SAINT LOUIS
SPORTS MEDICINE

Dear Returning SLU Student-Athlete:

On behalf of the Sports Medicine Department, I want to welcome you back for another exciting year of Billiken Athletics. In order to participate in intercollegiate athletics, returning student-athletes are required to complete/update the Student-Athlete Policy Overview, Acknowledgment of Insurance Form (provide a copy of your primary insurance cards), Student/Family Information Form, Returning Student-Athlete Medical Update, Authorization for Release of Protected Health Information and Supplement Notification Form (if needed). If you are under medical exception for ADD/ADHD medications you will also need to complete the ADD/ADHD medical exception letter – please note this letter is needed annually. **If you need a physical exam after completing the mandatory medical review, please make arrangements through your assigned athletic trainer to schedule.** These are the only eligible forms that will be accepted and must be on file in your medical chart prior to participating in any intercollegiate sport activity. All medical results are subject to final approval by the Saint Louis University team physician.

The NCAA recommends that all student athletes be aware of their sickle cell status. If you have not received a sickle cell test please notify your assigned athletic trainer immediately. Please see the Sickle Cell Information Sheet. All medical records on file in the athletic training room become confidential property of Saint Louis University Athletics Department and cannot be used for non-athletic purposes.

**Confidential medical updates must be completed yearly to be valid for participation.**

**All completed medical forms and insurance form must be submitted.**

Should you develop a significant injury or illness after completing the medical update, but before the first sanctioned practice, you must present, to the Saint Louis University athletic training staff, a letter from a qualified physician stating you are eligible to be cleared by Saint Louis University team physician to participate in intercollegiate sports activities. The athletic training staff will review the injury / illness with you and determine an appropriate course of action upon your return to campus.

If you have any questions, contact your assigned athletic trainer or Jonathan Burch via e-mail at jonathan.burch@slu.edu.

**Mail to:**
Jonathan Burch
Director of Sports Medicine
Saint Louis University
Chaifetz Arena – Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
jonathan.burch@slu.edu

**Fax:** (314) 977-3183

SAINT LOUIS
SPORTS MEDICINE

# RETURNING STUDENT-ATHLETE MEDICAL UPDATE

*All information provided on this form is confidential and will be available only to the Saint Louis University Sports Medicine Staff.*

Name_____ Sport_____ Year ☐ So. ☐ Jr. ☐ Sr.

Birth date_____ Banner #_____ Gender ☐ M ☐ F

**SINCE YOUR LAST PHYSICAL EXAM ON** _____ Sickle Cell Test Date/Result _____

| | | |
|---|---|---|
| Have you sprained or dislocated a joint? | ☐ YES | ☐ NO |
| Have you strained (pulled) a muscle? | ☐ YES | ☐ NO |
| Have you fractured a bone? | ☐ YES | ☐ NO |
| Have you sustained ANY injuries? | ☐ YES | ☐ NO |
| Have you had surgery to a bone or joint? | ☐ YES | ☐ NO |
| Have you had a head or neck injury? | ☐ YES | ☐ NO |
| Have you been knocked out or been unconscious? | ☐ YES | ☐ NO |
| Have you had a concussion? | ☐ YES | ☐ NO |
| Have you had frequent or repeated headaches? | ☐ YES | ☐ NO |
| Have you had a burner, stinger or had one of your limbs feel numb or "fall asleep" during activity? | ☐ YES | ☐ NO |
| Have you had numbness, tingling and/or muscle weakness? | ☐ YES | ☐ NO |
| Have you experienced pain/discomfort in the chest, neck, jaw or arms during/after sport participation? | ☐ YES | ☐ NO |
| Have you experienced dizziness or passed out during or after sport participation? | ☐ YES | ☐ NO |
| Have you experienced shortness of breath at rest or with mild exercise? | ☐ YES | ☐ NO |
| Have you experienced high or low blood pressure? | ☐ YES | ☐ NO |
| Have you noticed rapid heart palpitations or felt like your heart raced? | ☐ YES | ☐ NO |
| Have you been told you have a heart murmur, an irregular heartbeat or any heart disease? | ☐ YES | ☐ NO |
| Has anyone in your family been diagnosed with a disease or medical condition? | ☐ YES | ☐ NO |
| Has anyone in your family died suddenly due to a heart-related disease? | ☐ YES | ☐ NO |
| Have you experienced excessive coughing during or after sport participation? | ☐ YES | ☐ NO |
| Have you experienced breathing difficulties or been told you have asthma, bronchitis or allergies? | ☐ YES | ☐ NO |
| Have you been advised that you should not participate in the sport(s) that you intend to participate? | ☐ YES | ☐ NO |
| Are you currently seeing a doctor for a medical problem? | ☐ YES | ☐ NO |
| Have you been diagnosed with a disease or been hospitalized overnight for a disease? | ☐ YES | ☐ NO |
| Have you experienced an epileptic seizure or been informed that you might have epilepsy? | ☐ YES | ☐ NO |
| Have you had any surgery or procedure? | ☐ YES | ☐ NO |
| Have you experienced any allergic reactions? | ☐ YES | ☐ NO |
| Are you currently taking any prescription medications? | ☐ YES | ☐ NO |
| Are you currently taking any nutritional supplements? | ☐ YES | ☐ NO |
| Are these supplements prescribed by a physician? | ☐ YES | ☐ NO |
| Have you experienced any injury or illness not covered above? | ☐ YES | ☐ NO |
| Would you like to see the team physician in private, for any reason? (You will not be asked to explain.) | ☐ YES | ☐ NO |

***Please explain all "yes" answers:*** _____

_____

_____

_____

**FEMALES ONLY:**

When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of the next? _____

☐ YES ☐ NO Has your menstrual period changed appearance within the past 6 months? _____

What was the longest time between periods in the past year? _____

☐ YES ☐ NO Have you had menstrual periods within the past 12 months? If yes, how many? _____

☐ YES ☐ NO Do you take birth control pills? Brand _____

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? _____

SAINT LOUIS
SPORTS MEDICINE

# RETURNING STUDENT-ATHLETE MEDICAL UPDATE

*All information provided on this form is confidential and will be available only to the Saint Louis University Sports Medicine Staff.*

Name _____ Sport _____ Year ☐ So. ☐ Jr. ☐ Sr.

## SECTION 1

| | | |
|---|---|---|
| I often have trouble sleeping. | ☐ YES | ☐ NO |
| I wish I had more energy most days of the week. | ☐ YES | ☐ NO |
| I think about things over and over. | ☐ YES | ☐ NO |
| I feel anxious and nervous much of the time. | ☐ YES | ☐ NO |
| I often feel sad or depressed. | ☐ YES | ☐ NO |
| I struggle with being confident. | ☐ YES | ☐ NO |
| I don't feel hopeful about the future. | ☐ YES | ☐ NO |
| I have a hard time managing my emotions (frustration, anger, impatience). | ☐ YES | ☐ NO |
| I have feelings of hurting myself or others. | ☐ YES | ☐ NO |

## SECTION 2

| | | |
|---|---|---|
| Do you make yourself sick because you feel uncomfortably full? | ☐ YES | ☐ NO |
| Do you worry that you have lost control over how much you eat? | ☐ YES | ☐ NO |
| Have you recently lost more than 15 pounds in a 3-month period? | ☐ YES | ☐ NO |
| Do you believe yourself to be fat when others say you are thin? | ☐ YES | ☐ NO |
| Would you say food dominates your life? | ☐ YES | ☐ NO |

## SECTION 3

**Please answer using the following scale:**
**0**=None or a little of the time; **1**=Some of the time;
**2**=Most of the time; **3**=All of the time

**Over the past two weeks, how often have you:**

| | | | | |
|---|---|---|---|---|
| Been feeling low in energy, slowed down? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Blamed yourself for things? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Had poor appetite? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Had difficulty falling asleep, staying awake? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Been feeling hopeless about the future? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Been feeling blue? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Had feelings of no interest in things? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Had feelings of worthlessness? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Thought about or wanted to commit suicide? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Had difficulty concentrating or making decisions? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

## SECTION 4

**Please carefully read each item in the list.** Indicate how much you have been bothered by that symptom during the past month, including today, by indicating the response option using:
**0**=not at all; **1**=mildly but it didn't bother me much;
**2**=moderately – it wasn't pleasant at times;
**3**=severely – it bothered me a lot

| | | | | |
|---|---|---|---|---|
| Numbness or tingling | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling hot | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Wobbliness in legs | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Unable to relax | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Fear of worst happening | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dizzy or lightheaded | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Heart pounding/racing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Unsteady | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Terrified or afraid | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Nervous | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling of choking | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hands trembling | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Shaky/unsteady | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Fear of losing control | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty in breathing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Fear of dying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Scared | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Indigestion | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Faint/lightheaded | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Face flushed | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hot/cold sweats | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

## SECTION 5

| | | |
|---|---|---|
| Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | ☐ YES | ☐ NO |
| Do you often feel tired, fatigued, or sleepy during daytime? | ☐ YES | ☐ NO |
| Has anyone observed you stop breathing during your sleep? | ☐ YES | ☐ NO |
| Do you have or are you being treated for high blood pressure? | ☐ YES | ☐ NO |

SAINT LOUIS
SPORTS MEDICINE

# RETURNING STUDENT-ATHLETE MEDICAL UPDATE

*All information provided on this form is confidential and will be available only to the Saint Louis University Sports Medicine Staff.*

Name_____ Sport _____ Year ☐ So. ☐ Jr. ☐ Sr.

## SECTION 6

Please rate the current (i.e. last 2 weeks) **severity** of your insomnia problem(s).

| | | | | | |
|---|---|---|---|---|---|
| Difficulty falling asleep | ☐ none | ☐ mild | ☐ moderate | ☐ severe | ☐ very |
| Difficulty staying asleep | ☐ none | ☐ mild | ☐ moderate | ☐ severe | ☐ very |
| Problem waking up too early | ☐ none | ☐ mild | ☐ moderate | ☐ severe | ☐ very |
| How **satisfied**/disappointed are you with your current sleep pattern? | | | ☐ very satisfied | ☐ very dissatisfied | |
| To what extent do you consider your sleep problems to **interfere** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)? | ☐ not at all interfering | ☐ a little | ☐ somewhat | ☐ much | ☐ very much interfering |
| How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life? | ☐ not at all noticeable | ☐ a little | ☐ somewhat | ☐ much | ☐ very much noticeable |
| How **worried**/distressed are you about your current sleep problem? | ☐ not at all | ☐ a little | ☐ somewhat | ☐ much | ☐ very much |

## SECTION 7

**Select the response option that best describes how you have felt and conducted yourself over the past 6 months.**

| | | | | | |
|---|---|---|---|---|---|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |
| 3. How often do you have problems remembering appointments or obligations? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |
| 6. How often do you feel overly active and compelled to do things like you were driven by a motor? | ☐ never | ☐ rarely | ☐ sometimes | ☐ often | ☐ very often |

*I hereby certify that all answers to the preceding questions are correct and true. I understand that having passed my physical examination does not mean that I am physically qualified to engage in athletics, but only that the examiner found no medical reason to disqualify me.*

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

| | | |
|---|---|---|
| ☐ **Cleared** | ☐ **Follow-up** | ☐ **Refer to Physician** |
| | Reason:_____ | Date_____ |
| | ☐ **Cleared** | ☐ **Cleared** |

_____ _____ _____ _____

ATHLETIC TRAINER SIGNATURE DATE PHYSICIAN SIGNATURE DATE

SAINT LOUIS
SPORTS MEDICINE

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student-Athlete Name _____
First Middle Initial Last

Date of Birth _____ Age _____ Student ID# _____ Sport _____

1. I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

2. I hereby grant permission to the Sports Medicine Staff of Saint Louis University Department of Athletics to release health information pertaining to my fitness to participate in SLU Intercollegiate Athletic activities to Athletic Department administrators, coaches, and administrative staff responsible for assessing or approving my participation to the extent the information is needed for that purpose.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

3. I hereby grant permission to SLU Department of Athletics administrators and coaches to release to the news media the nature of any athletic-related injury or illness and my expected rehabilitation period, if any, for purposes of addressing my participation in intercollegiate athletic activities. This information may also be released to my parent or guardian.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Athletics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that SLU Department of Athletics may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

   I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize SLU to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE
☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

**EACH AUTHORIZATION EXPIRES ONE CALENDAR YEAR FROM SIGNATURE DATE.**

SAINT LOUIS
SPORTS MEDICINE

# STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

**I, _____, acknowledge that I am currently taking, have taken (within the past 6 months) or plan to take the following ergogenic aids, creatine powder, amino acids, protein supplements or other similar substances, hereinafter referred to as "Supplements." (Use back of form if necessary).**

| NAME | DOSAGE | MAIN INGREDIENTS | COMMENTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I understand and agree:

a. Saint Louis University Department of Athletics neither approves nor condones the use of Supplements.

b. Saint Louis University does its best to ensure that all supplements distributed comply with NCAA, A10 and IOC recommendations. However, I understand that I voluntarily consume these beverages and understand the risks associated with taking them.

c. I have been informed of the Saint Louis University Department of Athletics, A10, National Collegiate Athletic Association(NCAA) and USOC policies with regards to the use of Supplements and have had any questions about these policies answered.

d. The use of Supplements may result in serious harm to me, possible permanent injury to my health and even death.

e. I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance.

f. I must list all Supplements of the chain of custody forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at any time in the future any form of Supplements.

I further understand and agree Saint Louis University, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, or future use of Supplements. I agree to hold harmless, indemnify and irrevocably release, Saint Louis University, and its officers, employees, and agents from any and all liability, and demands claims and causes of action relating to my use of Supplements.

I understand the statements in this form and have had all questions about the information in this form answered to my satisfaction.

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

SAINT LOUIS
SPORTS MEDICINE

# POLICY OVERVIEW

**NCAA INFORMATION FOR DRUG TESTING MEDICAL EXCEPTIONS**

Beginning August 1, 2009, the NCAA has indicated that there will be a stricter application of the NCAA Medical Exception Policy as it applies to banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD). This stricter application will require documentation that demonstrates the student athlete has undergone a clinical assessment to diagnose ADHD, is being monitored regularly for use of the stimulant medication, and has a current prescription on file.

These documentation requirements are very stringent. Refer to the attached "Athletic Training Room – NCAA Information for Drug Testing Medical Exceptions" form and complete in its entirety. Additional information can be found at www.ncaa.org.

**SICKLE CELL STATUS**

The NCAA recommends that all student athletes be aware of their sickle cell status. If the student athlete does not know whether they are positive for sickle cell trait, the NCAA recommends that student athletes undergo testing to determine their status.

Saint Louis is supportive of this recommendation, and requests that each student provide Sports Medicine with documentation of their sickle cell trait status. To help you make an informed decision regarding this issue, some basic information is provided in the attached "Sickle Cell Trait Information Sheet" and at the additional resource links referenced on that information sheet.

**CONCUSSION INFORMATION**

Saint Louis wants its student athletes to be aware of the risks of concussion associated with participation in intercollegiate athletics, and is therefore providing the attached information about the risks and symptoms of concussions. My signature below acknowledges that I have received this educational information and that I specifically agree that I will immediately report to Saint Louis University if I experience any symptoms of concussion.

**ASSUMPTION OF RISK**

I am aware that participating in athletic activity involves risks of injury, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of participation in athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Furthermore, I understand that the possibility of injury, including catastrophic injury, is beyond Saint Louis University's control, and exists even though proper rules and techniques are followed. I also understand that there are risks involved with travel in connection with intercollegiate athletics. I acknowledge that my decision to participate in athletic activity at Saint Louis University is voluntary, and in consideration of Saint Louis University permitting me to participate in intercollegiate athletics, I agree to assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Saint Louis University and its officers, agents, and employees from any and all liability, any medical expenses not covered by Saint Louis University Department of Athletics medical insurance policies, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics, except to the extent such claims are solely caused by the negligence or intentionally willful actions of Saint Louis University.

**DISCLOSURE OF PHYSICAL CONDITION**

Recognizing that an assessment of my physical condition is dependent upon my providing an accurate medical history and fully disclosing any symptoms, complaints, prior injuries, ailments, and/or disabilities I have experienced, I agree that I will fully disclose in writing my prior medical history by accurately completing this Health History Questionnaire Form and by providing any supplemental materials necessary to present Saint Louis University with complete information about my medical history. I understand that it is also my responsibility to report to the Sports Medicine Department any present symptoms, complaints, ailments, and disabilities, and to report immediately any new health issues that may arise while I am a student athlete at Saint Louis University.

By signing below, I confirm that I have read and understand the above, that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or health problems not disclosed and discussed to Saint Louis University's Sports Medicine Department. I acknowledge and agree that all future injuries, medical, dental, or mental health problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately and directly reported to the Saint Louis University's Team Physician, the Head Athletic Trainer, and/or the member of the Saint Louis University Athletic Training staff specifically assigned to my team, no matter how minor or insignificant I may deem the health issue.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.