Southern Nazarene University
Athletic Training Department
6729 NW 39th Expressway – Bethany, OK – 73008
Office Number (405) 717-6236 – Fax (405) 717-6285

INCOMING ATHLETES
PRE-PARTICIPATION CHECKLIST

- ☐ Physical Form- **NCAA WILL NOT ACCEPT PHYSICALS SIGNED BY CHIROPRACTORS**
- ☐ Emergency Contact Information
- ☐ Health Insurance Requirements
- ☐ Initial Health History
- ☐ NCAA Sickle Cell Statement
- ☐ Securing Medical Assistance
- ☐ Medical Information Release
- ☐ Agreement to Hold Harmless
- ☐ SNU Policy Acknowledgements
- ☐ Drug & Alcohol Testing Consent Form
- ☐ Copy of Insurance Card (both sides)
- ☐ NCAA ADHD/ADD Medical Exception forms*
- ☐ Copy of Prescription Card (both sides)*
- ☐ Copy of Dental Insurance Card (both sides)*

*If applicable.

PLEASE NOTE: All forms and proof of insurance must be completed and returned to the Athletic Training Department before any student athlete will be allowed to participate in any form of practice or competition.

Please return forms to: Southern Nazarene University

Athletic Training, Sawyer Center

6729 Northwest 39th Expressway

Bethany, OK 73008

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WELCOME TO SOUTHERN NAZARENE UNIVERSITY ATHLETICS:

All forms in this packet need to be completed in full and returned to the Southern Nazarene University (SNU) Athletic Training Department. If this is your first semester to attend SNU, please fill out the "**Incoming**" packet. If you are a returning athlete, please complete the "**Returners**" packet. All forms can be obtained from the SNU Athletic Department website, http://www.snuathletics.com. You may either mail in your packet, or return it in person once you have arrived on campus. It is recommended that you complete and return the packet by August 1st for the fall semesters and as soon as possible for the spring semester to ensure immediate participation. **It is the policy of the SNU Athletic Department that no student-athlete will be allowed to participate in any practice or competition until ALL information has been received by the Athletic Training Department and proof of insurance has been established.**

THE NCAA DOES NOT ACCEPT PHYSICALS SIGNED/ COMPLETED BY CHIROPRACTORS.
At SNU, we strive to keep student-athletes healthy, but when injuries occur it is essential for us to have all necessary information on hand to insure appropriate treatment can be given.

SNU REQUIRES ALL STUDENT ATHLETES TO HAVE A PRIMARY INSURANCE POLICY THAT COVERS ACCIDENTS. SNU HAS A SECONDARY POLICY THAT BACKS UP THE STUDENT ATHLETES PRIMARY COVERAGE. THE PRIMARY COVERAGE MUST BE MAINTAINED THROUGHOUT THE ENTIRE ACADEMIC SCHOOL YEAR.

Due to the different start dates of all sports at SNU, it is impossible to coordinate mass physicals. All athletes must obtain a physical from your primary care physician. **We do request that you use only the SNU Pre-participation Physical Exam (PPE) form.** We know filling out these forms can be quite time-consuming but we do this to make certain the best medical response can be delivered without any delays.

Sincerely,

Travis Veatch, MBA-HC, LAT, ATC
Head Athletic Trainer

Michael Brobston, MEd, LAT, ATC
Asst. Athletic Trainer

Emmalee Heinen, MEd, LAT, ATC
Asst. Athletic Trainer

Southern Nazarene University - Preparticipation Physical Exam

NCAA WILL NOT ACCEPT PHYSICALS SIGNED BY CHIROPRACTORS

Name_____**SNU ID#**_____**DOB**_____

Height_____**Weight**_____**Pulse**_____(_____) **BP** _____/_____(_____/_____)

Medical	Normal	Abnormal	Initials	Musculoskeletal	Normal	Abnormal	Initials
Appearance				**Neck**			
Eyes/Ears/ Nose/Throat				**Back**			
Lymph Nodes				**Shoulder/arm**			
Heart				**Elbow/Forearm**			
Pulses				**Wrist/Hand/Fingers**			
Lungs				**Hip/Thigh**			
Abdomen				**Knee**			
Genitourinary (Males Only)				**Leg/Ankle**			
Skin				**Foot/Toes**			

Notes: _____

_____

_____

Recommendations: _____

_____

_____

□ **Necessary Labs/X-Rays:**_____

Clearance Status:	
□ **Not Cleared**	**Reason(s):**
□ **Cleared**	**Clearance Date:**

Name of Physician(print):_____**Date**_____

Signature of Physician:_____

SOUTHERN NAZARENE UNIVERSITY
Emergency Contact Information

Athlete's Full Name:_____Gender:_____

Classification: FR SOPH JR SR 5th Yr Sport_____

Date of Birth_____ Cell Phone_____

Social Security_____ Student Email_____

SNU ID# _____

Athlete's Permanent Address:

_____

_____

_____

Athlete's Campus Address

_____

_____

_____

EMERGENCY CONTACTS

Primary Contact

Name:_____Relation:_____

Cell Phone:_____Home Phone:_____

Secondary Contact

Name:_____Relation:_____

Cell Phone:_____ Home Phone:_____

SOUTHERN NAZARENE UNIVERSITY
HEALTH INSURANCE REQUIREMENTS

ALL SNU STUDENT ATHLETES MUST HAVE AND MAINTAIN AN INSURANCE POLICY THAT COVERS ACCIDENTS AS WELL AS HEALTH RELATED ISSUES. SNU HAS A WRITTEN SECONDARY POLICY THAT BECOMES AFFECTIVE AFTER THE CLAIM HAS BEEN PROCESSED BY THE STUDENT ATHLETE'S PRIMARY INSURANCE. WHEN DECIDING ON A POLICY, YOU MAY CHOOSE ANY DEDUCTIBLE AMOUNT YOU WISH; HOWEVER, SNU WILL ONLY COVER THE FIRST $2,000.00 OF THE STUDENT ATHLETE'S DEDUCTIBLE. FOR EXAMPLE, IF YOU CHOOSE AN INSURANCE POLICY WITH A $5,000.00 DEDUCTIBLE, SNU WILL PAY $2,000.00 AND THE STUDENT ATHLETE WILL BE RESPONSIBLE FOR THE REMAINING $3,000.00. TO AVOID ENCOUNTERING MEDICAL BILLS, CHOOSE AN INSURANCE POLICY WITH A MAXIMUM DEDUCTIBLE OF $2,000.00. FAILURE TO MAINTAIN AN INSURANCE POLICY THROUGHOUT THE ENTIRE ACADEMIC SCHOOL YEAR WILL RESULT IN THE STUDENT ATHLETE BEING RESPONSIBLE FOR ALL MEDICAL BILLS NOT PROCESSED BY THEIR PRIMARY INSURANCE DUE TO TERMINATION OF THE POLICY.

If you do not currently have insurance, possible options are http://www.bcbsok.com or http://www.healthcare.gov.

Policy Holder's Name: _____

Insurance Company_____

Address: _____

_____

_____

Policy #:_____Group#:_____

Deductible: $ _____PCP_____

INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD WHEN SUBMITTING THE COMPLETED PACKET.

By signing below, I declare that I have a primary insurance policy that covers accidents and I will maintain this policy for the duration of the academic school year. I also acknowledge that I am aware of my deductible amount and acknowledge that I am responsible for any deductible amount over $2,000.00.

_____ _____

Signature of Student Athlete Date Signed

_____ _____

Signature of Policy Holder if different Date Signed

SOUTHERN NAZARENE UNIVERSITY
INCOMING HEALTH HISTORY

Name_____ Sport_____ Date_____

The following questions are to be answered yes or no. Please comment in the space provided for all "YES" answers. Have you ever been diagnosed with or currently have any of the following conditions:

	Yes	No	Comments
Asthma	( )	( )	_____
Allergies	( )	( )	_____
Pneumonia	( )	( )	_____
Frequent Sore Throats / Colds	( )	( )	_____
Excessive or un-explained fatigue associated with exercise	( )	( )	_____
High Blood Pressure	( )	( )	_____
Heart Murmur/Problem	( )	( )	_____
Frequent Headaches	( )	( )	_____
Migraine Headaches	( )	( )	_____
Mononucleosis	( )	( )	_____
Hearing Loss	( )	( )	_____
Impaired Vision (Glasses/Contacts)	( )	( )	_____
Unexplained fainting	( )	( )	_____
Heat Illness	( )	( )	_____
Dizziness with Exercise	( )	( )	_____
Chest Pain with Exercise	( )	( )	_____
Sickle Cell Anemia	( )	( )	_____
Appendicitis	( )	( )	_____
Hernia	( )	( )	_____
Stomach Disorder	( )	( )	_____
Anemia	( )	( )	_____
Diabetes	( )	( )	_____
Kidney Dysfunction	( )	( )	_____

SNU HEALTH HISTORY CONTINUED

	Yes	No	Comments
Loss of Function (Testes)	( )	( )	_____
Menstrual irregularities/absence	( )	( )	_____
Other medical conditions	( )	( )	_____
Are you happy with your current weight?	( )	( )	_____
Are you missing any paired organ?	( )	( )	_____

Has anyone in your immediate family ever had any of the following conditions?

	Yes	No	Explain
Diabetes	( )	( )	_____
Sudden Death (age less than 50)	( )	( )	_____
High Blood Pressure	( )	( )	_____
Heart Attack/Heart Disease	( )	( )	_____
Hypertrophic Cardiomyopathy	( )	( )	_____
Long QT Syndrome	( )	( )	_____
Marfan Syndrome	( )	( )	_____
Irregular heart rhythms	( )	( )	_____

Have you in the past or do you currently use:

	Yes	No	Explain
Chewing Tobacco	( )	( )	_____
Vitamins or Nutritional Supplements	( )	( )	_____
Weight Loss Medication/Laxatives	( )	( )	_____

List any current medications (include any over the counter medications) that you are currently taking:

_____

_____

Do you use an asthma inhaler? Yes_____ No_____

List any current nutritional supplements or vitamins that you are currently taking:

_____

_____

List any ALLERGIES: (food, insect, or medications)

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH AS MUCH DETAIL AS POSSIBLE:

1. Have you ever had a head injury involving any of the symptoms listed? If yes, please give date of injury, follow-up care, and time that was lost in participation from sports related activity.

	Yes	No		Yes	No
Loss of Memory	( )	( )	**Headaches**	( )	( )
Disorientation	( )	( )	**Blurry/Double Vision**	( )	( )
Dizziness	( )	( )	**Loss of Vision**	( )	( )
Mental Confusion	( )	( )	**Nausea/Vomiting**	( )	( )
Loss of Consciousness	( )	( )	**Skull Fracture**	( )	( )

2. Have you ever been hospitalized or had any surgery? (Please specify when and why)

3. Have you ever had a MRI performed? (Please specify when and body part(s) that were examined)

4. Have you ever had a neck injury? "Stinger", "Burner", or "Pinched Nerve?"
   If yes, please specify when, follow-up care, time lost in participation, and how often.

5. Have you ever sustained a back injury?
   If yes, please specify when, follow-up care, and time lost in participation

6. Have you ever had a shoulder injury? (Y or N)
   If yes, please specify right or left, when, follow-up care, time lost, etc.

7. Have you ever sustained an injury to your hand, wrist, or elbow? (Y or N)
   If yes, please specify which body part, right or left, when, follow-up care, time lost, etc.

8. Have you ever had a hip injury?
If yes please specify right or left, when, follow-up care, time lost, etc.

9. Have you ever sustained a knee injury? (Y or N)
If yes, please specify right or left, when, follow-up care, time lost, etc.

10. Have you ever had an ankle injury? (Y or N)
If yes, please specify right or left, when, follow-up care, time lost, etc.

11. Have you ever had a foot injury? (Y or N)
If yes, please specify right or left, when, follow-up care, time lost, etc.

12. Have you ever had a stress fracture? (Y or N)
If yes, please specify where, when, follow-up care, time lost, etc.

13. Do you currently wear prescribed orthotics? (Y or N)
If yes, why?

NCAA SICKLE CELL STATEMENT

The NCAA has asked member institutions to educate all athletes on sickle cell trait. Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin (red blood cell) and one for normal hemoglobin. Sickle cell trait is a life long condition that will not change over time. The danger of this condition occurs when an athlete with sickle cell trait exercises intensely. Some athletes have experienced significant physical distress, collapse and some have even died. To be in compliance with NCAA recommendations you are asked to identify your sickle cell trait status. The test for sickle cell trait may have been conducted at your birth. More information on sickle cell trait can be obtained from the NCAA at http://www.ncaa.org/health-and-safety/medical-conditions/sickle-cell-trait. Please be aware that having this condition will not exclude your participation, but will require that exercise pre-cautions be put in place.

ONLY CHECK ONE BOX.

_____ I am unsure of my status for sickle cell trait but waive the SNU Athletic department from the responsibility to discover this condition.

_____ **I HAVE** sickle cell trait as confirmed by testing. Date tested:_____
(Test results must be included)

_____ **I DO NOT HAVE** sickle cell trait as confirmed by testing. Date tested:_____
(Test results must be included)

_____ I am unsure of my status for sickle cell trait but wish to be tested. Cost in SNU Health Center is $25.

_____ _____
Signature of Student-Athlete Date

_____ _____
Parent/Guardian Signature Date
If under 18 years of age

SOUTHERN NAZARENE UNIVERSITY
Securing Medical Assistance and Expenses Policy

1. All student athletes must have a completed Athletic Training Packet on file with the SNU Athletic Training Department prior to any participation. These forms shall be updated annually. Please provide a front and back copy of your medical insurance card as well as your prescription and dental insurance cards (if applicable). **SNU will not be responsible for any injury until ALL documentation has been received by the Athletic Training Department and the athlete has been cleared for workouts by the Certified Athletic Trainers of SNU.**

2. The student athlete will report all injuries to the SNU Athletic Training Department. The SNU Athletic Department will only be responsible for injuries sustained while conditioning, practicing, or competing during programmed hours under supervision of the SNU coaching staff. SNU will not be responsible for injuries sustained prior to attending SNU. If an athlete "brings in" a pre-existing injury or sustains an injury outside of the programmed hours for their sport, (i.e. intramurals, pick-up basketball, long boarding, etc.), the SNU Athletic Training Department will try to assist the student athlete in their rehab but is not obligated in any way to the injury. If the injury is athletically related in accordance with the SNU policy, the following statements apply.

3. A Certified Athletic Trainer (ATC) will evaluate all injuries to determine if the athlete needs to be referred to a team physician or if the injury can be treated in the Athletic Training room. The ATC will refer student-athletes to an SNU team physician or SNU-appointed specialist. If the student-athlete has an established relationship with a physician other than a SNU team physician, the student-athlete must get authorization from a SNU ATC before scheduling an appointment. This is done to insure that the Athletic Training Department is aware of the care that is being given for the injury. Failure to secure authorization before seeing a physician outside of the SNU network can result in the student athlete being responsible for all medical bills incurred with the visit.

4. The student athlete must take a referral form from the SNU Athletic Training Department to all appointments including but not limited to SNU team physician(s), SNU-appointed specialist(s), diagnostic testing facilities, or any other authorized provider.

5. The SNU Athletic Department's policy is to financially cover athletic injuries sustained during programmed hours in all varsity and junior varsity athletics. This policy requires the SNU Athletic Department to use the student-athlete's primary insurance before it will consider medical bills for payment. This policy covers the injured student athlete only and is an accident-only policy. This policy does not cover illnesses or injuries related to non-programmed hours unsupervised by the SNU coaching staff. SNU is not responsible for any medical bills that are encountered due to the termination of the primary insurance policy during the academic year. If a student athlete is being treated after the academic school year, they must maintain their monthly premium to ensure the primary policy remains in affect. Failure to do so will result in the student athlete being responsible for all remaining medical bills not submitted to a primary insurance.

6. All itemized bills (UB 92, HCFA 1500, or statements) for medical care received shall be forwarded to the athletic training department at SNU. A copy of the insurance company's Explanation of Benefits (a worksheet that documents how the insurance policy covered the charges associated with a particular claim) should be forwarded to the SNU Athletic Training department so that excess charges may be paid. If the student athlete or parent(s)/guardian(s) has any out-of-pocket expenses for medical bills, a copy of the receipt can be forwarded to the Athletic Training department for reimbursement.

7. Parent(s) or Guardian(s) that has money sent to them by their insurance companies including but not limited to payment of medical services rendered, medications, etc. must endorse the check(s) and forward them to the SNU Athletic Training department. Failure to do so will result in the patient being responsible for the outstanding billed amount.

8. If the student athlete is covered by a HMO policy, the student athlete must have services rendered by a physician or hospital in the HMO's payable network.

9. SNU will pay a maximum of $4,000.00 for dental related medical bills resulting from an injury sustained during programmed hours of their varsity or junior varsity sport. Dental teeth cleaning, provisional filling of teeth, or other dental work not directly related to an injury occurring during practice or competition will not be covered by SNU.

10. Medical or hospital expenses incurred as the result of an injury while going to or from class, while participating in classroom requirements (e.g., activity classes), or intra-mural activities WILL NOT be covered by the SNU Athletic policy.

11. SNU will process medical claims for one calendar year from the date of injury sustained during programmed hours. Any medical bill beyond one year from the date of injury will be reviewed with the Director of Athletics for the possibility of continued medical payments. SNU's coverage is for one year from date of injury, not "life-long". SNU will not cover cosmetic related expenses such as teeth whitening or bleaching due to a dental related injury or any other procedure considered cosmetic.

12. Flu shots are a non-covered expense.

13. Non-prescription medications dispensed by an ATC shall be dispensed in single-dosage packages. If additional medication is necessary, the student athlete will be referred to the student health center for prescription medication.

14. The use of the SNU Athletic Department's facilities is limited to periods when authorized supervisory personnel are present. The SNU Athletic Department is not responsible for expenses incurred from injuries sustained during unsupervised or unauthorized use of SNU facilities.

15. Any medical expenses that occur from an injury/illness sustained while participating in an unsanctioned SNU activity, while out-of-season, or during the summer months WILL NOT be covered.

16. Southern Nazarene University Athletic Training Services reserves the right to seek reimbursement for rehabilitation services from the student-athlete's primary insurance company.

I have read the above and foregoing Securing Medical Expenses Form and submit that I fully understand the statements contained therein. A copy of this form may be requested at any time from the Southern Nazarene University Athletic Training staff. It will not be signed annually and it is assumed that the student athlete understands its content.

_____

Signature of Student-Athlete Date

_____

Signature of Parent/Guardian if under 18 Date

Student-Athlete/Consent

For Disclosure of Protected Health Information

To the Southern Nazarene University Athletic Training Department

I, _____ hereby authorize Southern Nazarene University's
(Name of Student Athlete)
Athletic Training Department, its physicians, certified athletic trainers, and other non-affiliated health care personnel to disclose my protected health information and any related information regarding an injury or illness sustained during my training or participation in intercollegiate athletics at Southern Nazarene University.

I understand that my injury/illness information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization under HIPAA. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in Southern Nazarene University athletics.

I understand that while HIPAA regulations do not apply to Southern Nazarene University Athletic Training Department's use or disclosure of my injury/illness information, Southern Nazarene University is committed to protecting my privacy. I understand that this consent will remain valid until I revoke it in writing and that I can revoke it at any time. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

_____

Athlete's Signature Date

_____

Parent/Guardian Signature if athlete is under 18 Date

SOUTHERN NAZARENE UNIVERSITY
ASSUMPTION OF RISK AND AGREEMENT TO HOLD HARMLESS

I am aware that conditioning, practicing or playing competitive athletics can be a dangerous activity involving many risks of injury. I understand that the dangers and risks of playing or practicing to play and conditioning for competitive athletics include, but are not limited to death, serious neck and spinal injury (spinal cord or vertebral bodies) which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of the muscular skeletal system and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing or practicing to play and conditioning for competitive athletics may result not only in serious injury but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and the general enjoyment of life.

Because of the dangers of competitive athletics, I recognize the importance of following the coaches' instructions regarding playing techniques, training, and other team rules, etc., and to agree to obey instructions.

In consideration of Southern Nazarene University providing medical services and in permitting me to play competitive athletics and to engage in all activities related to the team, including but not limited to practicing or playing competitive athletics and for other good and valuable consideration, I hereby assume all the risks associated with competitive athletics and agree to hold Southern Nazarene University, and their respective employees, representatives, athletic trainers, team physicians, equipment managers and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demand of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the Southern Nazarene University Athletics. The terms hereof serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

This release remains valid until a written revocation, signed by the undersigned, is delivered to duly authorized representatives of Southern Nazarene University.

_____

Signature of Student-Athlete Date

_____

Signature of Parent or Legal Guardian Date

*Necessary if Student Athlete is under the age of 18

SOUTHERN NAZARENE UNIVERSITY
POLICY ACKNOWLEDGEMENTS

Initial each policy acknowledgement and sign and date the bottom of the page.

_____ **SNU Concussion Policy:** My initials indicate that I am aware that SNU's Concussion Policy is on the SNU Athletic Training web page and that I have read and fully understand the policy. I also agree to notify my coaches or athletic training staff if I suspect I may be suffering from concussion symptoms. The NCAA provides additional concussion education at http://www.ncaa.org/health-and-safety/medical-conditions/concussions.

_____ **SNU Lightning Policy:** My initials indicate that I am aware that SNU's Lightning Policy is on the SNU Athletic Training web page and that I have read and fully understand the policy. I also agree to follow all instructions from my coaches and SNU administration regarding the stoppage of practice or play due to lightning.

_____ **SNU Drug Testing Policy:** My initials indicate that I am aware that SNU's Drug Testing Policy is on the SNU Athletic Training web page and that I have read and fully understand the policy. I am aware that SNU's Drug Testing Policy has nothing to do with the NCAA Drug Testing Policy and I will have to sign consent forms for both policies.

_____ **SNU Emergency Action Plan:** My initials indicate that I am aware that SNU's Emergency Action Plan is on the SNU Athletic Training web page and that I have read and fully understand the plan.

_____

Print Name Date

_____

Signature Date

_____

Parent/Guardian, if athlete under 18 Date

SOUTHERN NAZARENE UNIVERSITY
DEPARTMENT OF ATHLETICS

Drug & Alcohol Testing Consent Form

I, _____, hereby acknowledge that I have been made aware that the SNU Drug/Alcohol Testing policy is posted online and been given the opportunity to ask questions regarding the Drug/Alcohol Testing Program implemented by the Department of Athletics at **Southern Nazarene University**. I understand the policies, procedures and my responsibilities as described in such policy.

As a condition to my participation in intercollegiate athletics at **Southern Nazarene University**, I consent to participate in the Drug/Alcohol Testing Program. I understand that my participation in this program includes the collection and testing of my urine at various times during the academic year for drugs, alcohol, and/or other banned substances.

I further consent to the release of the results of any drug test to the Director of Athletics or his/her designee, Assistant Director of Athletics, my Head Coach, the Head Athletic Trainer and/or Assistant Athletic Trainers, Team Physician, Appeals Committee and/or my parent(s) or guardian(s). I acknowledge and understand that a copy of this consent form may be sent to my parent(s) or guardian(s) along with a copy of the Drug/Alcohol Testing Program. To the extent set forth in this document, I waive any privilege I may have in connection with such information.

I fully understand that the **Southern Nazarene University** Drug/Alcohol Testing Program is separate and distinct from the NCAA drug-testing program and its sanction's, however, I also understand that sanctions may be imposed by **Southern Nazarene University** under its Drug/Alcohol Testing Program upon a positive result under the NCAA drug-testing program.

Notwithstanding anything to the contrary in the policy, I fully understand that I may be suspended from competition and/or practice by the team physician if credible evidence suggests that such competition and/or practice poses a health and safety risk to myself, my teammates, and/or my competitors.

Southern Nazarene University, its officers, employees, and agents are hereby released from legal responsibility and/or liability for the release of any information and/or record as authorized by this consent form. I fully and forever release and discharge the aforementioned parties from any claims, demands, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from my participation in **Southern Nazarene University** Drug/Alcohol Testing Program including those claims, demands, rights of action, or causes of action arising out of any positive result under such Drug/Alcohol Testing Program. This consent form will remain valid for as long as the student-athlete competes for **Southern Nazarene University.**

_____

Student-Athlete Signature Date

_____

Printed Name of Student-Athlete

_____

Parent/Guardian Signature (if a minor) Date

(IF APPLICABLE) NCAA ADHD MEDICATION STATEMENT

The NCAA requires documentation for stimulant medication commonly prescribed for Attention Deficit Hyperactivity Disorder (ADHD). Many medications used to treat this disorder are among those substances banned by the NCAA. Institutions must present documentation that these medications have been prescribed by a physician and also have been supported by a clinical assessment for education or health reasons. See Banned Drugs and Medical Exceptions Policy for further explanation. (http://www.ncaa.org/health-and-safety/policy/2013-14-ncaa-banned-drugs)

- **IF** you are taking medication for ADHD, the NCAA requires the prescribing physician complete a medical exception form. The forms are located at the back of this packet. The medical exception form must be completed and returned with the rest of this packet. Failure to do so will result in the student athlete not being cleared for practice/competition.

(IF APPLICABLE) BANNED PRESCRIPTION MEDICATION

- **ALSO,** the NCAA bans performance- enhancing drugs to protect student-athlete health and safety and ensure a level playing field, and it also recognizes that some of these substances may be legitimately used as medications to treat student-athletes respective medical conditions.

  Accordingly, the NCAA allows exceptions to be made for those student-athletes with a documented medical history demonstrating the need for regular use of such a drug. Exceptions may be granted for the following classes of banned drugs: stimulants, beta-blockers, diuretics, anti-estrogens, anabolic agents, and peptide hormones.

  Therefore, if you are taking any medications banned by the NCAA you **MUST** provide documentation from the treating physician, outlining in specific detail the diagnosis, treatment plan and medications, to Southern Nazarene University Athletic Training prior to participation in your chosen sport. Failure to comply with this requirement could keep you from participating in your sport for up to one year should you have a positive drug test, as a result of the NCAA's Year Round Drug Testing Program. (No forms provided) For questions regarding NCAA banned substances, visit www.drugfreesport.com. Click on Axis login. Use password: ncaa2.

IF Applicable
ADD/ADHD Physician Letter

Dear Health Care Provider,

Your patient, a student-athlete at Southern Nazarene University plans to or already participates in intercollegiate athletics at our institution. The NCAA (National Collegiate Athletic Association) requires that all athletes on stimulant medication for the treatment of ADD/ADHD provide adequate documentation of diagnosis and treatment to allow for a medical exemption. Stimulant medications are typically by NCAA athletes unless medical necessity is clearly documented by the host university. Southern Nazarene Athletic Training is requesting the following information in order for your student-athlete to continue or begin their NCAA participation. **This is critical for their participation in sports.**

Please complete the enclosed form that **will be required annually** if your patient participates in NCAA athletics and continues to require stimulant medications for their treatment. In completing this paper work, you acknowledge that you have reviewed the patient's health history and have informed them at some time of the safety information regarding stimulant use as well as misuse guidelines. Please attach any consult letters or notes that may clarify their diagnosis and the need to use stimulant medications for treatment.

We thank you for your time.

Sincerely,

Southern Nazarene University
Athletic Training Department

By mail to:
Attn: Athletic Training Department
Southern Nazarene University
6729 NW 39th Expressway
Bethany, OK 73008

OR

By Fax: 405-717-6285

Medical Exception ADHD/ADD

Date____/____/____

Name_____ Date of Birth ____/____/____
Provider: Your patient is a student athlete (SA) participating in intercollegiate athletics. The NCAA bans the use of some stimulant medications and requires that the following documentation be submitted to support a request for a medical exception in the case of a positive drug test for such use. For additional information, please visit the NCAA Health & Safety website. (http://www.ncaa.org)

Date of Clinical Evaluation: ____/____/_____

Required ADHD evaluation components **Comments:**

- ☐ **Comprehensive clinical evaluation (using DSM-IV criteria)** _____
- ☐ **Adult ADHD Rating Scale (e.g. Adult ADHD self report scale (ASRS), CONNER's Adult ADHD reporting scale (CAARS) Score:**_____ **Comments:**_____
- ☐ **Monitored blood pressure and pulse. Comments:**_____
- ☐ **Alternative non-banned medications have been considered** _____

Please submit copies of test results for the SA's medical record & NCAA purposes

Additional ADHD evaluation components

Reporting of ADHD symptoms by other significant individual(s): _____
Other Psychological testing: _____
Physical exam date: ____/____/_____ Results: _____
Laboratory/testing: _____
Previous documentation of ADHD diagnosis: _____
Other/Comments: _____
_____

Diagnosis: _____
Medication(s) and Dosage: _____
The student-athlete will follow-up with me in (circle one) 3 months, 6 months, 12 months, other_____
Physician Name (Printed):_____ **Date:**____/____/_____
Physician Signature: _____ **Specialty:**_____
Office Address: _____ Contact #:_____
_____

Please feel free to attach any clinical SOAP notes that may help clarify your patient/ our athlete's diagnosis of ADHD/ADD and the need for stimulant medications. **Thank you for your time!**

Student Athletes: Please complete the following:

I, _____, give _____
permission to release all information regarding my treatment for ADHD to Southern Nazarene University Athletic Training, and the National Collegiate Athletic Association. This authorization will be valid for one calendar year beginning on the date I sign this authorization. I may revoke this authorization at any time by submitting a letter in writing to the Head Athletic Trainer or the Director of Athletics, understanding that all information released prior to my revocation is excluded.
My signature below indicates that I have read and understand the above statement.
Signature:_____ Date:_____
Parent/Guardian signature: _____Date:_____(if under 18years)