

Barton College Athletic Department
Acceptance of Risk/Liability

1. Understands by its very nature, competitive athletics may put students in situations in which SERIOUS, CATASTROPHIC and perhaps, FATAL ACCIDENTS may occur
2. Understands many forms of athletic competition result in violent physical contact among players, the use of equipment which may result in accidents, strenuous physical exertion, and numerous other exposures to risk of injury.
3. Students and parents must assess the risks involved in such participation and make their choice to participate in spite of those risks. No amount of instruction, precaution, or supervision will totally eliminate all risk of injury. Just driving an automobile involves choice of risk, athletic participation by middle/junior, senior high school and college students also may be inherently dangerous.
4. Understands that even with the best of coaching, use of protective equipment, proper playing techniques, and strict observance of the rules, injuries are still a possibility. On rare occasion, these injuries can be so severe as to result in disability, total disability, paralysis, quadriplegia, or even death.
5. Understands that having passed a physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her
6. Understands the Barton College Athletic Training Staff and Team Physicians may review the health history questionnaire and physical examination and if necessary, require a follow-up examination or, further evaluation for injury or illness that may interfere/affect athletic participation. If such injury or condition warrants, athletic activity may be restricted, limited, or even discontinued by the Barton College Athletic Training Staff and Team Physicians
7. Understands and accepts the risks of injury, permanent disability and death inherent in his/her sport. By signing the verification of understanding, he/she pledges to do the best to reduce these risks by keeping in the best possible condition and following the advice of the team physician, attending physicians, athletic training staff and coach concerning prevention, treatment and rehabilitation of athletic injuries/illnesses.

We/I the undersigned have read and fully understand the preceding policy statements and warnings and agree to its procedures. We/I hereby release Barton College, its agents and employees, particularly the athletic training staff, from any liability caused by, or arising out of my athletic participation in the Barton College Athletic Program. ***By signing this consent, you agree that it will remain a valid consent form from the date signed until you request to have it changed.***

Print Name: _____ Sport: _____

Athlete Signature: _____ Date: ___/___/___

Parent Signature: _____ Date: ___/___/___

RETURN COMPLETED FORM TO: Randy Pridgen, ATC Barton College PO Box 5000 Wilson, NC 27893

**Barton College Athletic Department
Verification of Understanding**

- Policies on Drug Education and Testing, Alcohol, Tobacco, Banned Substances and Performance Enhancing Drugs
- Athletic Insurance Coverage Information
- How to File an Athletic Insurance Claim
- Policies on Determination of Play Following an Injury, Physician Referral, Second Opinions

We/I the undersigned have read and fully understand the preceding policy statements and warnings and agree to its procedures. We/I hereby release Barton College, its agents and employees, particularly the athletic training staff, from any liability caused by, or arising out of my athletic participation in the Barton College Athletic Program.

Print Name: _____ Sport: _____

Athlete Signature: _____ Date: ___/___/___

Parent Signature: _____ Date: ___/___/___

**BARTON COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM**

Name of Athlete: _____ Date: _____

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M F Social Security #: _____

College/Local Address:		

Street		

City	State	Zip
_____	_____	_____
Athlete Cell Phone #		

Home/Permanent Address:		

Street		

City	State	Zip
_____	_____	_____
Home Phone		

MEDICAL HISTORY: Please answer each of the following questions by circling YES or NO. Answer all questions fully and provide explanation for each "YES" in the space provided. Failure to disclose any medical information may invalidate insurance coverage. The information provided is strictly confidential and used for health care purposes only.

Family History:

Has any parent, grandparent, or sibling had:

- | | | | | | |
|---------------------|--------|-------|-----------------------|--------|-------|
| Cancer | YES NO | _____ | Bleeding disorder | YES NO | _____ |
| Leukemia | YES NO | _____ | Kidney disease | YES NO | _____ |
| Tuberculosis | YES NO | _____ | Glaucoma | YES NO | _____ |
| Diabetes | YES NO | _____ | Sickle cell anemia | YES NO | _____ |
| Heart disease | YES NO | _____ | Arthritis | YES NO | _____ |
| High blood pressure | YES NO | _____ | Alcohol or drug abuse | YES NO | _____ |
| Asthma | YES NO | _____ | Nervous or mental | | |
| Liver disease | YES NO | _____ | disease | YES NO | _____ |
| Migraine headaches | YES NO | _____ | Sudden death before | | |
| Emphysema | YES NO | _____ | age 50 | YES NO | _____ |
| Stroke | YES NO | _____ | Any other serious | | |
| Epilepsy/Seizures | YES NO | _____ | disease | YES NO | _____ |

Allergies:

Do you have an allergies to:

- | | | |
|----------------------|--------|-------|
| Penicillin | YES NO | _____ |
| Sulfa | YES NO | _____ |
| Aspirin | YES NO | _____ |
| Codeine | YES NO | _____ |
| Other drugs/medicine | YES NO | _____ |
| Foods | YES NO | _____ |
| Insect bites | YES NO | _____ |
| Hay fever | YES NO | _____ |
| Seasonal allergies | YES NO | _____ |
| Latex | YES NO | _____ |
| Iodine or Betadine | YES NO | _____ |
| Other: | YES NO | _____ |

Personal History:

- | | | |
|-------------------------|--------|-------|
| Do you smoke? | YES NO | _____ |
| Do you use any other | | |
| forms of tobacco? | YES NO | _____ |
| Do you drink? | YES NO | _____ |
| If yes, how much? | | _____ |
| Do you use drugs? | YES NO | _____ |
| Are you on a special | | |
| diet? | YES NO | _____ |
| Have you lost weight in | | |
| the past year? | YES NO | _____ |
| Are you satisfied with | | |
| your weight? | YES NO | _____ |
| Do you think you have | | |
| an eating disorder? | YES NO | _____ |

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**BARTON COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM**

Name: _____

Health History:

Do you have now or have you had in the past, any of the following:

Concussion	YES	NO	_____
Loss of consciousness	YES	NO	_____
Memory loss	YES	NO	_____
Numbness/weakness in an arm or leg	YES	NO	_____
Migraine headaches	YES	NO	_____
Mouth/tooth/tongue problem	YES	NO	_____
Recurrent nosebleeds	YES	NO	_____
Broken nose	YES	NO	_____
Epilepsy/seizures	YES	NO	_____
Heat cramps, head exhaustion, heat stroke	YES	NO	_____
Eye disease	YES	NO	_____
Blindness (either eye)	YES	NO	_____
Blurred vision (not corrected by glasses)	YES	NO	_____
Ear infections	YES	NO	_____
Deafness/Hearing Deficiency	YES	NO	_____
Difficulty sleeping	YES	NO	_____
Sleep apnea	YES	NO	_____
Asthma	YES	NO	_____
Currently taking medication for this?	YES	NO	_____
Name of medication			_____
Shortness of breath/wheezing	YES	NO	_____
Chronic bronchitis	YES	NO	_____
Tuberculosis	YES	NO	_____
Heart murmur	YES	NO	_____
Pain/pressure in chest	YES	NO	_____
Marfan's Syndrome	YES	NO	_____
Rheumatic fever	YES	NO	_____
High blood pressure	YES	NO	_____
Mononucleosis	YES	NO	_____
Hepatitis or Jaundice	YES	NO	_____
Digestive disorder	YES	NO	_____
Bladder/Urinary tract infection	YES	NO	_____
Appendicitis (surgery required?)	YES	NO	_____
Kidney infection or stones	YES	NO	_____
Anemia	YES	NO	_____
Bleeding disorder	YES	NO	_____
Hernia	YES	NO	_____
Absence of a paired organ (kidney, eye, testicle, etc.)	YES	NO	_____
Diabetes	YES	NO	_____
Currently taking medication for this?	YES	NO	_____
Name of medication			_____
Thyroid problems	YES	NO	_____
Arthritis	YES	NO	_____
Phlebitis	YES	NO	_____
Changing mole	YES	NO	_____
Other skin disease	YES	NO	_____
Depression/Anxiety	YES	NO	_____

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**BARTON COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM**

Serious emotional illness YES NO _____
 Other problems not mentioned: YES NO _____

Name: _____

Musculoskeletal History:

Shin, Ankle & Foot:

Have you ever had a serious ankle, foot or shin injury which required a doctor's visit? YES NO _____
 Was surgery performed? YES NO _____
 Have you ever sustained severe shin splints or a stress fracture to your shin? YES NO _____
 Do you have any chronic pain, swelling, burning, numbness or tingling in your shin, ankle or foot? YES NO _____
 Does your ankle feel "unstable" or as though it wants to "buckle" or "give way"? YES NO _____
 Does your ankle require taping or other support on a regular basis? YES NO _____
 Have you had any severe heel, arch, foot or toe injuries? YES NO _____
 Do you wear orthotics? YES NO _____

Knee:

Have you ever had a serious knee injury which required a doctor's visit? YES NO _____
 Was surgery performed? YES NO _____
 Do you wear a knee brace? YES NO _____
 Did you have ligament damage? YES NO _____
 Did you have cartilage or meniscus damage? YES NO _____
 Have you sustained a severe case of patellar tendinitis or "jumper's knee"? YES NO _____
 Have you sustained a severe patella (knee cap) dislocation or slippage? YES NO _____
 Do you have chronic knee pain, "popping", "clicking", "snapping" or swelling? YES NO _____
 Does your knee feel "unstable" or as though it wants to "buckle" or "give way"? YES NO _____

Hip & Thigh:

Have you ever had a serious hip or thigh injury which required a doctor's visit? YES NO _____
 Have you ever sustained a severe sprain, contusion or dislocation to your hip or thigh? YES NO _____
 Have you ever sustained a severe muscle strain or bruise to either the hamstrings, quadriceps or groin muscles? YES NO _____
 Does your hip or thigh have constant pain, "pop", "snap", or "click" with athletic activity or running? YES NO _____

Back:

Have you ever had a serious back injury which required a doctor's visit? YES NO _____
 Have you ever sustained a disk rupture or a "slipped" disk to your back? YES NO _____
 Do you have any pain, burning, numbness or tingling in your

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**BARTON COLLEGE ATHLETIC DEPARTMENT
MEDICAL HISTORY FORM**

back or going down into the back of your leg? YES NO _____
 Have you ever been told your back is "out of line"? YES NO _____
 Do you suffer from chronic back pain, soreness or stiffness? YES NO _____
 Name: _____

Shoulder:

Have you ever had a serious shoulder injury which required a doctor's visit? YES NO _____
 Was surgery performed? YES NO _____
 Have you ever dislocated or separated your shoulder? YES NO _____
 Have you ever sustained a severe strain or tear to your rotator cuff? YES NO _____
 Does your shoulder feel unstable, slips out or wants to come out? YES NO _____
 Do you have problems with throwing or overhead shoulder activities? YES NO _____
 Have you ever been told that you have a cartilage, labrum or a SLAP lesion? YES NO _____
 Have you ever been advised to have surgery to correct a shoulder problem? YES NO _____

Elbow, Wrist, Hand & Fingers:

Have you ever had a serious elbow, wrist, hand or finger injury which required a doctor's visit? YES NO _____
 Was surgery performed? YES NO _____
 Do you get elbow pain with throwing or any burning, numbness or tingling with throwing? YES NO _____
 Do you have any chronic pain or burning, numbness or tingling to your wrist, hand, thumb or fingers? YES NO _____

Head, Neck, Chest and General Injury Assessment:

Have you ever been "knocked out" or lost consciousness for any reason? YES NO _____
 Have you ever sustained a concussion or head injury? YES NO _____
 If yes, how many times has this occurred and what are the dates of the injury? YES NO _____
 Have you ever had a "burner", "stinger" or "pinched nerve" in your neck? YES NO _____
 Have you ever sustained an abdominal, chest or rib injury? YES NO _____
 Have you ever had a fracture or sustained a broken bone? YES NO _____
 Do you have any pins, screws, metal plates or bone graft in your body as a result of a surgery? YES NO _____

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**BARTON COLLEGE ATHLETIC DEPARTMENT
HEALTH INSURANCE INFORMATION FORM**

Name of Athlete: _____ Date: _____

College/Local Address: _____
Street City State Zip

Home/Permanent Address: _____
Street City State Zip

Athlete Cell Phone # () _____ Athlete DOB: _____
 Athlete SS#: _____ - _____ - _____

Sport(s): MSOC WSOC VB CC MBK WBK BB SB TEN GOLF

Father/Guardian: _____ Address: _____ <small>Street</small> _____ <small>City State Zip</small> Father's Medical Insurance or Plan: _____ Address: _____ _____ Policy Number: _____ Group Number: _____ Is your son or daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
--

Mother/Guardian: _____ Address: _____ <small>Street</small> _____ <small>City State Zip</small> Mother's Medical Insurance or Plan: _____ Address: _____ _____ Policy Number: _____ Group Number: _____ Is your son or daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Are the companies or plans listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? YES NO

Is a referral necessary for a non-emergency physician visit? YES NO

Does your plan require a second opinion BEFORE surgery? YES NO

**A COPY OF YOUR INSURANCE CARD IS REQUIRED.
PLEASE PHOTOCOPY THE FRONT & BACK AND ATTACH.**

I hereby authorize Barton College, First Agency Insurance Company and its' representatives to secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or disabilities. A photostatic copy of this authorization shall be deemed effective and valid as the original.

Parent's Signature: _____ Date: _____
 Student's Signature: _____ Date: _____

**BARTON COLLEGE ATHLETIC DEPARTMENT
EMERGENCY CONSENT FORM**

Name of Athlete: _____ Date: _____

Sport MSOC WSOC VB CC MBK WBK BB SB TEN GOLF

Date of Birth: ____ / ____ / ____ Age: _____ Sex: M F Social Security #: _____

College/Local Address:		

Street		

City	State	Zip
()		
Athlete Cell Phone #		

Home/Permanent Address:		

Street		

City	State	Zip
()		
Home Phone		

FATHER's Information:	
Full Name: _____	
DOB: _____	
Social Security #: _____	
Employed By: _____	
Work Phone: _____	
Other Phone: _____	

MOTHER's Information:	
Full Name: _____	
DOB: _____	
Social Security #: _____	
Employed By: _____	
Work Phone: _____	
Other Phone: _____	

Insurance Company: _____ HMO or PPO? Y N

Policy Number: _____ Group Number: _____

Referral necessary for non-emergency physician visits? Y N

Primary care physician: _____ Phone: _____

Previous injuries/surgeries: _____

Allergies: _____

Medications used regularly: (includes inhalers, birth control, etc.) _____

Person to notify in case of emergency (other than parent):

Name: _____ Relationship to athlete: _____

Phone: _____ Alternate Phone: _____

I grant permission for transportation and treatment necessary for a condition arising during participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact my nearest relative prior to treatment.

Parent's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

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Barton College Athletic Department
Student-Athlete Nutritional Supplement Disclosure and Review Form

I, the undersigned, am taking or intend to take the following nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements. I acknowledge the possible health risks that may be associated with taking an over-the-counter nutritional supplement.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate because they are not regulated by the Food and Drug Administration (FDA) and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or safe to use, or that the NCAA endorses a product or approves its usage. In other words, what's in the bottle is not always on the label. If I do not know what I'm taking, I'm risking both my health and my eligibility.

The NCAA does not accept ignorance as an excuse following a positive drug test for a banned substance. Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's head athletic trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's head athletic trainer.

Brand Name	Listed Ingredients
1. _____	_____ _____ _____
2. _____	_____ _____ _____
3. _____	_____ _____ _____

Printed Name _____ Sport _____

Athlete Signature _____ Date ____/____/____

Do Not Write In This Box

Reviewed by Staff Athletic Trainer: _____ Date ____/____/____

Substance Listed are: Banned _____ Acceptable _____ Do Not Take _____

Student Athlete Notified Regarding This List On ____/____/____ ATC Init _____ Ath Init _____

**Barton College Athletic Department
Urinalysis Authorization and Release Consent**

I, the undersigned, have had an opportunity to review the Barton College Drug Testing Program and agree as a participant in the collegiate athletics program to be a part of this testing. I will also have the opportunity to ask questions and fully understand the provisions of the program. I consent to the taking of such samples if required, and understand that the testing will be done by a laboratory employee of the College.

I understand that the results will be treated confidentially, but I consent to the release of the results to the Athletic Director, Head Athletic Trainer and to my parents and/or guardian. If the Athletic Director feels it necessary, the team coach will be notified. I also consent to the release of these results to any other party deemed necessary by the Athletic Director for the purpose of special counseling or medical treatment.

I understand that I am free to withdraw this consent for urinalysis testing. However, I also understand that should I do so or refuse to submit to testing at the time requested, I will not be permitted to participate in any intercollegiate sporting program, and may lose my athletic financial aid.

I hereby release Barton College, its Trustees, Officers, Employees, Agents, and Representatives from legal responsibility or liability for the release of such information and records as authorized by this form. ***By signing this consent, you agree that it will remain a valid consent form from the date signed until the day after you are not enrolled at Barton***

PRINTED NAME OF STUDENT ATHLETE

SPORT(S)

SIGNATURE OF STUDENT ATHLETE

DATE

SIGNATURE OF PARENT OR LEGAL GUARDIAN
(If student is under 18 years of age)

DATE

**Barton College Athletic Department
Release of Athletic Healthcare Information**

I, the undersigned, hereby grant permission and request that the Barton College Athletic Training Department release and discuss what they deem necessary for my safety, any information relating to my health care to the coaching staff, athletic administration, sports information office and my parents/guardians. This shall include injury/illness evaluation and diagnosis, treatment/rehabilitation plans and progress, availability and extent of my athletic participation and information related to referrals and possible surgical interventions. I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/release is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics. I do understand that failure to sign this consent/release that my privilege to participate in athletics at Barton College will be terminated.

I also permit the medical providers for Barton College Athletic Department, Barton College Student Health Services and the Athletic Training Department to discuss all aspects of my injuries/illnesses with each other, as they deem necessary for my safety and health care as well as to share all medical documentations. Documentation can include but not limited to physician notes/records, diagnostic test reports, physical and insurance information, referrals, medical notes, radiological test results and operative notes. Communications can include but not limited to injury/illness evaluation and diagnosis, treatment/rehabilitation plans and progress, availability and extent of my athletic participation and information related to referrals and possible surgical interventions. ***By signing this consent, you agree that it will remain a valid consent form from the date signed until you request to have it changed.***

Printed Name _____ Sport _____

Athlete Signature _____ Date ____/____/____