Dear Student-Athletes and Parents,

Welcome to Hilbert College Athletics. I would like to take some time to introduce our Hilbert College sports medicine team. I am head athletic trainer Curtis Campbell, ATC. My job is to develop and coordinate an overall sports medicine program including pre-participation physical examinations, injury prevention programs, injury evaluations, injury management, injury treatment and rehabilitation, educational programs and counseling for student-athletes in conjunction with our collaborating team physician.

Our team physician, Dr. Jennifer Teeter, DO., is a fellowship trained sports medicine physician working with Buffalo Orthopaedic Group in Williamsville, NY. Dr. Teeter evaluates and treats Hilbert College athletes at weekly athletic training room clinics as well as seeing student-athletes from her Williamsville office during Hilbert College Sports Medicine coordinated appointments. Dr. Teeter is in charge of decisions regarding medical eligibility of all Hilbert College athletes as well as return to play decisions after injury. Cooperation between the head athletic trainer, the student-athlete, and the team physician is integral to ensuring a safe collegiate athletics experience.

The third and most recent addition to our team is part-time assistant athletic trainer Sheila Tatsunami, ATC. Sheila will be on campus 15-20 hours per week during peak hours in the athletics schedule and will also be working with area professional women’s soccer team the WNY Flash through Buffalo Orthopaedic Group.

Please feel free to contact me in my office at (716) 926-8806 with questions or consult the sports medicine webpage found on the Hilbert College Athletics website at any time while completing the attached pre-participation physical exam and pre-participation forms. Take this entire form with you when having your pre-participation physical exam performed by your primary care physician. These forms must be completed no sooner than 6 months before the beginning of fall 2012 semester. Please mail these forms to the address below by August 15th, 2012. Thank you for your cooperation.

Hilbert College Sports Medicine
Hilbert College
5200 South Park Ave.
Hamburg, NY 14075
Attn: Athletic Training

Curtis N. Campbell, ATC.
Head Athletic Trainer
Hilbert College Athletics
**Student Name (Last, First):**

**Date of Pre-Participation Exam:**

**Sex: M/F**  **Sport(s):**  **Age:**  **Date of Birth:**  **Graduation Year:**

**Social Security #:**  **Student Cell #:**  **Home Address:**  **City**  **State**  **Zip**  **School Address:**  **Dorm/Apt:**  **Street**  **City**  **Zip**

**Parent/Legal Guardian: Mothers Name:**  **Address:**  **Home Phone #:**  **Cell Phone #:**

**Fathers Name:**  **Address:**  **Home Phone #:**  **Cell Phone #:**

**Emergency Contact (NOT parents): Name:**  **Address:**  **Home Phone #:**  **Cell Phone #:**

**Primary Care Physician (PCP):**  **Policy Number:**  **PCP Phone #:**

**List ALL Provider:**  **Insurance:**  **Policy Number:**  **Phone #:**

**List ALL Medications**

**List ALL Allergies**

**List Allergies to Medications**

1. Has a doctor ever denied or restricted your participation in sports for any reason? __________________________  Y   N
2. Do you have an ongoing medical condition (i.e. diabetes or asthma)? __________________________  Y   N
3. Are you taking any prescription or non-prescription (over the counter) medicines or pills? __________________________  Y   N
4. Do you have allergies to medicines, pollens, foods, or stinging insects? __________________________  Y   N
5. Have you ever passed out or nearly passed out DURING exercise? __________________________  Y   N
6. Have you ever passed out or nearly passed out AFTER exercise? __________________________  Y   N
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? __________________________  Y   N
8. Does your heart race or skip beats during exercise? __________________________  Y   N
9. Has your doctor ever told you that you have high blood pressure, high cholesterol, a heart murmur, or a heart infection? __________________________  Y   N
10. Has a doctor ever ordered a test for your heart (i.e. ECG, echocardiogram)? __________________________  Y   N
11. Has anyone in your family ever died for no apparent reason? __________________________  Y   N
12. Does anyone in your family have a heart problem? __________________________  Y   N
13. Has any family member or relative died of heart problems or of sudden death before age 50? __________________________  Y   N
14. Does anyone on your family have Marfan syndrome? __________________________  Y   N
15. Have you ever spent the night in a hospital? __________________________  Y   N
16. Have you ever had surgery? __________________________  Y   N
17. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? __________________________  Y   N
18. Do you regularly use a brace or assistive device? __________________________  Y   N
19. Has a doctor ever told you that you have asthma or allergies? __________________________  Y   N
20. Do you cough, wheeze, or have difficulty breathing during or after exercise? __________________________  Y   N
21. Is there anyone in your family that has asthma? __________________________  Y   N
22. Have you ever used an inhaler or taken asthma medicine? __________________________  Y   N
23. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? __________________________  Y   N
24. Have you had infectious mononucleosis (mono) within the last month? __________________________  Y   N
25. Do you have rashes, pressure sores, or other skin problems? __________________________  Y   N
26. Have you had a herpes skin infection? __________________________  Y   N
27. Have you ever had a head injury or concussion? If YES, how many? __________________________  Y   N
28. Have you been hit in the head and been confused or lost your memory? __________________________  Y   N
29. Have you ever had a seizure? __________________________  Y   N
30. Do you have headaches with exercise? __________________________  Y   N
31. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? __________________________  Y   N
32. Have you ever been unable to move your arms or legs after being hit or falling? __________________________  Y   N
33. When exercising in the heat, do you have severe muscle cramps or become ill? __________________________  Y   N
34. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? __________________________  Y   N
35. Have you had any problems with your eyes or vision? __________________________  Y   N
36. Do you wear protective eyewear such as goggles or a face shield? __________________________  Y   N
37. Are you happy with your weight? __________________________  Y   N
38. Are you trying to gain or lose weight? __________________________  Y   N
39. Has anyone recommended you change your weight or eating habits? __________________________  Y   N
40. Do you limit or carefully control what you eat? __________________________  Y   N
41. Do you have any concerns that you would like to discuss with a doctor? __________________________  Y   N

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**Contact Hilbert College Head Athletic Trainer Curtis Campbell, ATC. With Any Questions or Concerns**

**email:** ccampbell@hilbert.edu  **office phone:** (716) 926-8806
Please circle if you:

42. Have you ever had an injury like a sprain, muscle, or ligament tear that caused you to miss a practice or game? …………Y  N
43. Have you have had any broken or fractured bones or dislocated joints? …………………………………………..Y  N
44. Have had a bone or joint injury that required x-ray, MRI, CT, surgery, injection, or physical therapy? …………..Y  N

<table>
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<tr>
<th>Head</th>
<th>Neck</th>
<th>Shoulder</th>
<th>Upper Arm</th>
<th>Elbow</th>
<th>Forearm</th>
<th>Hand/Fingers</th>
<th>Chest</th>
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<tbody>
<tr>
<td>Upper back</td>
<td>Lower back</td>
<td>Hip</td>
<td>Thigh</td>
<td>Knee</td>
<td>Calf/shin</td>
<td>Ankle</td>
<td>Foot/foes</td>
</tr>
</tbody>
</table>

**Females Only**

45. Have you ever had a menstrual period? Yes_______ No________
46. How old were you when you had your first menstrual period? __________
47. How many periods have you had in the last 12 months? __________

**Explanation of any “YES” answers from the front of sheet (by number):**

__________________________________________________________________________

List of ALL Current Medications:______________________________________________
List of Allergies to Medications:______________________________________________
List of Environmental Allergies:______________________________________________
Smoking Yes□ No□ packs per day/______ years                                  Alcohol: Yes□ No□ day/week/month
Recreational Drugs: Yes□ No □______________________________________________
Caffeine: Yes□ No□ cups/glasses per day                                      

**Family History**
(Health Status is good, poor, deceased)

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Health Status</th>
<th>Age + Cause of Death</th>
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</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mother</td>
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<td>Brothers</td>
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<td>Sisters</td>
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Have you ever had an injury/surgery in which a physician was notified? (If yes, briefly explain) YES / NO
__________________________________________________________________________

**Are you currently under the care of a Physician?** (If yes, briefly explain) YES / NO

MD Name_______________________________
Address_______________________________

Please list any other information regarding your recent medical history that the Sports Medicine Staff should be aware of (including changes in health status, dietary habits, weight gain/loss, allergies, family history, etc.)__________________________________________________________
### PHYSICIAN USE ONLY

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Initials</th>
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<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<tr>
<td>Hearing</td>
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<td>Murmurs</td>
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<td>Pulses</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Genitourinary (Males Only)</td>
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<tr>
<td><strong>Musculoskeletal</strong></td>
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<td>Shoulder/Arm</td>
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<td>Elbow/Forearm</td>
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<td>Wrist/Hand/Fingers</td>
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<tr>
<td>Foot/Toes</td>
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</tbody>
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**Athlete Sickle Cell Trait Status (See Attached Waiver)**

- □ Negative
- □ Positive
- □ Unsure

- □ Athlete Cleared Without Restrictions
- □ Cleared with the following recommendation: ________________________________
- □ Athlete NOT cleared for □ All Sports
- □ Certain sports: ________________________________

**Reason:**

____________________________________________________

**Recommendation:**

____________________________________________________

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**Name of Physician (print):** __________________________
**Date:** __________________________
**Address:** __________________________
**Phone:** __________________________
**Signature of Physician:** __________________________
Hilbert College
Participation and Insurance Waiver

I understand that I am required to have my own personal insurance coverage should it be needed in case of accidental injury. I also realize that I am responsible for any charges, co-pays, or deductibles not covered by the insurance, and I agree that I will not hold Hilbert College responsible for these charges. I agree to notify Hilbert College of any changes, including expiration of coverage. I also understand that a copy of both the front and back of my insurance card must be submitted with this form to allow for my participation in athletics.

______________________________
Athlete’s Signature

______________________________
Date

______________________________
Parent/Guardian Signature (If not 18 years of age)

______________________________
Date

I understand that these medical forms will be utilized to allow me to participate on intercollegiate athletic teams. Should the examination not be on file, be incomplete, or should participation be restricted on the form, I will not be allowed to participate until the circumstance is rectified.

I also understand that any student-athlete with a known history of a heart murmur must provide a copy of the most recent echocardiogram with their physical forms. If history of a heart murmur is mentioned in the physical but no documentation is provided I will need to have an echocardiogram evaluation conducted before beginning the season. Costs associated with this may be my responsibility.

I confirm that this information is accurate to the best of my knowledge. Furthermore, I understand that the following records will remain confidential and will become part of my medical records in the Department of Athletics’ Head Athletic Trainer’s Office.

______________________________
Athlete’s Signature

______________________________
Date

______________________________
Parent/Guardian Signature (If not 18 years of age)

______________________________
Date
Hilbert College Athletics Declaration of Medication

Print Name: 

Sport: 

If you are taking medication that contains an NCAA banned substance, it is your responsibility to obtain the documentation listed above: (Including the ADHD medications Adderall and Ritalin)

1. A letter from your Doctor stating the need for the use of the medication.
2. What the diagnosis is and how it was reached - include test results.
3. What the course of treatment is.
4. The student-athletes medical history
5. A copy of the prescription showing dosage and frequency of use.

Consult www.drugfreesport.com for more information on NCAA banned substances

(Parents signature required if Student-Athlete is UNDER Age 18)

<table>
<thead>
<tr>
<th>Athlete Initials</th>
<th>Parents Initials</th>
</tr>
</thead>
</table>
| I am NOT taking any medication

<table>
<thead>
<tr>
<th>Athlete Initials</th>
<th>Parents Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I am taking medication(s) &amp; if it contains a banned substance, I have obtained the required information listed above before I participate</td>
<td></td>
</tr>
<tr>
<td>Please CLEARLY list all medication that you are taking:</td>
<td></td>
</tr>
</tbody>
</table>

By checking above and signing below, I acknowledge that I have read, accepted and understand, and will comply with all of the above policies and procedures. I also acknowledge that if initially I did not understand, I have contacted the Hilbert College Athletic Dept. to clarify any issues I did not understand and have had those issues clarified. This signed form is required prior to participation in any intercollegiate athletics at Hilbert College. Parent signature required if student-athlete is under the age of 18.

Athlete Name ___________________________ Athlete Signature ___________ Date ___________

Parent Name ___________________________ Parent Signature (if under 18 years old) ___________ Date ___________
Sickle Cell Trait Status: Education, Awareness and Testing Waiver

Definition of Sickle Cell Trait: Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. During intense exercise, red blood cells containing the sickle hemoglobin can change from round to quarter-moon, or “sickle”. Sickled red blood cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to tissues and muscle. During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died. Heat, dehydration, altitude and asthma can increase the risk for complications associated with sickle cell trait, even when exercise is not intense.

People at High Risk for Sickle cell Trait: People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries. Eight percent of the U.S. African American population has the sickle cell trait but ANY person may carry the trait. Information regarding your sickle cell trait status can be retrieved from your primary care physician, pediatrician, or hospital of birth.

How can I prevent a collapse: Engage in a slow and gradual preseason conditioning program. Build up your intensity slowly while training. Use adequate rest and recovery between repetitions. Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather. Stay well hydrated at all times, especially in hot and humid conditions. Maintain proper asthma management. Be aware when adjusting to a change in altitude. Avoid using high caffeine energy drinks or supplements. If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop activity immediately and notify your athletic trainer and/or coach.

Sickle Cell Trait Testing: The NCAA recommends that all Division III student-athletes have knowledge of their sickle cell trait status and provide proof of testing/results. If not previously tested, the athlete should consider being tested at their own cost and provide proof of testing/results, or sign a testing waiver before participation in any intercollegiate athletics event, including strength and conditioning sessions, try outs, practices, competitions etc. Athletes may inquire about their sickle cell trait status with their pediatrician or the department of records at their hospital of birth.

PLEASE CHECK THE OPTION THAT APPLIES TO YOU

1) I KNOW my sickle cell trait status is NEGATIVE and proof of testing/results is attached
2) I KNOW my sickle cell trait status is POSITIVE and know the risks associated with it and would like to participate. Proof of testing/results is attached. I have been counseled and have watched NCAA video.
3) I DO NOT KNOW my sickle cell trait status and would like to be tested at my own expense.
4) I DO NOT KNOW my sickle cell trait status and waive the right to be tested. I understand the risks associated with the trait, have been counseled and watched NCAA video.

(If you choose to be tested, results must be made available prior to participation. Student athletes should be tested during the summer prior to arriving at Hilbert and include documentation with the pre-participation physical) Testing may be arranged via QUEST DIAGNOSTICS at the following website: https://sicklecelltesting.medivo.com/order/am, or through your primary care physician.

It is my express intent that this waiver shall bind my family, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a release, waiver, discharge and covenant not to sue Hilbert College, its trustees, officers, agents, and employees. I hereby further agree that this sickle cell trait testing waiver shall be construed in accordance with the laws of the State of New York. In signing this release, I acknowledge and represent that I have read the foregoing, Sickle Cell Trait Testing Waiver Release understand it and sign it voluntarily; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate and complete consideration fully intending to be bound by the same.

Signature of Student-Athlete ____________________________ Date______
Signature of Parent/Guardian (if under 18) ____________________________ Date______