2009-2010 Pre-Participation Medical Paperwork

This packet is to be completed by All Rostered Athletes ONLY! If you are trying out for a team, return to the Sports Medicine Page and print the TRY-OUT Packet. If you have a question about your status, contact the Coach of that sport.

THIS INFORMATION MUST BE COMPLETED AFTER JULY 1, 2009
(Unless you are a new athlete attending Summer Sessions)

New athletes attending Summer Sessions must complete this paperwork and their physical through the Athletic Training Room prior to any summer workouts.

Directions: (This packet must be completed each year)
-Complete the forms electronically and then print and sign where applicable.

-Your completed packet to be returned should contain the following:

- ☐ Student Athlete Information Form (completed electronically and printed)
- ☐ Media Relations Questionnaire
- ☐ Health History (3 Pages, completed electronically, printed and signed)
- ☐ Request for Exemption for use of NCAA Banned Substance or Physician Letter (If currently taking stimulant e.g. Adderall, Ritalin, etc)
- ☐ Signed Statements (completed electronically, printed and signed)
  - ○ Family Privacy Protection Act Notice
  - ○ Confidentiality of Medical Records Notice
  - ○ Athletic Participation Risk Acknowledgement
  - ○ Consent for Treatment
  - ○ Authorization For Release of Medical Information
  - ○ Consent to Institutional Drug Testing (*Refer to Policy and Information link before signing*)
  - ○ Acknowledgement of Alcohol Policy (*Refer to Policy and Information link before signing*)
- ☐ Statement of Student Athlete Insurance Information with copy of insurance card attached (1 page, completed electronically, printed and signed by athlete and parents)
- ☐ Acknowledgement of Athletic Accident Insurance Program Guidelines (2 pages, initialed and signed)
- ☐ Copy of Immunization Record (**Entering Freshman ONLY**)

- Ensure all forms are signed/initialed where indicated!!

- If you are 17 Years of Age a Parent must Co-Sign all forms!!

- If you have had any significant medical injuries or procedures completed during the summer, please include copies of all clinic notes, imaging reports, operative reports, etc.

AFTER COMPLETING ALL FORMS, PLEASE RETURN AS INDICATED TO:

College of Charleston Athletic Training Room
Attn: Pre-Participation Paperwork
30 George Street
Charleston, SC 29424

ALL FORMS SHOULD BE RECEIVED **NO LATER THAN AUGUST 1, 2009!**

Please note your teams physical time found on the included schedule. You must completed the physical before you will be allowed to participate! If you have a legitimate problem with your assigned physical time, please contact the Athletic Training Room at (843) 953-8245.

****PLEASE CALL WITH ANY QUESTIONS (843) 953-8245****

Pre-Participation Physical Dates/Schedule

July 7th, 2009
Summer II Physicals 5:00p

August 10th, 2009
Volleyball 7:00a

August 12th, 2009
Men's Soccer 5:00p

August 15th, 2009
Women's Soccer 8:00a

August 19th, 2009
Cross Country – Women 7:00a
Cross Country - Men 7:15a

August 24th, 2009
Track- 7:30a
Equestrian- 8:00a
Tennis-Women 8:30a
Tennis-Men 8:50a
Baseball- 9:10a
Softball- 9:40a
Swimming-Women -10:05a
Swimming-Men -10:35a
Sailing -11:05a
Golf-Women -11:35a
Golf-Men -11:50a
Cheerleading -12:05p
Dance -12:25p
Basketball-Women- 12:45p
Basketball-Men -1:00p

College of Charleston Student-Athlete Information Form

Full Name: _____ Sport: _____

SSN: _____ DOB: _____

Student ID #: _____ Year in School: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Home/Permanent Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____
(list email checked most frequently)

Home #: (_____) _____ Cell #: (_____) _____

Parent Information:

Mothers Name: _____ Phone #: (_____) _____

Email Address: _____

Fathers Name: _____ Phone #: (_____) _____

Email Address: _____

Emergency Contact: (*Other than Parent*)

Name: _____ Relation: _____

Phone #: (_____) _____

College of Charleston Media Relations Questionnaire

Name | Sport | Position/Event

High School attended, location, graduation year

JC attended (if applicable), location, year of graduation

Height | Weight | **Baseball/Softball Only:** Bat ◯ Right ◯ Left ◯ Switch Throw: ◯ Right ◯ Left

Academic Major | How do you want your parents listed? (son/daughter of)

Married? | If so, spouse's name: | Children? (name&age)

Have you been drafted by a pro team? | If so, list team, year, and round:

Relatives who have been or are currently in college or professional athletics: (List name, relationship, sports, team, and years)

Hich school conference or league:

Year	Sport	Position	Team Record	Team Honors

JC conference or league:

Year	Sport	Position	Team Record	Team Honors

Athletic achievements and honors (Records set, championships, "All" team you were named to, all star games, letters, etc.

List detailed stats compiled in HS, JC, or other 4 year school:

HS Academic Honors:

HS activities other than athletics

Community Service or volunteer work

Why did you choose CofC?

What are you athletic goals at CofC?

What is your career ambition?

Summer jobs/ Hobbies?

Who was your biggest influence and why?

List any local newspapers that would publish a story on you:

Name (LAST, First, MI) _____ **Sport** _____

College of Charleston Athletics 2009-2010 Pre-Participation Health Record

Health History: Please review and answer each question below (every question must be answered). Explain all "YES" answers. Be specific and include dates whenever possible.

1a. Have you had an illness or injury since your last check up or sports physical? ◯ YES ◯ NO

If yes, explain: _____

1b. Do you have an ongoing or chronic illness? ◯ YES ◯ NO

If yes, explain: _____

2a. Have you ever been hopitalized overnight? ◯ YES ◯ NO

If yes, explain: _____

2b. Have you ever had surgery? ◯ YES ◯ NO

If yes, explain: _____

3a. Are you currently taking any prescription or nonprescription (over the counter) medications or using an inhaler? ◯ YES ◯ NO

If yes, explain: _____

3b. Have you ever taken any supplements or vitamins to help gain or lose weight or improve performance? ◯ YES ◯ NO

If yes, explain: _____

4a. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? ◯ YES ◯ NO

If yes, explain: _____

4b. Have you ever had a rash or hives develop during or after exercise? ◯ YES ◯ NO

If yes, explain: _____

5a. Have you ever passed out during or after exercise? ◯ YES ◯ NO

If yes, explain: _____

5b. Have you ever been dizzy during or after exercise? ◯ YES ◯ NO

If yes, explain: _____

5c. Have you ever had chest pain during or after exercise? ◯ YES ◯ NO

If yes, explain: _____

5d. Do you get tired more quickly than your friends do during exercise? ◯ YES ◯ NO

If yes, explain: _____

5e. Have you ever had racing of your heart or skipped heartbeats? ◯ YES ◯ NO

If yes, explain: _____

5f. Have you ever had high blood pressure or high cholesterol? ◯ YES ◯ NO

If yes, explain: _____

5g. Have you been told you have a heart murmur? ◯ YES ◯ NO

If yes, explain: _____

5h. Has any family member or relative died of heart problems or of sudden death before age 50? ◯ YES ◯ NO

If yes, explain: _____

5i. Have had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ◯ YES ◯ NO

If yes, explain: _____

5j. Has a physician ever denied or restricted your participation in sports for any heart problem? ◯ YES ◯ NO

If yes, explain: _____

Name (LAST, First, MI) _____ **Sport** _____

6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? ◯ YES ◯ NO

If yes, explain: _____

7a. Have you ever had a head injury or concussion? ◯ YES ◯ NO

If yes, explain: _____

7b. Have you ever been knocked out, become unconscious, or lost your memory? ◯ YES ◯ NO

If yes, explain: _____

7c. Have you ever had a seizure? ◯ YES ◯ NO

If yes, explain: _____

7d. Do you have frequent or severe headaches? ◯ YES ◯ NO

If yes, explain: _____

7e. Have you ever had numbness or tingling in your arms, hands, legs, or feet? ◯ YES ◯ NO

If yes, explain: _____

7f. Have you ever had a stinger, burner, or pinched nerve? ◯ YES ◯ NO

If yes, explain: _____

8. Have you ever become ill from exercising in the heat? ◯ YES ◯ NO

If yes, explain: _____

9a. Do you cough, wheeze, or have trouble breathing during or after activity? ◯ YES ◯ NO

If yes, explain: _____

9b. Do you have asthma? ◯ YES ◯ NO

If yes, explain: _____

9c. Do you have seasonal allergies that require medical attention? ◯ YES ◯ NO

If yes, explain: _____

10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, hearing aid)? ◯ YES ◯ NO

If yes, explain: _____

11a. Have you had problems with your eyes or vision? ◯ YES ◯ NO

If yes, explain: _____

11b. Do you wear glasses, contacts, or protective eyewear? ◯ YES ◯ NO

If yes, explain: _____

12. Orthopaedic Injuries: Including, but not limited to sprains, strains, fractures, dislocations, swelling, etc. Please list and explain beside the appropriate body area, INCLUDE: Date of injury and right or left side.

Head/Neck _____

Back _____

Chest _____

Shoulder/ Upper Arm _____

Elbow _____

Forearm/ Wrist _____

Hand/ Finger _____

Hip/ Thigh _____

Knee _____

Lower Leg _____

Foot/ Ankle _____

Name (LAST, First, MI) | **Sport**

13a. Do you want to weigh more or less than you do now? ◯ YES ◯ NO

If yes, explain:

13b. Do you lose weight regularly to meet weight requirements for your sport? ◯ YES ◯ NO

If yes, explain:

14. Do you have a single eye or kidney? ◯ YES ◯ NO

If yes, explain:

15. Are you currently under a physicians care for ADD or ADHD and/or taking medication for ADD or ADHD? ◯ YES ◯ NO

If you answer YES you must have the Request for Exemption for use of a Banned Substance Form and supporting documentation completed by your prescribing physician

If yes, explain:

FEMALES ONLY: Do you have regular menstral periods? ◯ YES ◯ NO

If NO, explain:

MALES ONLY: Do you have a single testicle? ◯ YES ◯ NO

If yes, explain:

I hereby state, that to the best of my knowledge, my answers to the above questions are complete and correct.
Please print completed form and sign below.

Signature of athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

NCAA Banned Drugs and Medical Exceptions Policy
Guidelines Regarding Medical Reporting
for Student-Athletes with Attention Deficit Hyperactivity Disorder (ADHD)
Taking Prescribed Stimulants

The NCAA bans classes of drugs because they can harm student-athletes and can create an unfair advantage in competition. Some legitimate medications contain NCAA banned substances, and student-athletes may need to use these medicines to support their academics and their general health. The NCAA has a procedure to review and approve legitimate use of medications that contain NCAA banned substances through a Medical Exceptions Procedure.

The prescribing Physician must provide documentation to the Athletics Department/Sports Medicine staff regarding assessment of student-athletes taking prescribed stimulants for Attention Deficit Hyperactivity Disorder (ADHD), in support of an NCAA Medical Exception request for the use of a banned substance.

The attached form must be completed in its entirety by the prescribing Physician and supporting documentation included when availible

College of Charleston Sports Medicine
Medical Exemption Request for the use of a NCAA Banned Substance

In accordance with NCAA guidelines this form must be completed by the prescribing physician of stimulants for Attention Deficit Hyperactivity Disorder (ADHD). Failure to provide all requested information may result in severe disciplinary action by the NCAA and College of Charleston should student athlete test positive for stimulants.

Student-athlete Name: _____ DOB:_____ Date of evaluation: _____

Clinical Evaluation:

-Summary of comprehensive clinical evaluation (reference DSM-IV criteria, please attach supporting documentation):

_____

_____

_____

_____

_____

-ADHD rating Scale(s) (e.g. Connors, ASRS, CAARS) scores and report summary, please attach supporting documentation:

_____

_____

_____

_____

-Blood Pressure and Pulse Readings and Comments:

_____

_____

-Alternative treatments considered and comments (required):

_____

_____

_____

-Diagnosis:

_____

-Medications and Dosages:

_____

_____

-Follow-up Orders:

_____

_____

_____

Additional comments:

_____

_____

_____

Physician Name (printed):_____ Specialty:_____

Physician Signature:_____ Date:_____

Practice Name:_____ Address:_____

City:_____ State:_____ Phone: ( )-_____

South Carolina Family Privacy Protection Act (FPPA) Notice

Please be advised that personal information (i.e. addresses, phone numbers, email, etc.) collected on all College of Charleston Athletic Training Room paperwork is subject to public scrutiny and release. Any request for information from a third party for personal information on any student athlete will be scrutinized and every effort will be made to ascertain whether the intended use will be for commercial solicitation purposes.

Every effort will be made not to release any information intended for commercial use as dictated by the South Carolina Family Privacy Protection Act (FPPA). Use of the above noted information for commercial purposes is prohibited by law and violation of the Act may result in criminal penalties.

As always, AT NO TIME WILL YOUR CONFIDENTIAL MEDICAL RECORDS be released to any party without your written permission.

My signature below indicates that I have read, understand and have had the opportunity to as questions related to the above information.

Student Athlete Name: _____

Student Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Confidentiality of Medical Records

As defined by the Health Insurance Portability and Accountability Act (HIPAA), the College of Charleston Athletic Training Room is not a covered entity. However, in accordance with the confidentiality of medical records practices as designated by HIPAA, the College of Charleston Athletic Training Staff will not release information to any of the below mentioned parties unless specifically designated.

I give permission to release medical information when necessary as it relates to my participation in my sport to the below designated persons: (Check all that apply)

- ☐ Coach of the sport in which I participate
- ☐ Athletic Department Administration
- ☐ My parents/legal guardians

I understand that I may specifically request, in writing, that certain medical information not be released to the above noted persons on an incident specific basis.

I understand that the College of Charleston Athletic Training Staff will not release any information related to my medical condition to any other persons, except those previously designated, including members of the media unless permission is obtained from me on an incident specific basis.

Student Athlete Name: _____

Student Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Athlete Participation Risk Acknowledgement

WARNING: Although participation is supervised intercollegiate athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERCOLLEGIATE ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate risk.

Participants can, and have the responsibility to, help reduce the chance of injury. **PARTICIPANTS MUST OBEY ALL RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACH AND ATHLETIC TRAINER, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this statement, I(we) acknowledge that we have read and understand this warning.

Student Athlete Name: _____

Student Athlete Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

Consent for Treatment

By signing this statement, I(we) acknowledge that we have read and understand this warning.

Permission is granted to the medical personnel (Certified Athletic Trainers, Team Physicians) of the CollegeofCharlestonto seek, initiate, and/or coordinate emergency medical treatment, hospitalization or any other medical treatment as may be necessary for the immediate welfare of:

Student Athlete Full Name: _____ Date of Birth: _____

Social Security #: _____

Student Athlete Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

Authorization for Release of Medical Information

Permission is granted to the medical personnel (Certified Athletic Trainers, Team Physicians) of the CollegeofCharlestonto seek, initiate, and/or coordinate emergency medical treatment, hospitalization or any other medical treatment as may be necessary for the immediate welfare of:

I hereby authorize any physician, nurse, physical therapist, or athletic trainer who has attended to me, or any hospital or infirmary at which I have been treated or admitted to furnish the College of Charleston though its designated medical personnel (Certified Athletic Trainers, Physicians) copies of any information, notes or hospital records concerning the attendance upon, treatment, care, or confinement of the student athlete undersigned. This authority extends to all records including history, diagnostic tests, copies of findings, imaging studies, examinations, consultation, options of physicians and surgeons or other medical personnel who may have the knowledge of any condition, examination or treatment of the student athlete undersigned.

Student Athlete Full Name: _____ Date of Birth: _____

Social Security #: _____

Student Athlete Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

Student Athlete Consent to Institutional Drug Testing

I understand that during the 2009-2010 academic year, I will be subject to random drug testing coordinated by the College of Charleston through an outside testing agency. I have read and have been provided a copy of the College of Charleston Institutional Drug Testing Guidelines. I understand that provisions within the policy provide for testing individuals who exhibit characteristics that would indicate potential drug usage. I also understand that at any point prior to testing I may self refer for assistance with a drug abuse problem and penalties associated with violation of the departmental drug policy may result in loss of competition time and possibly dismissal from team and loss of scholarship. In addition, I understand that the results of my drug test may be made available to the Athletics Director, the Director of Sports Medicine, the NCAA Compliance Coordinator, my coach and my parent(s)/legal guardian(s) (minors only).

Student Athlete Name: _____ Sport _____

_____ _____

Student Athlete Signature Date Parent/Guardian Signature Date

Student Athlete Acknowledgement of Institutional Alcohol Policy

I have read and been provided a copy of the CollegeofCharleston Athletics Department Alcohol Policy. I understand that the legal drinking age in the State ofSouth Carolina is 21 years of age. I understand that regardless of my legal drinking age I am responsible for representing the CollegeofCharleston, the Department of Athletics and my respective team in a positive manner at all times. I also understand that penalties associated with violation of the departmental alcohol policy may result in loss of competition time and possibly dismissal from team and loss of scholarship.

Student Athlete Name: _____ Sport _____

_____ _____

Student Athlete Signature Date Parent/Guardian Signature Date

2009-2010 Statement of Student Athlete Insurance Information

Name: Sport: DOB: SS#:

College Address: Home Address

College Phone: Home Phone:

The above Student Athlete has:

COMPLETE ALL BLANKS FOR BOTH PARENTS!! Failure to do so will result in claims processing delays.

If information is not applicable, indicate reason (e.g. deceased, divorced, unknown, none)

FATHER/GUARDIAN INFORMATION:

Name: SS#:

Address:
If different than home:

Employer:

Address:

Work Telephone:

Medical Insurance Company:

Address:

Policy #: Group:

Phone #: Plan Type:

Is student covered under this policy?

MOTHER/GUARDIAN INFORMATION:

Name: SS#:

Address:
If different than home:

Employer:

Address:

Work Telephone:

Medical Insurance Company:

Address:

Policy #: Group:

Phone #: Plan Type:

Is student covered under this policy?

PLEASE COPY THE FRONT AND BACK OF YOUR INSURANCE CARD AND AFFIX IT BELOW

COPY OF FRONT OF INSURANCE CARD	COPY OF BACK OF INSURANCE CARD

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

FATHER/GUARDIAN:_____ DATE:_____ MOTHER/GUARDIAN:_____ DATE:_____

STUDENT ATHLETE:_____ DATE:_____

ACKNOWLEDGEMENT OF ATHLETIC ACCIDENT INSURANCE PROGRAM GUIDELINES

For your information, athletic accident insurance is provided by our institution for the benefit of our student athletes. This coverage is offered on an **"excess" basis only.** Under the terms of the policy, this coverage is considered to be excess of all other valid and collectible medical insurance policies. Most notable would be parental insurance coverage through a place of employment under which the student-athlete is covered as an eligible dependent or an individual policy purchased for the student athlete.

Please read and initial beside each of the following statements (in the blank provided) indicating understanding of and agreement with:

The insurance designee of the College of Charleston Athletics Department will assume responsibility of payment of bills **ONLY** if the following stipulations are met:

- The accident must have occurred as a result of participating in a sponsored practice or event with an intercollegiate sport. _____
- The athlete must notify a staff athletic trainer of the condition, and arrangements for claim filing, treatment, or referral should be made through the Athletic Training Room. _____
- Treatment must be rendered or requested within a reasonable and specified time frame from date of accident (60 days). _____
- Itemized bills must be submitted **FIRST** to all personal insurance programs for which the athlete may be eligible for coverage (even if you expect payment to be denied due to deductible not having been met, or non-network providers). _____

Your personal insurance company will return to you an official statement (Explanation of Benefits-EOB) of what they will/will not cover and the reason for non-payment. The insurance designee (or Athletic Department representative) must be presented with an EOB statement for each itemized bill for which you are requesting payment through our excess coverage policy.

Due to the delays associated with filing through multiple insurance providers, parents/athletes may choose to pay a bill to avoid possibility of collection action. Reimbursement may be requested by presenting copies of cancelled checks along with itemized bills and EOBs.

THE ATHLETICS DEPARTMENT OF THE COLLEGE OF CHARLESTON DOES NOT ASSUME ANY RESPONSBILITY FOR ACTION TAKEN BY COLLECTION AGENCIES FOR NON-PAYMENT OF **MEDICAL BILLS. THE INDIVIDUAL ATHLETE IS RESPONSIBLE BY LAW FOR ALL SERVICES RENDERED TO HIM/HER.**

The insurance designee of the College of Charleston Athletics Department **will NOT cover** the following:

- Out-of-season accidents or accidents **NOT DIRECTLY ASSOCIATED** with intercollegiate sports participation. _____
- MEDICAL ILLNESSES (not limited to, colds, intestinal viruses, flu, tonsillitis, mono, appendicitis, heart irregularities, wart removal, etc.) or any other conditions not directly related to an intercollegiate athletic accident. *NOTE: Arrangements may be made through the athletic training staff for the care and treatment of any illness or injury condition, but they are made only for the convenience and quality health care of the athlete.* ***These arrangements do not constitute Athletic Department responsibility for payment.*** _____
- "Pre-Existing conditions" includes any injury or illness for which treatment has been provided during a specific time period prior to subsequent injury or illness, or any injury that has not been deemed completely rehabilitated by the appropriate professional. _____
- Drugs or medications. _____
- Lost contact lenses (regardless of circumstances of loss) dental work (bridges, caps or braces) to previously repaired or unsound teeth (regardless of cause of injury). _____

- Any injury or loss resulting from the use of narcotic, alcohol or other chemical agent except as prescribed by a licensed, qualified physician. _____
- Bills incurred **AFTER TWO CALENDAR YEARS** from date of injury for a previously legitimate claim. _____

IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN/STUDENT ATHLETE TO ENSURE THAN ANY SPECIAL PROCEDURES REQUIRED BY THEIR INSURANCE POLICY ARE FOLLOWED, regarding claim submission and maximizing benefits paid, for care resulting from athletic injury. _____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE COLLEGE OF CHARLESTON OF ANY CHANGES IN POLICY STATUS. I UNDERSTAND THAT INCORRECT OR UNDISCLOSED

INFORMATION COULD RESULT IN DELAYED CLAIMS PROCESSING (or in duplicate payments, creating a substantial overpayment. The responsibility of reimbursement in full, upon request; all amounts deemed refundable will be the obligation of the undersigned. _____

My signature below indicates that I have read and understand the above stated information.
All questions may be directed to Michelle Futrell, Director of Sports Medicine 843-953-3267.

Student Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____