## I. Cardiovascular Risk Factors:

- Have you ever had chest pain and/or shortness of breath during or after exercise / practice?  [ ] YES  [ ] NO
- Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice?  [ ] YES  [ ] NO
- Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? [ ] YES  [ ] NO
- Do you get tired more quickly than your teammates / friends do during exercise / practice?  [ ] YES  [ ] NO
- Have you ever been told that you have a heart murmur?  [ ] YES  [ ] NO
- Has any family member or relative died or heart problems and/or of sudden death before age 50?  [ ] YES  [ ] NO
- Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems?  [ ] YES  [ ] NO
- Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?  [ ] YES  [ ] NO
- Does anyone in your family have a history of high blood pressure?  [ ] YES  [ ] NO
- Have you ever been told that you have / had high blood pressure?  [ ] YES  [ ] NO
- Does anyone in your family have a history of high blood cholesterol?  [ ] YES  [ ] NO
- Have you ever been told that you have / had high blood cholesterol?  [ ] YES  [ ] NO

If you answered “Yes” please describe and include dates where necessary ________________________________

## II. Allergies:

- Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications?  [ ] YES  [ ] NO
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items?  [ ] YES  [ ] NO
- Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.?  [ ] YES  [ ] NO
- Have You Ever Been Diagnosed With Seasonal Allergies?  [ ] YES  [ ] NO
- Are You Presently Taking / Have You Previously Taken Any Allergy Medications?  [ ] YES  [ ] NO

If you answered “Yes” please describe and include dates where necessary ________________________________

## III. Asthma:

- Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma?  [ ] YES  [ ] NO
- Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler?  [ ] YES  [ ] NO
- How Many Times Do You Use Your Rescue Inhaller (e.g. Albuterol, Proventil, etc.) During An Average Week? ________________________________
- How Many Acute Asthma Attacks Have You Had In The Past 12 Months? ________________________________
- Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma?  [ ] YES  [ ] NO
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition?  [ ] YES  [ ] NO
IV. Head Injuries / Concussion:

Have You Ever Suffered A Head Injury / Concussion (no matter how minor)?

☐ YES  ☐ NO

Have You Ever Been Evaluated By A Doctor For A Head Injury / Concussion?

☐ YES  ☐ NO

Were Any Diagnostic Tests Performed?  ☐ YES  ☐ NO  (check all that apply)

☐ X-ray  ☐ MRI  ☐ CT-Scan  ☐ Neuropsychological Testing  ☐ Other __________________________

Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion?

☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion?

☐ YES  ☐ NO

Do You Suffer From Headaches?

☐ YES  ☐ NO

♦ When?

☐ Every Day  ☐ 1-2 Times/Week  ☐ 1-2 Times/Month

♦ Where Are Your Headaches Located?

☐ Front of Head  ☐ Back of Head  ☐ All Over Your Head

Do You Have A History of Migraine Headaches?

☐ YES  ☐ NO

♦ How Often

Please Describe __________________________

♦ Medications Taken for Migraines?

Have You Had Headaches For More Than Three (3) Months?

☐ YES  ☐ NO

If you answered “Yes” please describe and include dates where necessary __________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

V. Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury?

☐ YES  ☐ NO  (check all that apply):

♦ ☐ Heat Cramps- Date(s)?

♦ ☐ Heat Syncope (Fainting)- Date(s)?

♦ ☐ Heat Exhaustion- Date(s)?

♦ ☐ Heat Stroke- Date(s)?

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem?

☐ YES  ☐ NO

Have You Ever Been Hospitalized For a Heat-Related Problem?

☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury?

☐ YES  ☐ NO

If you answered “Yes” please describe and include dates where necessary __________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________
VI. Diabetic History:

Have You Ever Been Diagnosed With Diabetes?  
☐ YES  ☐ NO

Are You Presently Taking or Have You Taken Any Diabetic Medications?  
☐ YES  ☐ NO

<table>
<thead>
<tr>
<th>Medication</th>
<th>Form</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
</table>

Do You Daily Monitor Your Blood Sugar Level?  
☐ YES  ☐ NO

♦ How Many Times Per Day? ____________________________  
What Is Your Average Level? ________________________

Have You Had Your A1C Level Checked Within The Last Three (3) Months?  
☐ YES  ☐ NO  Level ________________________

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months?  
☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes?  
☐ YES  ☐ NO

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

If you answered “Yes” please describe and include dates where necessary ____________________________

VII. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of?  
☐ YES  ☐ NO

♦ Date? ____________________________  Result? ____________________________

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of?  
☐ YES  ☐ NO

♦ Please Describe ____________________________

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia?  
☐ YES  ☐ NO

♦ Please Describe ____________________________

VIII. For Females Only:

At what age did you have your first menstrual period? ____________________________

☐ YES  ☐ NO  Have you had menstrual periods within the past 12 months?  
♦ If yes, how many? ____________________________  When was your most recent menstrual period? ____________________________

♦ How much time do you usually have from the start of one period to the start of another? ____________________________

♦ What was the longest time between menstrual periods within the past year? ____________________________

☐ YES  ☐ NO  Do you have painful or heavy menstrual periods?

☐ YES  ☐ NO  Do you take any medications during your menstrual periods?  If yes, what?

☐ YES  ☐ NO  Do you take birth control pills?  If yes, what brand?

☐ YES  ☐ NO  Have you ever had any problems with your breasts?

☐ YES  ☐ NO  Have you had a pelvic examination within the last year?
IX. Eye:
When Was Your Last Eye Exam? ________________________________

Findings? ________________________________________________

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? ☐ YES ☐ NO
Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)
☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ________________________________

Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? ☐ YES ☐ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? ☐ YES ☐ NO
Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO
Do you routinely wear glasses? ☐ YES ☐ NO
Do you routinely wear contact lenses? ☐ YES ☐ NO Type ________________________________
Do you require any special devices / equipment? ☐ YES ☐ NO Type ________________________________
If you answered “Yes” please describe and include dates where necessary ________________________________

X. Ear / Nose / Throat:
Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? ☐ YES ☐ NO
Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)
☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ________________________________

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO
If you answered “Yes” please describe and include dates where necessary ________________________________

 XI. Dental:
When Was Your Last Dental Exam? ________________________________

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? ☐ YES ☐ NO
Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)
☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ________________________________

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? ☐ YES ☐ NO
If you answered “Yes” please describe and include dates where necessary ________________________________
XII. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck?  □ YES □ NO

Were Any Diagnostic Tests Performed? (check all that apply)  □ X-Rays  □ MRI  □ CT-Scan  □ Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury?  □ YES □ NO

Have You Ever Had “Burners”, “Stingers”, or Brachial Plexus Injuries?  □ YES □ NO

♦ How Many? _____________ Date(s)/Time Missed? ___________________________

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers?  □ YES □ NO

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck?  □ YES □ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury?  □ YES □ NO

Do You Presently Wear A Neck Roll / Collar, “Cowboy Collar” or Helmet Restrictor Plate?  □ YES □ NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, “Cowboy Collar”, and/or Helmet Restrictor Plate?  □ YES □ NO

If you answered “Yes” please describe and include dates where necessary ________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

XIII. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm?  □ YES □ NO

Were Any Diagnostic Tests Performed? (check all that apply)  □ X-Rays  □ MRI  □ CT-Scan  □ Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury?  □ YES □ NO

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm?  □ YES □ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury?  □ YES □ NO

If you answered “Yes” please describe and include dates where necessary ________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

XIV. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm?  □ YES □ NO

Were Any Diagnostic Tests Performed? (check all that apply)  □ X-Rays  □ MRI  □ CT-Scan  □ Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury?  □ YES □ NO

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm?  □ YES □ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Elbow / Forearm Injury?  □ YES □ NO

If you answered “Yes” please describe and include dates where necessary ________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
XV. Wrist, Hand, & Fingers:
Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? □ YES □ NO
Were Any Diagnostic Tests Performed? (check all that apply) □ X-Rays □ MRI □ CT-Scan □ Bone Scan
Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? □ YES □ NO
Have You Ever Had Surgery Of Any Kind On Your Wrist, Hand, and/or Finger(s)? □ YES □ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? □ YES □ NO
If you answered “Yes” please describe and include dates where necessary

XVI. Spine / Low Back / Sacroiliac Joint: 
Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? □ YES □ NO
Were Any Diagnostic Tests Performed? (check all that apply) □ X-Rays □ MRI □ CT-Scan □ Bone Scan
Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? □ YES □ NO
Have You Ever Had Surgery Of Any Kind On Your Spine / Low Back / Sacroiliac Joint? □ YES □ NO
Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? □ YES □ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? □ YES □ NO
If you answered “Yes” please describe and include dates where necessary

XVII. Hip / Groin:
Have You Ever Suffered An Injury To Your Hip / Groin (including hernias and/or sports hernias)? □ YES □ NO
Were Any Diagnostic Tests Performed? (check all that apply) □ X-Rays □ MRI □ CT-Scan □ Bone Scan
Have You Ever Had Surgery For A Hip / Groin Injury? □ YES □ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? □ YES □ NO
If you answered “Yes” please describe and include dates where necessary

XVIII. Thigh / Hamstring / Quadriceps:
Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? □ YES □ NO
Were Any Diagnostic Tests Performed? (check all that apply) □ X-Rays □ MRI □ CT-Scan □ Bone Scan
Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? □ YES □ NO
Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? □ YES □ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? □ YES □ NO
XIV. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)?

☐ YES  ☐ NO

Were Any Diagnostic Tests Performed? (check all that apply)  ☐ X-Rays  ☐ MRI  ☐ CT-Scan  ☐ Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury?

☐ YES  ☐ NO

Have You Ever Had Surgery For A Knee and/or Patella Injury?

☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury?

☐ YES  ☐ NO

Have You Ever/Do You Presently Wear A Knee Brace?

☐ YES  ☐ NO

If you answered “Yes” please describe and include dates where necessary ____________________________

_____________________________________________________________________________________

XX. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg?

☐ YES  ☐ NO

Were Any Diagnostic Tests Performed? (check all that apply)  ☐ X-Rays  ☐ MRI  ☐ CT-Scan  ☐ Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury?

☐ YES  ☐ NO

Have You Ever Had Surgery For An Ankle / Lower Leg Injury?

☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury?

☐ YES  ☐ NO

Do You Presently  ☐ Tape Your Ankle(s)  ☐ Use Ankle Brace(s)  ☐ Other

If you answered “Yes” or “Other” please describe and include dates where necessary ____________________________

_____________________________________________________________________________________

XXI. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)?

☐ YES  ☐ NO

Were Any Diagnostic Tests Performed? (check all that apply)  ☐ X-Rays  ☐ MRI  ☐ CT-Scan  ☐ Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury?

☐ YES  ☐ NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury?

☐ YES  ☐ NO

If you answered “Yes” please describe and include dates where necessary ____________________________

_____________________________________________________________________________________
XXII. Ribs / Thorax / Chest:
Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? ☐ YES ☐ NO
Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan
Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? ☐ YES ☐ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? ☐ YES ☐ NO
If you answered “Yes” please describe and include dates where necessary __________________________

XXIII. Abdomen:
Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? ☐ YES ☐ NO
Have You Ever Suffered An Injury To Your Abdomen? ☐ YES ☐ NO
Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan
Have You Ever Had Surgery For An Abdomen Injury? ☐ YES ☐ NO
Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? ☐ YES ☐ NO
Do you Routinely Suffer From Chronic or Recurrent Diarrhea? ☐ YES ☐ NO
Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO
Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? ☐ YES ☐ NO
If you answered “Yes” please describe and include dates where necessary __________________________

XXIV. Medications:
Please List ALL Prescription & Over-the-Counter Medications That You Are CURRENTLY Taking or Have Taken In The PAST Two (2) Years, & For What Purpose:

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<tr>
<th>MEDICATION</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
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NU Athletic Training Health History Information
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Student-Athlete’s Initials ____________
XXV. Supplements / Ergogenic Aids:
Please list **ALL** supplements/ergogenic aids that you are **CURRENTLY** taking or **have taken** in the past twelve (12) months and the purpose:

<table>
<thead>
<tr>
<th>SUPPLEMENT</th>
<th>PURPOSE</th>
<th>DOSAGE</th>
<th>DATE(S)</th>
</tr>
</thead>
<tbody>
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XXVI. Please Answer: *(All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!)*

- [ ] YES  [ ] NO  Has anyone in your family died before the age of 50 due to a medically related condition?
- [ ] YES  [ ] NO  Have you ever had any injury or illness other than those already noted?
- [ ] YES  [ ] NO  Do you have any ongoing or chronic illnesses?
- [ ] YES  [ ] NO  Have you ever been hospitalized overnight?
- [ ] YES  [ ] NO  Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
- [ ] YES  [ ] NO  Are you currently under a physician’s care for any medical conditions?
- [ ] YES  [ ] NO  Have you ever been under the care of a psychiatrist and/or psychologist?
- [ ] YES  [ ] NO  Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
- [ ] YES  [ ] NO  Have you ever had a rash or hives develop during and/or after exercise?
- [ ] YES  [ ] NO  Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
- [ ] YES  [ ] NO  Have you ever been told that you have kidney disease?
- [ ] YES  [ ] NO  Have you ever had rubella ("German Measles") and/or Rubella ("red measles")?
- [ ] YES  [ ] NO  Have you ever had a stomach and/or duodenal ulcer?
- [ ] YES  [ ] NO  Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
- [ ] YES  [ ] NO  Have you ever had seizures, convulsions, and/or epilepsy?
- [ ] YES  [ ] NO  Have you ever had gall bladder disease and/or a urinary problem?
- [ ] YES  [ ] NO  Do you have ringing in your ears or trouble hearing?
- [ ] YES  [ ] NO  Do you have frequent ear infections or nosebleeds?
- [ ] YES  [ ] NO  Have you ever had an abnormal chest x-ray and/or pneumonia?
- [ ] YES  [ ] NO  Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
- [ ] YES  [ ] NO  Have you ever had the chickenpox?  If yes, when?
- [ ] YES  [ ] NO  Have you had a tetanus booster within the past five (5) years?  If yes, when?
- [ ] YES  [ ] NO  Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)?  If yes, when?
- [ ] YES  [ ] NO  Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
- [ ] YES  [ ] NO  Do you use alcohol?  If yes, how often?
- [ ] YES  [ ] NO  Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
- [ ] YES  [ ] NO  Do you have any questions regarding drugs, tobacco, or alcohol?
- [ ] YES  [ ] NO  Do you feel stressed out?  If yes, do you feel as though you get the necessary support to deal with your stress?
- [ ] YES  [ ] NO  Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
- [ ] YES  [ ] NO  Are you a vegetarian?
- [ ] YES  [ ] NO  Are you a vegetarian?  If yes, what type?
- [ ] YES  [ ] NO  Do you regularly lose weight to participate in your sport?
- [ ] YES  [ ] NO  Do you want to weigh more or less than you presently do?
- [ ] YES  [ ] NO  Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
- [ ] YES  [ ] NO  Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
- [ ] YES  [ ] NO  Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?
- [ ] YES  [ ] NO  Are you aware of any reasons why you should not participate in intercollegiate athletics at Northwest University this time?
If you have answered **YES** to any of the above, please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If you have had surgery or been under the care of a physician for a medical condition in the past 12 months that has restricted your athletic participation in any way, you must provide Northwest University Athletic Department and Athletic Training Staff with a written release from the attending physician for participation in activities related to your condition and the specific sport you intend to participate in prior to **ANY** conditioning, practice or competition.

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through twelve (14) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

________________________________________________________________________

Student-Athlete Signature          Date

________________________________________________________________________

Student-Athlete Print Name

________________________________________________________________________

Parent/Guardian Signature (if under 18 years of age)          Date

________________________________________________________________________

Parent/Guardian Print Name

________________________________________________________________________

Witness          Date

Reviewed By NU Athletic Training Staff:

________________________________________________________________________

Reviewer’s Signature          Date

________________________________________________________________________

Reviewer Print Name
Northwest University
Authorization for Use/Disclosure of
Student-Athlete Protected Health Information

I, __________________________________________, authorize the Athletic Training Staff of Northwest University, and any other designated team physician(s), Counseling, Health and Wellness Services (CHWS) physician(s) and staff, paramedic(s) or other health care provider(s) associated with intercollegiate athletic participation at Northwest University, to release any and all information regarding my health or medical condition to any treating or attending health care provider in the normal and regular course of any treatment or procedure I may require as a result of my participation in intercollegiate sports, as well as to the health care providers at any treating hospital or other medical facility.

I authorize Northwest University Athletic Training Staff to release such medical information to coaches, administrators, teammates and designated medical personnel as it pertains to my safety and continued medical care. I authorize communication with the following family members or others (list parents, relatives, legal guardians, etc.), to whom information about your medical conditions may be communicated to:

1. __________________________________________
2. __________________________________________
3. __________________________________________

I further authorize the release of Protected Health Information to those listed above in paragraphs one and two, (initial) so appropriate determination may be made with regard to eligibility and to assist in processing intercollegiate secondary insurance policy claims through Summit America Claim Services.

This authorization is valid for the duration of the school year, for so long as I am receiving any medical treatment occurring as a result of my participation in intercollegiate athletics at Northwest University, and for any follow up consultations which are received for injuries that occur as a result of my participation in intercollegiate athletics. I also understand that I may revoke this authorization at any time by providing written notice to Northwest University Head Athletic Trainer.

All participants in the Northwest University intercollegiate athletics must complete this form as a condition of participation.

_________________________________________  __________________
Signature of Student Athlete     Date

OR

_________________________________________  __________________
Signature of Parent or Legal Guardian     Date

Name of Parent or Legal Guardian
I, the undersigned, hereby acknowledge, affirm, and represent the following:

A. PRESENT PHYSICAL CONDITION:
   I have previously warranted and represented to Northwest University Athletic Department that I am in excellent physical condition. Upon reporting to Northwest University, I completed a “Health History Questionnaire” form and was examined by a personal physician, nurse practitioner and/or his/her designee. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history; that my Health History Questionnaire Form was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with a personal physician, nurse practitioner and/or his/her designee; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition.

   Student-athlete initials

B. FUTURE COMPLAINTS:
   I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to a member of the Northwest University Athletic Training Staff and/or to the University’s Team Physician, no matter how minor or insignificant I may deem them to be.

   Student-athlete initials

C. CONSENT TO MEDICAL TREATMENT:
   I hereby authorize the Northwest University team physicians, athletic trainers, and designated medical staff to examine and treat any injuries, which may occur, while participating in intercollegiate athletics for Northwest University. I authorize the team physicians, athletic trainers, and designated medical staff to communicate with athletic department officials and coaching staff regarding their findings and recommendations. I further understand that the team physician and/or his/her designee have the authority to eliminate me from participation as a student-athlete due to an injury/illness, and/or due to undue liability risk of the Northwest University.

   Student-athlete initials

D. STATEMENT OF MEDICAL INSURANCE:
   I understand that as a student-athlete at Northwest University, I should be covered by some type of individual health insurance before participating in any strength and conditioning session, practice, game, and/or competition. This insurance shall be considered the PRIMARY insurance coverage for all athletic related injuries. I understand that the Northwest University Department of Intercollegiate Athletics will provide a medical and catastrophic insurance program for student-athletes injured in practices, games or competitions, and/or related travel that was supervised by approved University coaching staff and approved by the Director of Athletics according to NAIA regulations. This policy, however, is SECONDARY TO, OR IN EXCESS OF, THE STUDENT-ATHLETE’S INDIVIDUAL HEALTH INSURANCE AND WILL COVER RELATED EXPENSES AFTER PAYMENT OF THE $500.00 DEDUCTABLE FEE. In addition, I further understand and agree that the insurance of Northwest University Department of Intercollegiate Athletics is not effective for an aggravation or re-injury to a preexisting injury, and therefore, Northwest University, and their officers, employees, and agents will not be liable for any expenses resulting from such injury, regardless of its disclosure to the team physician(s) and/or members of the Sports Medicine Department.

   Student-athlete initials
E. ASSUMPTION OF RISK/AGREEMENT TO PARTICIPATE:

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, 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. Because of the aforementioned dangers of participating in any athletic activity, I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Athletic Training Staff. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

In consideration of Northwest University permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release the Northwest University, and its officers, agents, and employees from any and all liability, any medical expenses not covered by personal medical insurance coverage and Summit America’s secondary policy, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

_____ Student-athlete initials

F. AUTHORIZATION:

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at Northwest University.

I hereby attest that I have read and fully understand Northwest University’s Medical Examination and Authorization Waiver. Further, I agree to abide by all the requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

_________________________       _________________________
Student-Athlete Signature       Date

_________________________       _________________________
Student-Athlete Print Name       Sport

_________________________       _________________________
Parent/Guardian Signature (if under 18 years of age)       Date

_________________________
Parent/Guardian Print Name