

# Northwest University Intercollegiate Athletics New Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Athletic Training and Sports Medicine Department at Northwest University for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times. **PLEASE RETURN ALL FORMS TO THE NU ATHLETIC TRAINING DEPARTMENT, 5520 108<sup>th</sup> Ave NE, Kirkland, WA, 98033.**

(please **TYPE** or print clearly in **BLUE** or **BLACK INK ONLY!**)

## **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 of 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 even 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 Inhaler (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

If you answered "Yes" please describe and include dates where necessary \_\_\_\_\_

**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?  Left Side of Head  Right Side of Head  
 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

**Medication**

**Form**

**Dosage**

**Frequency**

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:**

YES  NO 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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 A Elbow / Forearm Injury?  YES  NO

If you answered "Yes" please describe and include dates where necessary \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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 \_\_\_\_\_

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**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

If you answered "Yes" please describe and include dates where necessary \_\_\_\_\_

**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:

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>
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**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:

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

**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 Rubeola ("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? 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: \_\_\_\_\_

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**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 BMI Benefits, LLC.

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**

**Northwest University Intercollegiate Athletics  
Medical Examination & Authorization Waiver**

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 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.** 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