



Dear VWC Student:

Virginia Wesleyan College would like to take this opportunity to welcome you to VWC. We look forward to an exciting year. We understand that this is a busy time for new and returning college students; however the following physical form paperwork **must** be completed before the school year begins. Please schedule an appointment with your doctor for your admission health evaluation and/or your athletic physical soon.

***All RESIDENT STUDENTS** at Virginia Wesleyan College should complete the Medical History, Medical Examination, Insurance Information, Immunization form, and the Medical Release form (Forms A-E) and **return them to the Office of Health Services.**

***All COMMUTER STUDENTS WHO ARE NOT ATHLETES** should complete forms A, C, and D. **Return these forms to the Office of Health Services only.**

***All FRESHMAN AND TRANSFER ATHLETES** should complete the ENTIRE packet of forms (Forms A-F, and Form G if applicable). All forms must be completed and photocopied. **The originals should be mailed to the Office of Health Services and the copies should be mailed to the Department of Athletic Training.**

***All RETURNING ATHLETES** should complete the ENTIRE packet of forms (Forms A-F, and Form G if applicable). All forms must be completed. **Return these forms to the Athletic Training Department only.**

The student and/or student athlete can furnish most of the information. Some forms may require the input and signature of a parent or legal guardian. It is very important that all forms be filled out completely. **If you are an athlete, the athletic training staff will withhold you from practice/game participation if all of the requested documents are not completed!!**

The deadline for return is August 1

Form A- Medical History
Form B- Medical Examination
Form C- Insurance Information
Form D- Immunization Form (2 pages)
Form E- Medical Release
Form F- Understanding of VWC Insurance Policy
Form G- ADD/ADHD Medication Restrictions

Return forms to:

Virginia Wesleyan College
Attn: Mary Cureton R.N.
Office of Health Services
1584 Wesleyan Drive
Norfolk, VA 23502

Virginia Wesleyan College
Athletic Training Department
1584 Wesleyan Drive
Norfolk, VA 23502

****Please mail health forms to Health Services (do not FAX) unless specifically requested!!**

The Physical Form Packet may also be found on the Virginia Wesleyan College Home Page. Go to the Athletics link and click on athletic training or go to the Campus Life link and click on health services. www.vwc.edu

Thank you,

Mary Cureton, R.N.
Director of Health Services

Amy M.H. Dunleavy, MEd, ATC, EMT-B
Head Athletic Trainer

ATTENTION ALL STUDENT-ATHLETES

New restrictions regarding medications prescribed for ADD/ADHD

The NCAA has placed new restrictions on the use of medications prescribed for **ADD/ADHD** for the upcoming 2009-2010 academic year. Those of you taking medications such as Ritalin (methylphenidate) and Adderall (amphetamine) or any other drug besides Strattera for these conditions must provide information to the Virginia Wesleyan Athletic Training Staff at the beginning of the academic year in August 2009.

Please see FORM G for a list of supporting documentation that must be turned in prior to being cleared to participate in VWC athletics for 2009-2010.

*For those of you that may “borrow” these medications on occasion, it is strongly recommended that you discontinue this practice because you will have no basis for which to appeal a positive drug test result caused by these medications.

Please contact a member of the Virginia Wesleyan College Athletic Training staff with any questions you may have regarding the new restrictions or the documentation you are required to provide in order to legalize use of these medications.

Virginia Wesleyan College
ADMISSION AND PRE-PARTICIPATION PHYSICAL
 Required for Athletics and Residential Students
Student must complete this side prior to physical examination.

Name _____, _____ Age _____
Last First
 Social Security Number _____ Sex _____

Admission Status () Freshman () Transfer () Returning Student () Special _____ Date of Entrance _____

Medical History

- | | Yes | No |
|---|-------|-------|
| 1. Do you have any allergies? (<i>Drugs, Food, Insect Stings, etc.</i>)
If yes, list: _____
If yes, Do you carry an Epi-pen? _____
If yes, Do you wear Medic-Alert jewelry? _____ | _____ | _____ |
| 2. Are you currently taking any drugs or medications; including steroids or protein supplements?
(<i>Daily or occasionally</i>) *If you are an athlete, please see FORM G
List: _____ | _____ | _____ |
| 3. Are you presently being treated for any condition by a health care professional?
Explain: _____ | _____ | _____ |
| 4. Have you ever been advised by a provider not to participate in any sport/activity?
If yes, explain: _____ | _____ | _____ |
| 5. Do you use any protective equipment/devices while playing sports?
If yes, explain: _____ | _____ | _____ |

6. Do you currently have any of the chronic conditions, disorders or diseases listed below? Check those applicable.

- | | | | | |
|---------------------------------|------------------------------|--|---------------------------|--------------|
| _____ Asthma | _____ Bleeding Disorders | _____ Diabetes | _____ Epilepsy (Seizures) | _____ Cancer |
| _____ Hepatitis (Liver Disease) | _____ Hypertension (High BP) | _____ Sickle Cell Anemia | _____ Mental Illness | _____ Other |
| _____ Mononucleosis Yr. _____ | _____ Heart Disease | _____ Handicap or congenital disease(describe) _____ | | |

Please check where applicable if you currently have or had in the past any of the following:

	Yes	No		Yes	No
Head injury, concussion, or been unconscious			Eye injury or retinal detachment		
Headaches more than once a week			Wear glasses or contact lenses		
Lack of feeling or numbness in any body part			Nose bleeds for no reason		
Heat exhaustion or heat stroke			False teeth, caps or braces		
Difficulty running 1/2 mile without stopping			Rash or skin problem		
Chest pain, dizziness or passing out during exercise			Missing or malfunction of any body part (eg. kidney, eye, ear, testicle)		
Coughing, wheezing or gasping for breath with exercise or cold weather			Severe viral infection (ie. Myocarditis or Mononucleosis) within the last month		
Smoke cigarettes or chew tobacco			Neck, spine or low back injury or pain		
Heart problem, murmur or arrhythmia			Lump(s) in arm pit or groin		
Family member with a heart attack or sudden death under age 50			Black or bloody bowel movements (stools)		
Loss or gain of more than 10 lbs. in last year			Diarrhea more than once a week		
Special diet for medical reasons			Kidney disease or dark, brown or bloody urine		
Females: <i>Date of last period:</i> _____			Disabling cramps with menstrual periods		
Absent or irregular monthly periods					

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check appropriate area and explain below.
 If you have sustained fractures in any of these areas, please check the appropriate area and explain below.

- Head Neck Back Chest Shoulder Upper arm Elbow Forearm Wrist Hand
 Finger Hip Thigh Knee Shin/Calf Ankle Foot

Within the last five years, have you been hospitalized (for medical or surgical reasons) or sustained an injury that did not allow you to participate in regular activities for more than a week? _____ Yes _____ No

If yes, provide the following information:

INJURY OR MEDICAL PROBLEM	YEAR	RESOLVED	
		YES	NO

I hereby state that I have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

STUDENT SIGNATURE	DATE	PARENT/ GUARDIAN SIGNATURE (IF STUDENT UNDER 18)	DATE
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Form B

Virginia Wesleyan College
HEALTH SERVICES
1584 Wesleyan Drive , Norfolk, VA 23502
PHONE: 757-455-3108

MEDICAL EXAMINATION – To be completed by Health Care Provider

NAME _____ DATE OF BIRTH _____

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		

HEIGHT _____ WEIGHT _____
BP _____ PULSE _____
URINALYSIS: _____protein _____blood _____glucose
VISUAL ACUITY: _____RIGHT _____LEFT
Hemoglobin _____ OR Hematocrit _____

***If patient is a student-athlete and is currently taking a prescribed stimulant for ADHD or ADD, please see FORM G**
List any medications student uses: _____

List any life-threatening allergies: _____

Does this student carry an Epi-pen? YES NO

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SHOULDERS		
ARMS/HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

PERTINENT HISTORY:

GENERAL SUMMARY OF PHYSICAL EXAMINATION:

CLEARANCE BASED UPON PHYSICAL EXAM AND REVIEW OF HISTORY (PLEASE ADD COMMENTS AS NEEDED TO OTHER SIDE)

_____ Cleared for participation in intercollegiate athletics
_____ Cleared after completing evaluation/rehabilitation for: _____
_____ NOT CLEARED FOR: _____ Collision _____ Contact _____ Non-contact

Recommendations: _____

Name of Provider (print/type/stamp) _____
Address _____ Phone _____

Signature of Provider _____ Date _____

Insurance & Emergency Contact Information Form

Student/Athlete's Name (PRINT) _____ Social Security# _____
Date of Birth _____ Sport _____ Date _____
Academic year (circle): Freshman, Sophomore, Junior, Senior

Allergies _____
Medical Alerts _____

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. THIS INFORMATION IS CRITICAL TO PROMPT TREATMENT IN THE CASE OF EMERGENCY AND ACCURATE BILLING PROCEDURES. AN INCOMPLETE FORM WILL DELAY THE PARTICIPATION OF THE ATHLETE AND/OR THE PROCESSING OF THE STUDENTS FORMS.

Please include a copy of your child's insurance card.

Parent/Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Student Cell Phone _____

Policy Holder Name _____ Policy Holders Date of Birth _____

Relationship to student-athlete _____

Address _____

Home Phone _____ Work Phone _____

Insurance Company Name _____

Insurance Company Address & Phone Number _____

Group # _____ I.D. # _____

Effective Date of Policy _____ Expiration Date _____

Primary Physician _____

Office Number _____

HMO _____ OR PPO _____ (Please check one)

Policy Deductible _____

Policy Co-Pay _____

Does the policy cover athletic-related injuries? _____

School Insurance with Virginia Wesleyan College: _____ Yes _____ No

Policy #: _____

Immunization Record
TO BE COMPLETED BY ALL STUDENTS.

Name _____

Social Security Number _____

Required: MMR, DPT, Polio, Meningitis vaccine & Tuberculosis Screening: others recommended.
PHYSICIAN MUST STAMP AND VERIFY THIS SHEET!

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose I given at age 12-15 months or later..... #1 _____/_____
Mo Yr

2. Dose 2 given at age 4-6 or later, and at least one month after first dose..... #2 _____/_____
Mo Yr

B. TETANUS-DIPHTHERIA (Primary series with DTaP, DTP, DT or Td, and booster with Td or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:

#1 _____/_____
Mo Yr #2 _____/_____
Mo Yr #3 _____/_____
Mo Yr #4 _____/_____
Mo Yr

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on patient age. Administer with MCV4 simultaneously if possible.)..... M / D / Y

3. Tetanus-Diphtheria (Td) booster within the last ten years M / D / Y

C. POLIO (Primary series in childhood meets requirements; three primary series schedules are acceptable. Refer to ACIP for details.)

1. OPV alone (oral Sabin three doses): #1 _____/_____
Mo Yr #2 _____/_____
Mo Yr #3 _____/_____
Mo Yr

2. IPV alone (injected Salk four doses): #1 _____/_____
Mo Yr #2 _____/_____
Mo Yr #3 _____/_____
Mo Yr #4 _____/_____
Mo Yr

3. IPV/OPV sequential..... IPV #1 _____/_____
Mo Yr IPV#2 _____/_____
Mo Yr OPV#3 _____/_____
Mo Yr OPV #4 _____/_____
Mo Yr

D. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 meets the requirement.)

1. History of Disease Yes _____ No _____ 2. Immunization Dose #1..... _____/_____
Dose 2 _____/_____

E. HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization

a. Dose #1 _____/_____
Mo Yr b. Dose #2 _____/_____
Mo Yr c. Dose #3 _____/_____
Mo Yr

2. Hepatitis B surface antibody Date _____/_____
Results : Reactive _____ Non-reactive _____

F. MENINGITIS VACCINE

_____/_____
Mo Yr. _____quadravalent or _____conjugate

Form D cont.

G. TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group? Yes _____ No _____
If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test:

Date Given: ____/____/____ Date Read: ____/____/____
 M D Y M D Y

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive____ negative____

4. Chest x-ray (required if tuberculin skin test is positive) result: normal____ abnormal____

Date of chest x-ray: ____/____/____
 M D Y

H. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)

a. Dose #1 ____/____/____
 M D Y

b. Dose #2 ____/____/____
 M D Y

c. Dose #3 ____/____/____
 M D Y

Physician Verification of Immunizations

(Please place stamp here)

Physician's Signature _____

Date _____

**Virginia Wesleyan College Health Services
MENINGOCOCCAL VACCINE WAIVER**

I have read the information provided about meningococcal meningitis and understand the risks of the disease; however, I choose not to receive the vaccine.
I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness.

Student's Printed Name: _____

Birth Date: _____ Social Security # _____

Signature of Student,

Date

Signature of Parent/Guardian

Date

ATHLETE MEDICAL AND INJURY RELEASE FORM

Student-Athlete's Name _____ Sport _____ Date _____

Date of Birth _____ Social Security# _____

Campus Phone: _____

Campus Address: _____
Street/ P.O. Box/ Apt # _____ City, State, & Zip Code _____

Permission to Treat Statement:

Permission is hereby granted to Virginia Wesleyan College to proceed with any medical treatment deemed necessary in the event the parent/guardian cannot be contacted. In the event of serious illness, the need for major surgery or significant accident or injury, I understand that an attempt will be made to contact me in an expeditious manner. In the event I cannot be contacted, permission is granted to render all treatment deemed necessary in the best interest of the above-named athlete.

Parent/Guardian Name (print)

Parent/Guardian Signature

Relationship to Student-Athlete

Home Phone

Work Phone

Parent/Guardian Address: _____
Street _____ City _____ State, Zip Code _____

Permission for Medical Records Release:

I hereby give Virginia Wesleyan College medical staff permission to obtain medical records pertaining to any injury or condition incurred while participating in intercollegiate athletics at Virginia Wesleyan College. I understand an attempt will be made to inform me of the necessity of obtaining medical records.

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

Student-Athlete Signature

Permission to Release Medical Record/Information to Parents/Guardian or VWC Medical Staff:

I hereby give Virginia Wesleyan College medical staff permission to release my medical record/information to my parent/guardian. I understand an attempt will be made to inform me of any release of medical record/information.

Student-Athlete's Signature

Acceptance of Risk Statement:

I, _____, am aware of and accept the risk of injury associated with participation in intercollegiate athletics and in particular _____. I will do my part to reduce the risk of injury by acquiring and maintaining my peak physical condition. I will follow the advice of the medical staff and coaching staff in the preparation to participate and in the event of injury or accident incurred due to participating in my sport. If I do not understand or have any questions concerning this Acceptance of Risk Statement, I will get a detailed explanation from the head athletic trainer prior to my participation.

Student-Athlete's Name(print)

Student-Athlete's Signature

Parent/Guardian Name if under 18 (print)

Parent/Guardian Signature if under 18

Today's Date: _____

Virginia Wesleyan College Athletic Insurance Coverage

All students of Virginia Wesleyan College MUST have primary insurance coverage through their own insurance provider OR the policy offered by the Business office. All students must be covered by the accident/health coverage offered by the college or sign the waiver attached to the insurance brochure sent under separate cover by the Business office. The waiver must include the name of the current accident/health insurance company and the policy number in which the athlete is covered. Please return the completed, signed waiver to the Business office if you do not wish the athlete to be covered under this policy and have other coverage. Please note that Virginia Wesleyan College assumes no responsibility whatsoever for any uninsured expenses, and we strongly recommend that the student have coverage through a primary health insurer to avoid possible, significant out-of-pocket expenses in the event of an injury. **VWC student athletes are required to have some form of health insurance. Athletes without health insurance WILL NOT BE ABLE TO PARTICIPATE IN ATHLETICS AT VIRGINIA WESLEYAN COLLEGE.**

Virginia Wesleyan College does carry a sports accident insurance policy that covers each student athlete participating in or traveling to or from an organized practice or game. **THE POLICY CARRIES A \$2000 DEDUCTIBLE. THIS MEANS THE ATHLETE AND/OR THEIR PRIMARY INSURANCE PROVIDER ARE RESPONSIBLE FOR THE FIRST \$2000 OF MEDICAL CHARGES ACCRUED.** Please note that it is ultimately the responsibility of the parent and/or the student-athlete to make sure their primary insurance provider will cover the medical bills from the physician the athlete chooses to see. Please also note that the NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a \$75,000 deductible and is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's web-site at www.ncaa.org.

IT IS EXTREMELY IMPORTANT THE ATTACHED INSURANCE INFORMATION FORM IS COMPLETELY FILLED OUT. It is especially critical to give all necessary claim information if a Health Maintenance Organization (HMO) or Preferred Provider Organization /Network (PPO) insures the athlete. **The student-athlete is ultimately responsible for contacting their insurance provider prior to seeking out of network or out of area medical attention.** If there is a physician within the HMO or PPO/PPN network who is in the Virginia Beach/Norfolk region, you may want to switch the student athlete's primary care to this physician.

I have read and understand the above Virginia Wesleyan College Insurance Information Form. I understand the student athlete's primary insurance or themselves are responsible for the first \$2000 of any medical bills resulting from injury while playing sports for Virginia Wesleyan College. I also understand that a student athlete cannot participate in athletics at Virginia Wesleyan College unless they have some form of health insurance coverage.

Student Athlete's Name: _____

Signature of Student-Athlete's Primary Insurance Policy Holder: _____

Date: _____

ADHD DOCUMENT CHECKLIST

The following documents are **REQUIRED**:

- Student-athlete name
- Student-athlete date of birth
- Date of clinical evaluation
- Clinical evaluation components including:
 - Summary of comprehensive clinical evaluation.
 - ADHD Rating Scale(s) scores and report summary.
 - Blood pressure and pulse readings and comments.
 - Note that alternative non-banned medications have been considered, and comments.
 - Diagnosis
 - Medication(s) and dosage.
 - Follow-up orders

The following information is recommended, if available:

- Report ADHD symptoms by other significant individual(s).
- Psychological testing results.
- Physical exam date and results.
- Laboratory/testing results.
- Summary of previous ADHD diagnosis.
- Other comments.

*Documentation from prescribing physician **MUST INCLUDE** the following:

- Physician name (Printed)
- Office address and contact information.
- Specialty.
- Physician signature and date.

Please attach this information to the back of the physical.