EMERGENCY CONTACT INFORMATION

Today's Date: __________ NU Email: ______________________________

Name:____ Sex: ______ Age:________
LAST *FIRST* *MIDDLE*

Sport:_______________ NU ID#:___________________ Birth Date: ________________

Address while at school: ________________________ City: ______________ State: ___ Zip: _________

Cell Phone: _______________________________

WITH WHOM DO YOU RESIDE WHILE NOT AT NU?
(Check One) ☐ Father ☐ Mother ☐ Both ☐ Guardian

****

Father's Name: _____________________________ Home Phone: ____________________
LAST *FIRST*

Work Phone: _______________________________ Cell Phone:_______________________

Address: __________________________________ City/State/Zip: ____________________

Country: __________________________________ Email: _________________________________

****

Mother's Name: ____________________________ Home Phone: _____________________
LAST *FIRST*

Work Phone: ______________________________ Cell Phone: _______________________

Address: _________________________________ City/State/Zip: ____________________

Country:_________________________________ Email: _________________________________

****

CONTACT PERSON IN CASE OF EMERGENCY (if different from above)

Name: __________________________________ Relation: _________________________
LAST *FIRST*

Home Phone:________________________ Cell Phone:_______________________

Address: __________________________________ City/Sate/Zip: _____________________

Country: _________________________ Email: _________________________________

****

PERSONAL/FAMILY PHYSICIAN INFORMATION

Name: ___________________________________ Address: _______________________________

City:____________________ State: ______ Zip: _____________ Country: ________________________

Phone: __________________________ Email: _________________________________

INSURANCE INFORMATION

Northwest University Athletics has an excess medical insurance policy that covers student-athletes in the event of an ATHLETIC-RELATED INJURY. This policy provides coverage for these injuries after all other available insurance pays on the claim. The option of waiving primary insurance is not available. The following insurance information must be fully completed, signed, and returned BEFORE you can practice or compete in any sport.

I understand I am financially responsible for balances not covered by insurance or the NU Excess Medical Insurance Policy.

Name: ____ Sport: ______________ DOB: __________

LAST *FIRST* *MI*

****

Please send good copies of Medical Insurance Cards front and back.

Or Tape or Paste below (DO NOT STAPLE)

PRIMARY INSURANCE COMPANY – A plan that provides benefits first for Intercollegiate Athletic Injuries

FRONT	BACK

Subscriber's Name:__________________________
Subscriber's DOB:__________________________
Relationship to Athlete: ____________________
Subscriber's Address: __________________________________
Subscriber's City/State/Zip:____________________________
Subscriber's Phone: ___________________________________

Employer's Name:______________________________
Subscriber's Phone: ____________________________
Employer's Address: __________________________________
Employer's City/State/Zip:____________________________

Insurance Company: ___________________________________
Policy ID #: ______________________________________
Group#: ____
Insurance Phone #: ___________________________________
____

Prescription Drug ID #: ____________________________
Prescription Drug Group #: _________________________
Prescription Drug BIN #: ___________________________
Prescription Drug PCN #: ___________________________
Prescription Drug Phone #: _________________________

Is the Athlete Covered for Intercollegiate Athletic Injuries? ☐ Yes ☐ No
Is the Athlete above covered by a secondary insurance policy? ☐ Yes ☐ No
Does the Athlete above need a second opinion? ☐ Yes ☐ No
Does the Athlete above need a pre-authorization for services? ☐ Yes ☐ No

I hereby certify that my answers are true, complete, and correct to the best of my knowledge. I hereby authorize a claim to be filed on behalf of the above athlete under the above medical policy in the event that an athletic injury is sustained.

Date:____________________ Signature:____

Returning Student-Athlete Medical Evaluation

ALL INFORMATION WITHIN THIS FORM IS KEPT CONFIDENTIAL

And only shared with those you have authorized in a separate release.

Name: ____ NU ID#: ________________ Date: ________

Last *First* *Middle*

Date of Birth: _________________ Age: _________ Cell Phone #: __________________ Sport: (M/W) _________

Medical History Questionnaire

Please answer these questions as they relate to the previous 12 months
(since your last physical or annual health appraisal)

I. General

Have you been diagnosed with any **NEW** injuries and/or medical problems ☐ Yes ☐ No
Please describe: ____

Have you been denied clearance by a medical professional to participate in any athletic activity? ☐ Yes ☐ No
Please describe: ____

Have you been told by a physician to restrict your activity or to not participate in sport? ☐ Yes ☐ No
Please describe: ____

Have you had a serious injury and/or been hospitalized? ☐ Yes ☐ No
Please describe: ____

Have you had a sprain, strain, and/or fracture? ☐ Yes ☐ No
Please describe: ____

Have you had a concussion and/or head injury? ☐ Yes ☐ No
Please describe: ____

Have you been unconscious for any reason other than anesthesia? ☐ Yes ☐ No
Please describe: ____

Have you had an operation? ☐ Yes ☐ No
Please describe: ____

Are you currently undergoing physical therapy or rehabilitation for an injury? ☐ Yes ☐ No
Please describe: ____

Do you require any special equipment to participate in athletics? ☐ Yes ☐ No
Please describe: ____

Do you have any ongoing or chronic illness? ☐ Yes ☐ No
Please describe: ____

Have you recently been diagnosed with infectious mononucleosis (Mono), hepatitis B or C, COVID-19 and/or any other severe infectious disease/viral infection? ☐ Yes ☐ No
Please describe: ____

Have you had a heat-related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time/ received special attention (IV fluids, etc.) for a heat related problem? ☐ Yes ☐ No
Please describe: ____

Have you experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise? ☐ Yes ☐ No
Please describe: ____

Do you experience frequent headaches? ☐ Yes ☐ No

Please describe: ____

Have you been diagnosed with anemia (low hematocrit or low iron)? ☐ Yes ☐ No

Please describe: ____

When was your last dental exam: __________________ When was your last eye/vision exam: __________________

II. Allergies

Are you allergic to or have you ever had an allergic reaction to any of the following: ☐ Yes ☐ No

- ☐ Prescription or Over-the Counter Medications: ______________________________
- ☐ Food and/or drink products: ______________________________
- ☐ Bee stings, insect bites, etc.: ______________________________
- ☐ Seasonal related allergies: ______________________________
- ☐ Other (please describe specific allergies): ______________________________

Please describe allergy(ies) and reaction: ______________________________

____

Have you ever been prescribed an Epi-Pen or similar product? ` ☐ Yes ☐ No

Are you presently or have you ever taken medication for allergies or allergic reactions? ☐ Yes ☐ No

Please describe incident and date: ______________________________

____

III. Medications (Prescription and Over the Counter) and Supplements

Are you currently taking **ANY** prescription medications or consistent over the counter medications? (including birth control)? ☐ Yes ☐ No

Please List (attach additional page if necessary:

____

____

____

Please list **ALL** supplements or ergogenic aids (protein shakes, energy drinks, vitamins, minerals, etc.) that you currently take or have taken in the past twelve (12) months (attach additional pages if necessary):

Please list supplement and reason for use: ______________________________

____

____

Please list names and titles of individuals who have recommended the above supplements or ergogenic aids:

____

IV. Cardiovascular Risk Factors

Have you experienced any of the following during of after practice? ☐ Yes ☐ No

- ☐ Chest pain or pressure
- ☐ Felt dizzy or lightheaded
- ☐ Irregular heart beat (palpitations), heart racing or skipping
- ☐ Lost consciousness or passed out
- ☐ Shortness of breath

Please describe: ____

Have you ever been informed that you have (or have had) any of the following: ☐ Yes ☐ No

- ☐ Heart disease or infection – when: ________________
- ☐ High blood pressure – when: ________________
- ☐ High blood cholesterol – when: __________________
- ☐ A Heart murmur – when: __________________

Does anyone in your family have any of the following: ☐ Yes ☐ No

☐ Heart disease: Relationship and age: ______

☐ High blood pressure: Relationship and age: ______

☐ High blood cholesterol: Relationship and age: ______

Has anyone in your family died of heart problems or sudden death prior to age 50? ☐ Yes ☐ No

Please describe: ______

______

Has anyone in your family been diagnosed with Marfan's Syndrome? ☐ Yes ☐ No

Please describe: ______

______

Has anyone recommended that you do a test for your heart, whether you did the test or not? ☐ Yes ☐ No

Please describe: ______

______

V. Asthma and Respiratory History

Have you ever been diagnosed with Asthma and/or Exercise Induced Asthma (EIA)? ☐ Yes ☐ No

Do you presently take or have you previously taken any asthma medication? Do you use an inhaler? ☐ Yes ☐ No

Please describe: ______

How often (per week): ______

In the past twelve (12) months, how many acute asthma attacks have you sustained? ______

Do you use an inhaler at other times when not exercising? ☐ Yes ☐ No

Please describe: ______

Do you cough frequently during exercise? ☐ Yes ☐ No

Please describe: ______

Have you ever been diagnosed with Tuberculosis, Pneumonia, or any other respiratory issues? ☐ Yes ☐ No

Please describe: ______

Have you ever been hospitalized for asthma or exercise induced asthma? ☐ Yes ☐ No

Please describe: ______

VI. Nutrition

Have you experienced a 10lb weight loss or weight gain over the summer? ☐ Yes ☐ No

Are there certain foods that you do not eat or avoid? ☐Yes ☐No

Please list food and reasons: ______

______

Food allergies: ______

Reactions: ______

Food intolerances: ______

Reactions: ______

Do you follow any special meal plan/diet (i.e. vegetarian, paleo, keto, gluten-free, etc.) ______

______

Have you had an eating disorder or altered your eating pattern for athletic performance? ☐Yes ☐No

Please explain: ______

______

Have you ever tired controlling your weight by any of the following methods? ☐Yes ☐No

☐Using laxatives ☐Vomiting ☐ Excessive exercise ☐Diuretics ☐Diet pills ☐Other: ______

Are you or have you ever taken supplements to help you gain or lose weight or improve your performance

☐ Yes ☐ No

Further nutrition concerns:

____
____
____
____
____
____

VII. Mental Health

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
Feeling down, depressed, or hopeless	0☐	1☐	2☐	3☐
Trouble falling asleep, stay asleep, or sleeping too much	0☐	1☐	2☐	3☐
Thoughts that you would be better off dead or hurting yourself in some way	0☐	1☐	2☐	3☐
Feeling nervous, anxious, or on edge	0☐	1☐	2☐	3☐
Not being able to stop or control worrying	0☐	1☐	2☐	3☐

Are you currently being emotionally, physically, or sexually abused by your partner or someone important to you?
☐ Yes ☐ No

Are you interested in meeting with a counselor or receiving mental health treatment? ☐ Yes ☐ No

If yes, what is a good contact number to send scheduling resources? ___________________________________

Have you received counselling from a Psychologist, Psychiatrist, or Counselor? ☐ Yes ☐ No

Have you been diagnosed by a physician with ADD or ADHD? ☐ Yes ☐ No

Diagnosis date: ___________________________ Medication(s) Used: _________________________________

How was your diagnosis made (i.e. questionnaire, consult with a physician, etc.) __________________________

When was your most recent follow-up visit with a physician for ADD or ADHD: ___________________________

Have you ever suffered from emotional disturbance (depression, anxiety, etc.)? ☐ Yes ☐ No

Diagnosis date: __________________________ Medication(s) used: ___________________________________

Have you ever used any type of tobacco products? ☐ Yes ☐ No

If yes, check all that apply: ☐Cigarettes/E-Cigarettes ☐Dip ☐Chew ☐Snuff ☐ Other: ____________

Do you use Alcohol? ☐ Yes ☐ No

If yes, what type and how often: ____

Have you tried/used Marijuana (THC) in any form in the last 12 months? ☐ Yes ☐ No

Have you tried/used CBD creams, oils, or topicals in the last 12 months? ☐ Yes ☐ No

Have you ever used/tried illicit drugs (cocaine, heroin, meth, etc.)? ☐ Yes ☐ No

VIII. Female Student-Athletes Only

What date did your last period start? ____________________ How many days do your periods last? ____________

How many periods have you had in the last 12 months? ____

Do you use a prescription birth control method? ☐ Yes ☐ No

Please describe method: ____

Have you ever had a pelvic exam or PAP smear? ☐ Yes ☐ No

When was your last pelvic exam? ______________________ Breast Exam? ___________________________

Have you ever had an abnormal pelvic exam or PAP smear? ☐ Yes ☐ No

If yes, when? ____

IX. Male Student-Athletes Only

Have you ever had a testicular exam? ☐Yes ☐No

Most recent date: ____

Do you/have you ever examined your testicles for masses? ☐Yes ☐No

Have you ever sustained a testicular torsion? ☐Yes ☐No

When? ____

Did you have an undescended testicle(s) at birth? ☐Yes ☐No

Have you ever undergone surgery for a testicular abnormality? ☐Yes ☐No

Please describe: ____

I affirm that all information contained in this medical history document is 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 that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student- Athlete Signature: ____ Date: _____________

Parent/Legal Guardian Signature: ____ Date: _____________
(If student-athlete is under age 18)

Athletic Trainer Signature: ____ Date: _____________

ATHLETIC MEDICINE POLICIES

Insurance Information

Initials _________

Northwest University Athletics has an excess accident insurance policy that covers student-athletes athletic-related injury. This policy provides coverage for these injuries **after** all benefits have been paid by the student-athletes primary and secondary insurance. The option of waiving primary insurance is not available. By signing below, I authorize NU Athletics/Health Services or insurance company to release any information required to process my claim(s). I also authorize NU Health Services to disclose health information to NU Athletics for the purpose of processing payment(s). I understand that I am financially responsible for balances not covered by insurance or NU's excess policy.

The following are the responsibilities of the student-athlete and/or parent to ensure athletic related bills are covered by NU Athletic Medicine.

- Provide and maintain up to date insurance information throughout the year, including front and back copies of all medical insurance cards to NU Athletic Training Staff.
- Complete and return, in a timely manner, any questionnaires received from your insurance company. Most Insurance companies won't process bills until questionnaires are received back.
- Fax, mail, or bring in all athletic related medical bills to the NU Athletic Training Staff. **If you are receiving the bill at home, then we have no knowledge of it and the bill will remain unpaid.** Collection agency action can result when bills are not promptly brought to our attention. Assist (if needed) in the process of athletic related medical/dental claims.
- Fax, mail, or bring any Explanation of Benefits (EOB) to the Northwest University Athletic Training Staff. To remain compliant with the Washington State guidelines, we might not be able to pay an athletic related bill(s) without a copy of the EOB for each bill. Your cooperation in this area will greatly assist in expediting payments of all bills.

Failure to do any of the above may result in the NU excess policy to deny coverage of an athletic related bill or the bill(s) moving to collections status, in which we are not responsible for collections fees.

Please send any of the above documentation to: NU Athletic Training, 5520 108th Ave NE, Kirkland, WA, 98033; Fax: 425-803-0413 and Phone: 425-889-5353.

Athletic Facilities Physician Clinics

*Initials*_________

If a student-athlete is seen in any of the athletic facilities physician clinics, and require further evaluation at a Team Physician's clinic, these visits will be billed to your primary and secondary insurance, with the NU excess policy covering any remaining balances or copays.

Missed or Late Appointment Charges

*Initials*_________

Northwest University will not cover any missed or late appointment fees. Any of these fees will be your responsibility to pay.

Exiting NU Athletics *Initials*_________

When you have completed your career at NU and/or are removed from the eligibility report, you will fill out an Exit Evaluation form with the NU Athletic Training Staff. This form needs to be completed within 30 days of your removal from the eligibility report or your file will be ***closed***. It is Athletic Department policy to provide financial support for injuries the occurred and were reported while participating in NU athletics, including competition, practice, and university supervised training. Exclusions to this would include a resolution of injury, transfer to another institution, or the signing of a professional contract.

Contact Information *Initials*__________

It is your responsibility to keep your home and school addresses updated with the NU Athletic Training Staff. These are the only address NU Athletic Training will use. It is also your responsibility to complete a change of address with the United States Postal Service anytime you move. NU Athletic Training will only use your @northwestu.edu email account. It is your responsibility to check or forward this account. NU Athletic Training may call or text information to you. It is your responsibility to make sure your cell phone number is up-to-date and correct with the NU Athletic Training Staff.

By signing below, I acknowledge that I have read and understand the policies and I don't have any questions.

Student Athlete Name (printed)	_Student Athlete Signature_	_Date_
Parent/Legal Guardian Name (if under 18)	_Parent/Legal Guardian Signature_	_Date_
NU Athletic Training Staff Signature	_Date_	

ATHLETIC TRAINING LEAGLESE & POLICIES
Student-Athlete

Assumption of Risk *Initials*__________

Participation in intercollegiate athletics at Northwest University (NU) involves inherent risks of injury despite the precautions taken to prevent injury. I am fully aware that conditioning, practicing or playing in ANY sport can be a dangerous activity involving numerous RISKS; including death, serious bodily injury, illness, or property damage. Participation in ANY sport involves different levels of physical activity by RISKS OF INJURY; both minor and serious are common to all sports. Some examples include, but are not limited to:

- Sudden death related to exercise, heart attack, respiratory failure
- Paralysis, spinal cord damage, nerve damage
- Head injuries, concussions, tooth damage
- Broken bones, joint damage, osteoporosis, arthritis
- Eye injury, vision loss, loss or injury to vital organs
- Muscle and ligament damage, sprains, etc.
- Menstrual irregularities
- Psychological damage as a result of injury

During the 2020-2021 athletic season, I will participate in NU Intercollegiate Athletics. The athletic season for all sports at NU is defined as conditioning, practicing, or playing ANY sport from August 1, 2020 to May 31, 2021.

I fully understand and appreciate the RISKS associated with my involvement in this specific sport. If I have any questions regarding the risks inherent in this sport, I understand that it is my responsibility to ask a member of the NU Athletic Training staff. In consideration for the opportunity for participation in this sport, I voluntarily agree to assume all RISKS, including death, serious bodily injury, illness, or property damage. I agree to follow and play within the rules of this sport and report any health of safety concerns immediately to the NU Athletic Training Staff.

Release of Liability *Initials*___________

I RELEASE the state of Washington, the Board of NU, NU, any subdivision or unit of NU, its officers, employees and agents; from any and all liability, claims, costs, expenses, injuries/death/losses suffered by me as a result of my participation in the sport. My participation includes, but is not limited to, athletic training and practice, travel to and from athletic event and associated activities in a private or public vehicle, and any activity connected with the sport and while using NU equipment or facilities whether on or off NU property.

By my signature below, I certify that I have carefully read this document and that I am fully informed about the RISKS associated with this activity. I am satisfied that I can safely participate in this sport. I understand this document is a contract with NU. I or my parents/legal guardians (if I am under the age of eighteen) sign this document freely and voluntarily.

Reporting Injuries/Illnesses *Initials*____________

I agree to report any injuries/illnesses in a timely manner to a Certified Athletic Trainer or Team Physician that have occurred while participating in Intercollegiate Athletics at Northwest University or that may be pre-existing. By doing this I will also comply with the treatment plan that is set forth by the Athletic Training Team.

In cases of serious injury or medical conditions (i.e. concussions, sickle cell trait, diabetes, or other medical conditions), I understand that these conditions can result in serious bodily harm, side effects, or even death. I agree to be truthful and honest with the Athletic Training team on any signs or symptoms that I am experiencing as a result of these injuries/illnesses.

Medical Treatment Authorization

*Initials*___________

I hereby authorize and give consent to the Northwest University Athletic Training and Northwest University Health Services, or any licensed physicians, to perform or administer any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor medical procedures.

I authorize NU Athletic Training to provide Northwest University Health Services any information requested, and authorize Northwest University Health Services to provide Northwest University Athletic Training any information requested concerning my health and athletic status.

In the event major surgery is necessary, Northwest University Athletic Training, Northwest University Health Services or licensed physicians are not excused from attempting to contact my parent(s)/legal guardian by phone or mail before relying on this authorization. This authorization does not entitle a licensed physician to render any medical or surgical treatment without my personal consent, unless I am unable to give consent.

I understand and agree that Northwest University Athletic Training may use or disclose protected health information for the purpose of treatment, billing and insurance, payment, and healthcare operations.

Disclosure of Protected Health Information Authorization

*Initials*________

I understand my injury/illness health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Education Rights and Privacy Act (FERPA) of 1974 (The Buckley Amendment) and RCW 70.02 (Washington Health Care and Access Disclosure Statute). In accordance with the confidentiality of students' individual educational records (FERPA), the NU Athletic Training Staff will not release information to anyone outside of the following mentioned parties unless specifically designated.

- I authorize NU's Athletic Training (Certified Athletic Trainers, Team Physicians, and other medical consultants as necessary) to speak in their sole discretion with the NU Athletic Department coaches about medical injuries, illnesses, treatment, and rehabilitation as that may affect my athletic performance.
- I give permission to release medical information when necessary as it relates to participation in my sport to other NU Athletic Department Staff and NU Health Services including administrators, nutrition, wellbeing, student services professionals, insurance personnel, financial services personnel, academic counselors, and your parent/guardian.

This does not authorize the release of any medical information regarding an injury/illness/medical condition not affecting my athletic performance. I understand that I may specifically request, in writing, that certain medical information not be release to the above noted persons on an incident specific basis.

This authorization/consent will be valid until **May 31, 2021** unless revoked by me. I may revoke this release at any time by delivering a signed and dated notice of revocation to a member of the NU Athletic Training Staff. My revocation will be valid except to the extent that the NU Athletic Training Staff has already acted in reliance upon the release.

By my signature below, I certify that I have carefully read this document and that I am fully informed about the RISKS associated with this activity. I am satisfied that I can safely participate in sport. I understand this document is a contract with NU. I or my parents/legal guardians (if I am under the age of eighteen) sig this document freely and voluntarily.

______________________________	______________________________	____________
Student Athlete Name (printed)	*Student Athlete Signature*	*Date*
______________________________	______________________________	____________
Parent/Legal Guardian Name (if under 18)	*Parent/Legal Guardian Signature*	*Date*

STATEMENT FOR NUTRITIONAL SUPPLEMENTS AND PERFORMANCE ENHANCING SUBSTANCES

Food should always be the primary source of nutrients. In conjunction with food, nutritional supplements can help student-athletes meet nutrition needs. Nutritional supplements may provide additional fluids, carbohydrates, protein, vitamins, and minerals to an athlete's diet. Student-athletes should not replace food with supplements or rely solely on nutritional supplements to provide adequate nutrients or calories.

Student-athletes are able to consume sufficient amounts of nutrients by eating a variety of food. Nutritional supplementation is ineffective if student-athletes do not regularly consume a variety of nutrient dense foods. Student-athletes have been known to abuse nutritional supplements as a means to enhance performance. This abuse occurs despite mixed empirical research data, financial cost, the potential for a positive drug test resulting in loss of eligibility, and potentially harmful side effects.

The use of nutritional supplements can be problematic because nutritional supplements ***are not*** subject to the United States Food and Drug Administration guidelines. Therefore, the contents of supplements may not be accurately listed on the label which can lead to health problems and a positive drug test. Many supplements and/or ingredients in the supplement are not approved for safe use, are also ***not*** NAIA compliant, and may not be accurately or consistently proven to positively affect performance.

Performance enhancing substances include, but are not limited to, stimulants such as ephedrine and caffeine (if the concentration in urine exceeds 15 microgram/ml), anabolic agents such as androstenedione and anabolic steroids, diuretics, and peptide hormones and analogues such as growth hormone. Performance enhancing substances are banned by the NAIA and will result in positive drug test, possibly affecting eligibility in post-season competition. If teams or student-athletes achieve play in post-season national competitions, a consent form will be filled out at that time.

Due to the potential problems related to supplement use, the position of the NU's athletic department is as follows:

Neither the NU Athletics Department, nor any of its employees, will purchase, distribute, or assist with the acquisition of an unapproved substances for student-athletes.

If a student-athlete is taking supplementation, or any drugs found on the NAIA banned substances list by prescription of a doctor, then an exemption form will be filled out by the prescribing doctor. For further information regarding supplements, medications, and banned drugs, please visit: https://www.naia.org/student-athlete-wellness-center/drug-education

I have read and reviewed Northwest University's supplement policy. I understand its contents and have no questions.

______________________________	______________________________	____________
Student Athlete Name (printed)	*Student Athlete Signature*	*Date*
______________________________	______________________________	____________
Parent/Legal Guardian Name (if under 18)	*Parent/Legal Guardian Signature*	*Date*
______________________________	____________	
Athletic Trainer Signature	*Date*	

Concussion Statement Form

Concussions are a potentially serious injury to the brain. Most concussions do not involve a loss of consciousness. Symptoms of concussion include, dizziness, headache, feeling "out of it" or "foggy", vision changes, sensitivity to light or noise, balance problems, and other symptoms. If you have any concerns that you may have suffered a concussion, you are obligated to report it to the Northwest University Athletic Training staff. Concussions frequently occur in sports and repetitive concussions have been relegated to long term changes in brain function.

Northwest University now requires *ALL* student-athletes to sign a statement in which each student-athlete accepts responsibility for reporting their injuries and illnesses to the institutional Athletic Training staff, including signs and symptoms of concussions. Our goal is to keep you participating safely.

By signing this form, I am acknowledging I have received educational materials about concussions and I understand my responsibility to inform the Athletic Training staff of my injuries and illnesses, including signs and symptoms of concussion.

I acknowledge that there are certain risks inherent in intercollegiate sports. I further acknowledge that suffering a concussion is a risk when I participate in intercollegiate sports and keeping my coaches and athletic training staff informed of any concussion symptoms is very important and my responsibility. I acknowledge that all risks cannot be prevented and I assume those risks beyond the control of the Northwest University Athletic Training staff. I further assume the risk of all consequences that result from my decision to not inform the NU Athletic Training staff of concussion symptoms.

______________________________ ______________________________ ____________

Student Athlete Name (printed) *Student Athlete Signature* *Date*

______________________________ ______________________________ ____________

Parent/Legal Guardian Name (if under 18) *Parent/Legal Guardian Signature* *Date*

______________________________ ____________

NU Athletic Training Staff Signature *Date*

SPORT SCIENCE INSTITUTE™

CONCUSSION SAFETY

WHAT STUDENT-ATHLETES NEED TO KNOW

What is a concussion?

The Consensus Statement on Concussion in Sport, which resulted from the 5th international conference on concussion in sport, defines sport-related concussion as follows:

Sport-related concussion (SRC) is a traumatic brain injury induced by biomechanical forces. Several common features that may be utilized to clinically define the nature of a concussion head injury include… For complete definition click **here**:

How can I keep myself safe?

1. Know the symptoms.

You may experience …

- Headache or head pressure
- Nausea
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy or foggy
- Confusion, concentration or memory problems

2. Speak up.

- If you think you have a concussion, stop playing and talk to your coach, athletic trainer or team physician immediately.

3. Take time to recover.

- Follow your team physician and athletic trainer's directions during concussion recovery. If left unmanaged, there may be serious consequences.
- Once you've recovered from a concussion, talk with your physician about the risks and benefits of continuing to participate in your sport.

How can I be a good teammate?

1. Know the symptoms.

You may notice that a teammate …

- Appears dazed or stunned
- Forgets an instruction
- Is confused about an assignment or position
- Is unsure of the game, score or opponent
- Appears less coordinated
- Answers questions slowly
- Loses consciousness

2. Encourage teammates to be safe.

- If you think one of your teammates has a concussion, tell your coach, athletic trainer or team physician immediately.
- Help create a culture of safety by encouraging your teammates to report any concussion symptoms.

3. Support your injured teammates.

- If one of your teammates has a concussion, let him or her know you and the team support playing it safe and following medical advice during recovery.
- Being unable to practice or join team activities can be isolating. Make sure your teammates know they're not alone.

No two concussions are the same. New symptoms can appear hours or days after the initial impact.
If you are unsure if you have a concussion, talk to your athletic trainer or team physician immediately.

What happens if I get a concussion and keep practicing or competing?

- Due to brain vulnerability after a concussion, an athlete may be more likely to suffer another concussion while symptomatic from the first one.
- In rare cases, repeat head trauma can result in brain swelling, permanent brain damage or even death.
- Continuing to play after a concussion increases the chance of sustaining other injuries too, not just concussion.
- Athletes with concussion have reduced concentration and slowed reaction time. This means that you won't be performing at your best.
- Athletes who delay reporting concussion take longer to recover fully.

What are the long-term effects of a concussion?

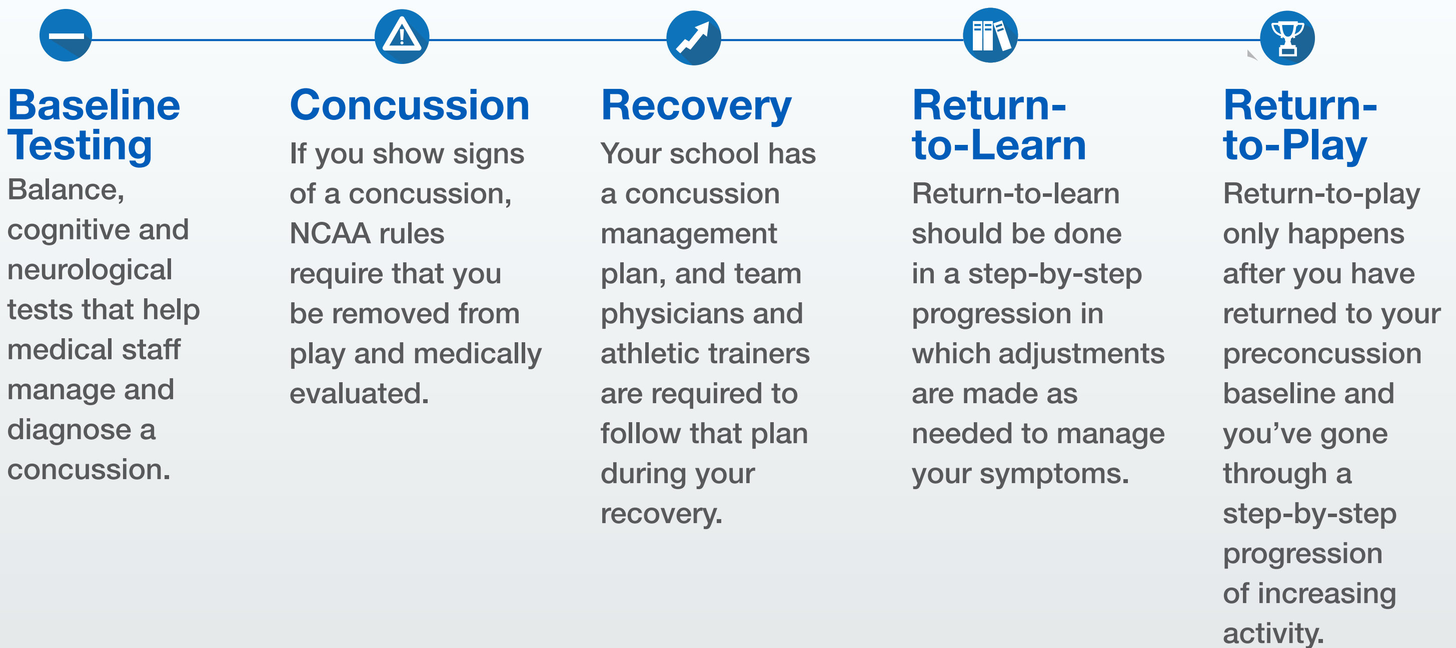
- We don't fully understand the long-term effects of a concussion, but ongoing studies raise concerns.
- Athletes who have had multiple concussions may have an increased risk of degenerative brain disease and cognitive and emotional difficulties later in life.

What do I need to know about repetitive head impacts?

- Repetitive head impacts mean that an individual has been exposed to repeated impact forces to the head. These forces may or may not meet the threshold of a concussion.
- Research is ongoing but emerging data suggest that repetitive head impact also may be harmful and place a student-athlete at an increased risk of neurological complications later in life.

Did you know?

- NCAA rules require that team physicians and athletic trainers manage your concussion and injury recovery independent of coaching staff, or other non-medical, influence.
- We're learning more about concussion every day. To find out more about the largest concussion study ever conducted, which is being led by the NCAA and U.S. Department of Defense, visit **ncaa.org/concussion**.



For more information, visit ncaa.org/concussion.

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