Baker University Student-Athletes and Parents,

Welcome from Baker University Sports Medicine. The athletic trainers at Baker University, along with medical doctors from OrthoKansas, LLC, consider all student-athletes members of our family and as such, we welcome you to the Baker family. We honor student-athletes by providing access to the best health care and will provide the care, evaluation, and rehabilitation when athletically related injuries occur.

Please review the following important materials. All information must be completed thoroughly and returned to the Sports Medicine Department before you are allowed to participate in any athletically related practices or competitions. When completed, fax, email or mail all documents in the sports medicine packet to the attention of the Sports Medicine Department by August 1, 2015. In the event that the packet is not received by this date, you will not be eligible to participate in practice and will be assessed a $20.00 late processing fee on your student account. Please call if you have any questions.

You must return the following by August 1, 2015:

- **Medical History & Physical Examination**
  - This is completed yearly and must be administered and signed by one of the following: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Physician Assistant (PA) or Nurse Practitioner (APRN). Physical examination signed by a health provider other than requested will not be accepted and a subsequent examination will be required.

- **Acceptance of Risk/Liability Waiver**
  - Please read thoroughly; then sign and date.

- **Insurance Questionnaire**
  - This requests a legible copy of your health care insurance card be copied, front and back, cut, and scotch taped in the designated spaces. Please complete in full and to the best of your knowledge. Please secure a card for your personal use. Providers require this upon admittance for services.

- **Student-Athlete Personal Data**
  - This form contains your contact information for the academic year. If some information is unknown, complete it as best you can and send it. We will complete it during health screens.

All four documents, 5 pages, may be submitted via fax, email, or mail.

Thank you,

Lynn Bott, MS, LAT, ATC  
Director of Sports Medicine  
Baseball, Football, Tennis  
lbott@bakeru.edu  
(O) 785-594-8424  
(C) 785-979-4882  
(F) 785-594-8465

Lynsey Payne, MS, LAT, ATC  
Athletic Trainer  
Basketball, Golf, Soccer, Cheer/Dance  
lpayne@bakeru.edu  
(O) 785-594-8499  
(C) 785-979-4883  
(F) 785-594-8465

Austin Hills, MS, LAT, ATC  
Athletic Trainer  
Bowling, Cross Country, Track & Field, Volleyball, Wrestling  
ahills@bakeru.edu  
(O) 785-594-8488  
(C) 785-979-4886  
(F) 785-594-8465

Baker University Sports Medicine, 618 8th Street, PO Box 65, Baldwin City, Kansas 66006
BAKER UNIVERSITY SPORTS MEDICINE
MEDICAL HISTORY & PHYSICAL EXAMINATION
ALL FORMS DUE AUGUST 1, 2015

Name________________________________________ Date__________ Date of Birth_____________ Sport___________

This section is to be completed by student-athlete.

I. Put an “X” in the blank if you have now or have ever had the following:

___ Allergy  ___ Hepatitis  ___ Heart Murmur  ___ High/Low Blood Sugar  ___ Chicken Pox
___ Asthma  ___ Measles  ___ Abnormal Heart Beat  ___ Eating Disorder  ___ Seizures/Epilepsy
___ Chest Pain  ___ Pneumonia  ___ Birth Deformities  ___ Mental Problems  ___ Tuberculosis
___ Diabetes  ___ Sickle Cell  ___ Heat Exhaustion/Stroke  ___ Mononucleosis  ___ Shortness of Breath
___ Hernia  ___ Anemia  ___ High Blood Pressure  ___ Rheumatic Fever  ___ Kidney Disease

II. Put an “X” in the blank if you ever had and illness/injury involving the following:

___ Ankle  ___ Calf  ___ Hand  ___ Hip  ___ Thigh  ___ Abdomen/Pelvis
___ Arm  ___ Elbow  ___ Head  ___ Knee  ___ Wrist  ___ Chest/Breast
___ Back  ___ Foot  ___ Heart  ___ Neck  ___ Shoulder

III. Put an “X” in the blank if you have a family history of:

___ Sudden Death at a Young Age
___ Syncope (Passing Out)
___ Sickle Cell Disease or Trait
___ High Blood Pressure

VI. Circle the appropriate answer to the following:

Yes or No 1. Have you ever been “knocked out” or experienced a concussion? If yes, how many times? ___
Yes or No 2. Have you ever been hospitalized due to a concussion?
Yes or No 3. Have you ever had a “burner or stinger”? If yes, how many? ___
Yes or No 4. Have you ever passed out?
Yes or No 5. Have you ever been withheld from participating in a sport for medical reasons?
Yes or No 6. Do you wear glasses or contacts? While playing? Yes or No
Yes or No 7. Do you have any dead, missing, chipped, or broken teeth?
Yes or No 8. Do you wear dental appliances?
Yes or No 9. Have you had any injuries to the neck or back nerves, vertebrae (bones) or vertebral discs?
Yes or No 10. Have you had any surgery on your neck or back?
Yes or No 11. Have you had any fractures within the last two years?
Yes or No 12. Have you had surgery within the last two years?
Yes or No 13. Are you taking any medications?
Yes or No 14. Are you allergic to any food or medication?

Explain and “X” or “Yes” answers in the space below or on the back of the page.

____________________________________________________________________________________________
____________________________________________________________________________________________

____________________________________________________________________________________________

Student-Athlete Signature _________________________ Date _________________________
BAKER UNIVERSITY SPORTS MEDICINE

PHYSICAL EXAMINATION (To be administered and completed by an MD, DO, APRN, or PA)

Name ___________________________ Sport _________ Date _______________

Height ___________ Weight ___________ Pulse _______ Blood Pressure ___________

Immunizations: Tetanus/TDAP (date) _______________ TB (date) _______________ Polio (date) _______________

MMR (dates) _______________ Hepatitis B (dates) _______________ Meningitis (date) _______________

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<td>Abdomen/Pelvis: Viscera Scars, Hernia</td>
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Cardiac Health

Rhythm: __________________________________________ Marfanoid? Yes / No

Murmurs: Supine ___________________________________ Standing __________________________

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Athletic participation approved without limitation: Yes / No

If no, specify participation limitations ___________________________________________

Specify actions needed for clearance ___________________________________________

Physician’s Name ___________________________ Signature ___________________________

Address ___________________________ City ___________________________ State ________ Zip ___________

Telephone ___________________________ Fax ___________________________
BAKER UNIVERSITY SPORTS MEDICINE

Acceptance of Risk/Liability Waiver

A. The undersigned hereby certifies that the answers to the attached medical history & physical examination, insurance questionnaire, and personal data are correct, true, and honest.

B. Understands that having passed the physical examination does not necessarily mean that you are physically qualified to engage in athletics participation, but that the MD, DO, APRN, or PA did not find a medical reason to disqualify you.

C. Understands that you must refrain from practices or games during medical treatment until you are discharged from treatment by both the athletic trainer and team physician or supervising physician in respect to the current medical condition or injury.

D. Understands that the university team physicians and athletic trainers may review the medical history and physical examination, and if necessary, require additional tests or examinations before clearing you to participate.

E. Understands and accepts the risk of injury, permanent disability, and/or death inherent to your sport(s). By signing below you pledge to do your best to reduce risks by using proper techniques in play and conditioning, keeping in the best possible condition, and following the advice of the team physician or supervising physician, athletic trainers, and coaches concerning the prevention and rehabilitation of athletically related injuries/illnesses.

F. Shall promptly notify the sports medicine staff of any injuries or changes in your health status, including injuries and illnesses occurring during the off-season and summer.

G. Grant permission to the sports medicine and/or coaching staff to secure treatment, ambulance transportation or emergency medical care in the event of a severe or catastrophic athletically related injury.

H. Grant permission to the sports medicine staff, student health services, my respective coach, and athletics director to communicate to one another, written and/or orally, any athletically related information concerning injuries and illnesses that affect my athletic involvement.

I. Understand that the excess or secondary athletic accident insurance that Baker University provides for athletically related injuries in not all inclusive and that you or parents/guardians may be liable for the deductible and the cost of services not considered medically necessary. Though Baker University provides the excess or secondary athletic insurance coverage at no out of pocket cost, Baker University does not pay out of pocket expenses for any injury. Failure to promptly notify the sports medicine staff of athletically related injuries shall result in loss of excess or secondary athletic insurance coverage.

J. Understand that I must have proof of primary health/medical insurance effective August 1, 2015 or prior to the start of the athletic season. This “full coverage” insurance must be carried throughout the schedule of athletic practices, contests, and participation, in and out of season. Any insurance lapse will result in your removal from participation, team roster, and the loss of continued athletic scholarship assistance. Additionally, your eligibility for excess or secondary athletic accident insurance benefits will be cancelled without proof of a primary insurance carrier.

I, the undersigned, have read and understand the preceding acceptance of risk/liability waiver and agree to follow its procedures. I also hereby release Baker University, its agents and employees from any liability caused by, or arising out of, my participation in the University’s athletics programs. By signing this, I also agree to the $20.00 late processing fee should my packet not be completed and received by sports medicine by August 1, 2015.

__________________________________________
Signature

__________________________________________
Parent/Guardian Signature (if under 18)

__________________________________________
Date
BAKER UNIVERSITY SPORTS MEDICINE
Insurance Questionnaire

The form should be completed in full by parents or the insuree prior to participation in athletics at Baker University and kept on file in the sports medicine department in the event of a serious injury or medical insurance claim.

Student-Athlete Name __________________________ Cell# ___________ Sport _______ Date of Birth ________

Member Name ________________________________

Member Date of Birth __________________________

Address ______________________________________

City/St/Zip __________________________________

Phone _________________________________________

Do you have group health care insurance coverage through your employment? Yes ___ No ___

Ins Co _________________________________________

Address ______________________________________

City/St/Zip __________________________________

Policy/Group # ________________________________

Member # _____________________________________

Claims Phone # ________________________________

Pre-Auth. Required? Yes ___ No ___

2nd Opinion/Surgery? Yes ___ No ___

Type of Plan:

____ Health Maintenance Organization (HMO)

____ Preferred Provider Organization (PPO)

____ Point of Service (POS)

____ Standard Medical/Hospital Coverage

____ State Organization

____ Other:

I/we agree that all information provided in this document is accurate and complete to the best of my/our knowledge.

Student-Athlete Print Name __________________________________________________________ Date __________

Student-Athlete Signature ____________________________________________________________

Parent/Guardian (if under 18) _________________________________________ Date __________________
### BAKER UNIVERSITY SPORTS MEDICINE

#### Student-Athlete Personal Data

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**Full Name:**

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**Personal Cell Phone:**

**School Address:**

Street and/or Dormitory/Greek House

**Permanent Address:**

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**Home Phone:**

**IN CASE OF EMERGENCY NOTIFY:**

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