



## ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

I, the undersigned Mount Mercy College student, do hereby expressly and affirmatively state that I voluntarily wish to participate (practice sessions and competition) in the following intercollegiate sport or activity(ies); \_\_\_\_\_ . I realize that my participation in this activity inherently involves risk of injury, including, but not limited to the following: death, neck and spinal injuries (which may result in complete or partial paralysis), brain damage, injury to internal organs, injury to the skeletal system, and injury or impairment to the body's general health and well-being. In addition, I acknowledge that injury may also result in serious impairment of future abilities to earn a living, engage in other business, social and recreational activities, and generally enjoy life. These types of injuries may result from my own actions, the actions or inactions of others, or a combination of both.

I understand that the rules and regulations are designed for the safety and protection of participants and I hereby agree to abide by the rules and regulations administered by the coaching staff and to accept the decisions of game officials as final. I also understand that certain activities require a minimum level of fitness for safe participation.

I acknowledge that I fully understand the contents of this Acknowledgement and Assumption of Risk statement before signing the same and have had an opportunity to ask questions. All questions I have asked have been answered to my complete satisfaction. Having done so, I agree to assume any and all potential risks of these activities and agree to hold Mount Mercy College, it's officers, employees, and agents harmless for liability as it relates to this activity.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s) Signature\*

\_\_\_\_\_  
Date

### MEDICAL CONSENT

I hereby grant permission to the Mount Mercy College Athletic Department, athletic trainer, and other medical personnel to render aid, emergency treatment, medical or surgical care, preventative, rehabilitative care deemed reasonably necessary to my health and well being.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s) Signature\*

\_\_\_\_\_  
Date

\*If the student is 18 years or older, a parent(s) signature is not required for medical consent. However, it is highly recommended that the parent(s) read and sign the form to indicate that they acknowledge and understand the information provided.

# ATHLETE INFORMATION SHEET

PLEASE PRINT

NAME: \_\_\_\_\_ ID #: \_\_\_\_\_  
                    First                      Middle Initial      Last

E-MAIL ADDRESS: \_\_\_\_\_

CAMPUS ADDRESS: \_\_\_\_\_ CAMPUS PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

FIRST SEMESTER ATTENDED AT MOUNT MERCY: FALL \_\_\_\_, 20\_\_ SPRING \_\_\_\_, 20\_\_

TRANSFER STUDENT? YES \_\_\_ NO \_\_\_ NAME OF PREVIOUS SCHOOL: \_\_\_\_\_

PARENTS' NAMES: FATHER: \_\_\_\_\_ MOTHER \_\_\_\_\_

PARENTS' ADDRESS: \_\_\_\_\_

SPORT(S) YOU WILL BE PARTICIPATING IN: \_\_\_\_\_

\_\_\_\_\_  
PARENTS' TELEPHONE NUMBER: \_\_\_\_\_ (      ) \_\_\_\_\_

PARENTS' INSURANCE COMPANY: \_\_\_\_\_

INSURANCE PHONE NUMBER: \_\_\_\_\_ (      ) \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

FATHER'S EMPLOYER: \_\_\_\_\_ PHONE # (      ) \_\_\_\_\_

MOTHER'S EMPLOYER: \_\_\_\_\_ PHONE # (      ) \_\_\_\_\_

HOMETOWN NEWSPAPER: \_\_\_\_\_ CITY: \_\_\_\_\_

HIGH SCHOOL COACH: \_\_\_\_\_ HIGH SCHOOL: \_\_\_\_\_

\_\_\_\_\_ I authorize the athletic department to list my name in game programs and news releases.

\_\_\_\_\_ I grant the athletic program permission to secure a copy of my college transcript at the end of each semester to review my academic progress.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## MOUNT MERCY COLLEGE PREPARTICIPATION PHYSICAL EVALUATION—MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed annually by **student-athlete** (or guardian if athlete is under the age of 18) in order for the student-athlete to participate in athletic activities. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in an athletic event.

Athlete's Name (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Year in College \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

***In case of an emergency, contact:***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

***Insurance Information:***

Company Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Policy Number \_\_\_\_\_

**Explain "Yes" answers in the box on the back page\*\*. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in MMC practice, games, matches, or meets**

- |   |  |               |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
|---|--|---------------|-----------|---------|----------|-------------|-----------|----------|-----------|----------|-----------|----------|---------------|--------------|------------|-----------|---------------|--|----------|
| <p>1. Have you had a medical injury since you last check up or sports evaluation?<br/>Yes No</p> <p>2. Have you been hospitalized overnight in the past year?<br/>Yes No<br/>Have you ever had surgery? Yes No</p> <p>3. Have you ever passed out during or after exercise?<br/>Yes No<br/>Have you ever had chest pain during or after exercise?<br/>Yes No<br/>Do you get tired more quickly than your friends do during exercise?<br/>Yes No<br/>Have you ever had racing of your heart or skipped heartbeats?<br/>Yes No<br/>Have you had high blood pressure or high cholesterol?<br/>Yes No<br/>Have your ever been told you have a heart murmur?<br/>Yes No<br/>Has any family member or relative died of heart problems or of sudden unexpected death before age 50? Yes No<br/>Had any family member been diagnosed with enlarged heart (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?<br/>Yes No<br/>Has a physician ever denied or restricted your participation in sports for any heart problems?<br/>Yes No</p> <p>4. Have you ever had a head injury or concussion?<br/>Yes No<br/>Have you ever been knocked out, become unconscious, or lost your memory? Yes No<br/>If yes how many times? _____<br/>When was the last concussion? _____<br/>How severe was each one? (Explain below)<br/>Have you ever had a seizure? Yes No<br/>Do you have frequent or severe headaches? Yes No<br/>Have you ever had numbness or tingling in your arms, hands, legs, or feet?<br/>Yes No<br/>Have you ever had a stinger, burner, or pinched nerve?<br/>Yes No</p> <p>5. Are you missing any paired organs? Yes No</p> <p>6. Are you under a doctor's care? Yes No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills, or using an inhaler?<br/>Yes No</p> <p>8. Do you have any allergies (i.e.: to pollen, medicine, food, or stinging insects)? Yes No</p> | <p>9. Have you ever been dizzy during or after exercise?<br/>Yes No</p> <p>10. Do you have any current skin problems (i.e.: itching, rashes, acne, warts, fungus, or blisters)? Yes No</p> <p>11. Have you ever become ill from exercising in the heat?<br/>Yes No</p> <p>12. Have you had any problems with your eyes or vision?<br/>Yes No</p> <p>13. Have you ever gotten unexpectedly short of breath with exercise?<br/>Yes No<br/>Do you have asthma? Yes No<br/>Do you have seasonal allergies that require medical treatment?<br/>Yes No</p> <p>14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e.: knee brace, foot orthotics, retainer on your teeth, hearing aid)?<br/>Yes No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury?<br/>Yes No<br/>Have you broken or fractured any bones or dislocated any joints?<br/>Yes No<br/>Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Yes No<br/>Is yes, check the appropriate line and explain below,<br/><br/> <table border="0" style="width: 100%;"> <tr> <td>___ Head</td> <td>___ Elbow</td> <td>___ Hip</td> </tr> <tr> <td>___ Neck</td> <td>___ Forearm</td> <td>___ Thigh</td> </tr> <tr> <td>___ Back</td> <td>___ Wrist</td> <td>___ Knee</td> </tr> <tr> <td>___ Chest</td> <td>___ Hand</td> <td>___ Shin/Calf</td> </tr> <tr> <td>___ Shoulder</td> <td>___ Finger</td> <td>___ Ankle</td> </tr> <tr> <td>___ Upper Arm</td> <td></td> <td>___ Foot</td> </tr> </table> </p> <p>16. Do you want to weigh more or less than you do now?<br/>Yes No</p> <p>17. Do you feel stressed out? Yes No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell train or sickle cell disease? Yes No</p> <p><b><i>Females Only</i></b></p> <p>19. When was your first menstrual period? _____<br/>When was your most recent menstrual period? _____<br/>How much time do you usually have from the start of one period to the start of another? _____<br/>How many periods have you had in the last year? _____<br/>What was the longest time between periods in the last year? _____</p> | ___ Head      | ___ Elbow | ___ Hip | ___ Neck | ___ Forearm | ___ Thigh | ___ Back | ___ Wrist | ___ Knee | ___ Chest | ___ Hand | ___ Shin/Calf | ___ Shoulder | ___ Finger | ___ Ankle | ___ Upper Arm |  | ___ Foot |
| ___ Head  | ___ Elbow  | ___ Hip       |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
| ___ Neck  | ___ Forearm  | ___ Thigh     |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
| ___ Back  | ___ Wrist  | ___ Knee      |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
| ___ Chest   | ___ Hand   | ___ Shin/Calf |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
| ___ Shoulder  | ___ Finger   | ___ Ankle     |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |
| ___ Upper Arm   |  | ___ Foot      |           |         |          |             |           |          |           |          |           |          |               |              |            |           |               |  |          |

*An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, or nurse practitioner.*

**\*\*Explain "Yes" answers on the lines below:**

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It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Mount Mercy College does not assume any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student-athlete should need immediate care and treatment as a result of injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student-athlete by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student-athlete.

If between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

***I hereby state, that to the best of my knowledge, my answers to the above questions are complete and correct.***

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(If student is under the age of 18)

**This form must be on file in the athletic office PRIOR to participation in any practice, scrimmage, or contest.**

*For school use only:*

This medical history form was reviewed by:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**MOUNT MERCY COLLEGE PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION**

Athlete's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
 Brachial blood pressure while sitting  
 Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: \_\_\_\_\_yes \_\_\_\_\_no Pupils: \_\_\_\_\_Equal \_\_\_\_\_Unequal

As a requirement, this physical must be completed annually and turned into the athletic office **prior to** participation in any practice (both in-season and out-of-season), or games/matches/meets.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart - Auscultation of the heart in the supine position.			
Heart – Auscultation of the heart In the standing position.			
Heart – Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

\_\_\_\_\_ Cleared  
 \_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by other health care practitioners will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_