Dear VSU Student Athlete and Parent/Gardian,

We are pleased to welcome you back to Virginia State University. It is important that a safe and knowledgeable environment is maintained for you, the student-athlete, the athletic department and the university. To provide you with the best medical care while you are a student at VSU, all information requested in this packet must be completed on corresponding forms prior to ANY official practice or event. An official practice or event is anything sanctioned by the NCAA where a coach is present. Therefore, it is important that you read all information and double check to make sure each form is filled out accurately, completely and with appropriate signatures where applicable.

CHECKLIST:

☐ Student Athlete Sheet
  1. ☑ Did you fill out ALL applicable information and provide emergency contact information?

☐ Physical Examination
  1. ☑ Was your physical completed on the VSU Physical Form?

  2. ☑ Were you tested for sickle cell trait and/or can you provide proof of your sickle cell status?
     o Infants born after 1984 were tested for the sickle cell trait and therefore the documentation should be available from your family pediatrician.

  3. ☑ Was this physical completed no earlier than six months prior to the academic school year or athletic participation?

  4. ☑ Was your physical stamped by the health care provider?
     o Receipt showing the service provided, name of healthcare facility/provider, and corresponding physical date is acceptable in absence of stamp.

☐ Insurance Information
  1. ☑ Did you provide a copy of the front and back of your insurance card?

  2. ☑ Did you include all insurance policy, group, and ID numbers for primary and/or secondary insurance?

  3. ☑ Did you include the name, D.O.B., and SSN # for the parent under whom you are covered?

☐ Parental Acknowledgement of Insurance Coverage Form
  1. ☑ Did the parent/guardian under whose insurance you are covered sign this form?

☐ Immunization
  1. ☑ Did you provide proof of and are your immunizations up-to-date?

☐ Student Athlete Concussion Reporting Agreement
  1. ☑ Did you sign and provide requested information?

*******************************************************************************************
---PLEASE KEEP A COPY OF ALL FORMS FOR YOUR OWN RECORDS---

Turn in 1 copy of pages 1-4, 6 to:
Virginia State University
Roland Lovelace MSED, ATC
P.O. Box 9058
Petersburg, Virginia 23806
Phone (804) 524-6798
Fax (804) 524-5763

Turn in 1 copy of pages 1-4, 6 to your head coach:
Virginia State University
(Head Coach)
P.O. Box 9058
Petersburg, Virginia 23806
Phone (804) 524-5030
Fax (804) 524-5763
Virginia State University
2017-2018 STUDENT ATHLETE INFORMATION SHEET
(Please Print)

<table>
<thead>
<tr>
<th>STUDENT ATHLETE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name:</td>
</tr>
<tr>
<td>First:</td>
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<tr>
<td>MI:</td>
</tr>
<tr>
<td>Sport(s):</td>
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<tr>
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<tr>
<td>SSN#:</td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>State:</td>
</tr>
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<tr>
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<tr>
<td>State:</td>
</tr>
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<tr>
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<tr>
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<tr>
<td>Anticipated Entry Date:</td>
</tr>
<tr>
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</tr>
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<tr>
<td>IN CASE OF EMERGENCY</td>
</tr>
<tr>
<td>Mother/Guardian Name:</td>
</tr>
<tr>
<td>Father/Guardian Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
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</tr>
<tr>
<td>Cell #:</td>
</tr>
<tr>
<td>Emergency Contact Name:</td>
</tr>
<tr>
<td>if different from parent(s)/guardian(s)</td>
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<tr>
<td>Address:</td>
</tr>
<tr>
<td>Home Phone#:</td>
</tr>
<tr>
<td>Cell Phone#:</td>
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</table>

<table>
<thead>
<tr>
<th>INSURANCE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>***** Please provide a front and back copy of your insurance card *****</td>
</tr>
<tr>
<td>Is this student athlete covered by ANY PRIMARY HEALTH INSURANCE?</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>Primary Insurance Co:</td>
</tr>
<tr>
<td>Secondary Insurance Co:</td>
</tr>
<tr>
<td>Name of Policy Holder:</td>
</tr>
<tr>
<td>Name of Policy Holder:</td>
</tr>
<tr>
<td>Relationship to you:</td>
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<tr>
<td>Employer:</td>
</tr>
<tr>
<td>Policy Holder’s Social Security #:</td>
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<tr>
<td>Policy Holder’s Date of Birth:</td>
</tr>
<tr>
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<tr>
<td>Phone #: ( ) -</td>
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<td>Phone #: ( ) -</td>
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<tr>
<td>Insurance Co. Phone #:</td>
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<tr>
<td>Insurance Co. Phone #:</td>
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</tbody>
</table>

***** Please provide a front and back copy of your insurance card if applicable *****
Medical History Questionnaire

I. Please circle to indicate whether any of the following conditions exist in your FAMILY:

- Allergies
- Anemia
- Asthma
- Bleeding disorder
- Cancer
- Diabetes
- Eye disorder
- Heart disease
- High Blood Pressure
- Lung Disease
- Psychiatric disorder
- Stroke
- Sudden death
- Tuberculosis
- Ulcer
- Other

Please circle to indicate whether YOU HAVE or HAD any of the following conditions:

- Allergies
- Anemia
- Asthma
- Bleeding disorder
- Bronchitis
- Cancer or malignancy
- Chickenpox
- Collapsed lung
- Diabetes
- Gastrointestinal disorder
- Gout
- Lung disease
- Hearing impairment
- Heart Disease
- Heart murmur
- Heat exhaustion
- Heart stroke
- Hepatitis or liver disease
- High blood pressure
- HIV
- Kidney infection or stone
- Meningitis
- Migraine headache
- Mononucleosis
- Pneumonia
- Psychological problems
- Rheumatic fever
- Rheumatoid arthritis
- Ruptured organs
- Seizure disorder
- Sexually transmitted disease
- Sickle cell disease
- Sickle cell trait
- Substance/alcohol abuse
- Thyroid disorder
- Tuberculosis or (+) TB test
- Visual impairment
- Other

General Medical Questions:

1. Have you ever been diagnosed with a concussion?  □ YES  □ NO
   If yes, how many times?
   Number of concussions that resulted in a loss of consciousness:
   Number of concussions that resulted in confusion:

2. Have you been admitted to a hospital or had inpatient surgery?  □ YES  □ NO
   Procedure performed:
   Name & Address of Physician:

3. Have you had outpatient surgery?  □ YES  □ NO
   Procedure performed:
   Name & Address of Physician:

4. Have you ever been advised to have surgery that you have not done?  □ YES  □ NO
   Please explain:

5. Do you have a COMPLETE and FUNCTIONAL set of all paired organs? (eyes, ears, kidneys, ovaries, testicles, lungs)  □ YES  □ NO
   Please explain:

6. Have you had any neck injuries or pinched nerves?  □ YES  □ NO
   Please explain:

7. Are you presently taking any medications, prescription or non-prescription, on a routine basis?  □ YES  □ NO
   Medication(s):

8. Have you ever passed out during exercise?  □ YES  □ NO
   Please explain:

9. Are you on a special diet (vegetarian, low salt), whether by choice or a physician's orders?  □ YES  □ NO
   Please explain:

10. Do you have any allergies and/or allergic reactions?  □ YES  □ NO
    Please explain:

11. Have you had or do you now have any other medical problems or injuries not listed on this form?  □ YES  □ NO
    Please explain:

12. Do you have any medical or health problems that you are currently receiving medical treatment for?  □ YES  □ NO
    Please explain:
II. PHYSICAL EXAMINATION: To be completed by THE LICENSED HEALTH PROFESSIONAL (M.D., P.A., N.P.) PERFORMING THE EVALUATION. Please review the student’s history (Part I), and provide additional details as needed. Please complete the physical exam and comment on all positive findings.

Name ___________________________ SID V# ___________________________

Last First Middle

HEIGHT: _______ WEIGHT: _______ lbs. BP _______ Pulse _______ Vision R 20/_____ L 20/_____

<table>
<thead>
<tr>
<th>Examination Findings</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Examination Findings</th>
<th>Normal</th>
<th>Abnormal</th>
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</thead>
<tbody>
<tr>
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<td>Back</td>
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<td>Cardiovascular</td>
<td>Skin</td>
<td></td>
<td></td>
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<tr>
<td>Breasts</td>
<td>Surgical Scars</td>
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<td>Gastrointestinal</td>
<td>Metabolic/Endocrine</td>
<td></td>
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<tr>
<td>Hernia</td>
<td>Neuroropsychiatric</td>
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</tbody>
</table>

Abnormal findings:
_______________________________________________________________________________________
_______________________________________________________________________________________

******REQUIRED FOR NEW ATHLETES**AND/ OR** MUST ATTACH TEST RESULTS******

Sickle Cell Trait Test:  □ Negative  □ Positive  Date test was performed:_____________________

RECOMMENDED:
Hct or Hgb: _________________ Urine: Alb. _______________ Glu. _______________ Micro. _______________

*******REQUIRED*******

1. PHYSICAL ACTIVITY:
□ UNLIMITED  OR  □ LIMITED (explain):

2. DIAGNOSIS:
□ Excellent health with no chronic medical problems  OR  □ Other diagnosis and recommendation - Please list:
_______________________________________________________________________________________

Allergies to Medications: ________________________________________________
Current Medications and Doses: ____________________________________________

Examiners Signature: ___________________________ Date of Exam: ___/___/____
Print Name: ___________________________ Address: ___________________________
PHONE: (OFFICE) (______) ______________ FAX: (______) __________________________

PLEASE APPLY PHYSICIAN OR PRACTICE STAMP IN THIS BOX IF APPLICABLE.

IMPORTANT NOTICE: Failure to comply with the Commonwealth Of Virginia Immunization laws will result in a Student Health HOLD being placed on your registration for the upcoming semester.
Parental Acknowledgement of Insurance Coverage

The NCAA discourages any college or university from providing coverage or paying the bills incurred for medical expenses related to illnesses or conditions which are not sustained as the direct result of an accident in our intercollegiate sports program. (This includes pre-existing conditions and non-athletic injuries.) The athletic accident insurance at Virginia State University provides supplemental coverage for your son/daughter for accidents while participating in a sanctioned intercollegiate practice or competition, including sponsored and authorized team travel. This insurance is designed to supplement your primary healthcare benefits. In ALL instances of an existing primary insurance, our insurance will be secondary. ONLY in the ABSENCE of a primary insurance will our insurance bear the sole responsibility for all claims.

If you do not have medical insurance coverage, a letter from your employer with verification will be necessary. Copies of ALL Explanation of Benefits (EOBs) regarding each injury must be forwarded to the university’s athletic department. These will be submitted to our accident insurance. All bills incurred that are not paid, or are denied, by your family, employer group insurance or plan, will be sent to our Intercollegiate Sports Accident Insurance. Our insurance must have ITEMIZED BILLS and all EXPLANATION OF BENEFITS from your insurance company before any claims will be processed.

I hereby authorize Virginia State University and its athletic insurance carrier to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize Virginia State University or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

Student Name (print)____________________________________   Sport(s)________________________

Student Signature_______________________________________   Date__________________________

Parent/Guardian Signature_________________________________   Date__________________________

****PARENT SIGNATURE IS NECESSARY IF STUDENT IS USING PARENT’S INSURANCE****
CONCUSSION
A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?
A concussion is a brain injury that:
• Is caused by a blow to the head or body.
  – From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
• Can change the way your brain normally works.
• Can range from mild to severe.
• Presents itself differently for each athlete.
• Can occur during practice or competition in ANY sport.
• Can happen even if you do not lose consciousness.

HOW CAN I PREVENT A CONCUSSION?
Basic steps you can take to protect yourself from concussion:
• Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
• Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
• Follow your athletics department's rules for safety and the rules of the sport.
• Practice good sportsmanship at all times.
• Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?
You can’t see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:
• Amnesia.
• Confusion.
• Headache.
• Loss of consciousness.
• Balance problems or dizziness.
• Double or fuzzy vision.
• Sensitivity to light or noise.
• Nausea (feeling that you might vomit).
• Feeling sluggish, foggy or groggy.
• Feeling unusually irritable.
• Concentration or memory problems (forgetting game plays, facts, meeting times).
• Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?
Don’t hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion.
Sports have injury timeouts and player substitutions so that you can get checked out.
Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.
Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.
Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

IT’S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.
WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.
Student Athlete Concussion Reporting Agreement

I, ________________, hereby acknowledge that I have received and read the concussion fact sheet for student athletes. I understand that it is my responsibility to report any and all concussive events and concussion like symptoms to a member of the VSU Sports Medicine Staff. The symptoms could include but are not limited to the following:

- HEADACHE
- NECK PAIN
- NAUSEA
- VOMITING
- LOSS OF APPETITE
- BALANCE PROBLEMS / DIZZINESS
- DROWSINESS / FATIGUE
- DIFFICULTY SLEEPING
- NERVOUSNESS / ANXIETY
- CONTINUED DOUBLE VISION

- RINGING IN THE EARS
- FEELING SLOWED DOWN
- FEELING IN A “FOG”
- DIFFICULTY CONCENTRATING OR REMEMBERING
- CONFUSION / DISORIENTATION
- BLURRED VISION
- SADNESS / ALTERED EMOTIONS
- SENSITIVITY TO LIGHT / NOISE
- ALTERED EMOTION/BEHAVIOR

I understand that concussions and head injuries have the potential to be life-threatening or can lead to Second Impact Syndrome. Concussions that are unreported and/or unmanaged carry a greater risk of traumatic brain injury. All head/neck related injuries must be reported to a member of the Sports Medicine Staff immediately upon occurrence.

______________________________                         _______________________________
Name (print or type)                                           Sport

______________________________                         _______________________________
Signature                                           Date

______________________________                         _______________________________
VSU ID#                                           Date of Birth

If Student Athlete is Under 18 Years of Age:

______________________________                         _______________________________
Parent/Gardian Signature                      Date