Dear Potomac State College Student Athletes and Parents:

We are pleased to have your son/daughter as a student athlete at Potomac State College of West Virginia University and hope that he/she will achieve academic and athletic success. Enclosed with this letter are the pre-participation physical examination, health insurance and medical forms needed to participate in intercollegiate athletics. Please thoroughly read and complete the enclosed paperwork. Athletes are required to return these completed forms to their coach or the Certified Athletic Trainer or they will not be permitted to participate in practice or competitions at Potomac State.

Please acknowledge the following key policy while reviewing this packet:

- Each student athlete is required to have a yearly medical physical examination. This can be completed by your physician, or our team physician will complete the physical the first week of classes in the fall. Student Athletes will not be permitted to participate if they do not have a completed physical. The Potomac State College Team Physician has the final authority to medically clear an athlete for participation.

It is the Athletic Training Department’s goal to provide high quality medical care to all student-athletes. Unfortunately accidents and injuries do occur while participating in intercollegiate athletics. Please contact me at 304-788-6879 or by email at sawhite@mail.wvu.edu if you have any questions or concerns.

Sincerely,

Shawn White
Athletic Director
Potomac State College of WVU
Pre-Participation Medical History Exam

Name: ____________________________________________________  Birthdate: ____/____/_____
Social Security Number: _____-_____-_____  Sport(s): ___________________________

History:
1) Has the student athlete ever:
   - Had a concussion?  Yes  No  ________________________
   - Had an Operation?  Yes  No  ________________________
   - Had heat exhaustion or heat stroke?  Yes  No  ________________________
   - Had a head or neck injury?  Yes  No  ________________________
   - Had a back or spinal injury?  Yes  No  ________________________
   - Had a Knee Injury?  Yes  No  ________________________
   - Had a heart murmur?  Yes  No  ________________________
   - Had High Blood Pressure?  Yes  No  ________________________
   - Had a Heart Problem?  Yes  No  ________________________
   - Fainted while exercising?  Yes  No  ________________________
   - Had Irregular Menstrual Cycles?  Yes  No  ________________________
   - Had any chronic illness?  Yes  No  ________________________

2) Does the student athlete:
   - Take Medication Regularly?  Yes  No  ________________________
     If Yes: __________________________________________________________________
   - Wear glasses or contact lenses?  Yes  No  ________________________
   - Wear Dental Appliances or Hearing aids?  Yes  No  ________________________
     If Yes: __________________________________________________________________
   - Have any Allergies?  Yes  No  ________________________
     If Yes: __________________________________________________________________
   - Have any chronic illnesses (i.e. asthma, diabetes?)  Yes  No  ________________________
     If Yes: __________________________________________________________________

3) Has any physician ever limited the student athlete’s athletic participation?  Yes  No  ________________________
   If Yes: __________________________________________________________________

4) Has the student athlete injured any of the following? If Yes, explain with date.
   - Hand/Wrist? ____________________________________
   - Arm? ____________________________________
   - Shoulder? ____________________________________
   - Foot? ____________________________________
   - Ankle? ____________________________________
   - Leg? ____________________________________

This is to certify that the responses to the above questions are correct and that I understand that this examination is designed solely for screening athletes prior to their participation in intercollegiate athletics and should not be considered a complete medical examination.

Signature: _______________________________________________  Date: ______________
Name: ____________________________________________  Birthdate: ____/____/____
Social Security Number: _____-____-______ Sport(s): __________________________

*This section to be completed by physician*

Height: ___________ Weight: ______________
Pulse: _______________ Blood Pressure: ______________

Medical Findings:

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<td>Feet/Ankles</td>
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<td>Skin</td>
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Clearance:
Cleared  Not Cleared  (Reason) ________________________________

Recommendations/Limitations/Comments:
____________________________________________________________________
____________________________________________________________________

Physician’s Signature: ____________________________  Date: ______________

Potomac State College of WVU

Athletic Insurance Information

This form must be returned to the Athletic Department before the first day of practice.

Student Information:
Name: _________________________________________
Birthdate: ____________________
Social Security Number: _______ - ______ - ______
Sport(s): ________________________
Home Address: __________________________________________________________
Home Phone Number: _____________
Cell Number: ________________
Local Address: __________________________________________________________
Emergency Contact: (if parent/guardian cannot be reached)
Name: ____________________________________________
Relation: ___________________
Home Number: ________________________
Cell Number: __________________
Guardian/Father Information: Guardian/Mother Information:
Name: _____________________________
Address: ___________________________
_______________________________________
Home Phone: _______________________
Employed: _____ Yes _____ No
Work/Cell Number: ________________

Does the Student Athlete have insurance coverage? _____ Yes _____ No
Insurance Company: _______________________________________________________
Address: __________________________________________________________________
Phone Number: ________________________
Group Number: ________________________
Group Name: __________________________
PPO? _____ HMO? _____

*Please Attach a Copy of front and Back of Insurance Card*
I hereby grant permission to Potomac State College team physicians and/or their consulting physicians to render any treatment or medical or surgical care that they deem necessary to the health and well-being of the undersigned student athlete.

I also hereby authorize the athletic trainers at Potomac State College, who are under the direction and guidance of the PSC team physicians, to render any preventative, first aid, rehabilitation, or emergency treatment that they deem reasonably necessary to the health or well-being to the undersigned student athlete.

Student Athlete’s Name: ______________________________________________________

Student Athlete’s Signature: ____________________________________________________

I, ______________________________________________,

A) understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me.

B) understand that I must refrain from practices or games during medical treatment until I am discharged from treatment by a physician and the Certified Athletic Trainer.

C) understand and accept the risks of injury, permanent disability, and death that are inherent in my sport. By signing below, I pledge to do the best to reduce these risks by keeping in the best possible condition and by following the advice of a physician, Certified Athletic Trainer and coach concerning the prevention, treatment and rehabilitation of athletic injuries.

D) I grant permission to the coaching staff, Athletic Department and Certified Athletic Trainer to hospitalize and secure treatment for myself for any athletic injuries. If the athlete is a minor, the undersigned parent grants permission to the coaching staff, Athletic Department and Certified Athletic Trainer to hospitalize and secure treatment for his/her son/daughter.

Student Athlete’s Signature: ____________________________________________ Date: ____________

Parent/Guardian Signature (if athlete is minor): ________________________________