (w/ city/ state) _____

_____

Hometown newspaper(s) _____

_____

Father and Mother's names _____

_____

High school coach _____

High school athletic honors _____
(all-league, all-state, etc.)

_____

Most memorable athletic experience _____

_____

_____

Major, GPA, & vocational goals _____

_____