PARENT INFORMATION FORM

Parents/ Guardian to Complete and Return to: Olivet Nazarene University
One University Avenue, Box 6055
Bourbonnais, IL 60914

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.
(NOTE: Complete all blanks with information or N/A if not applicable).

1. **Name of Athlete:** _____ Sport:_____
   College Address: _____ Phone: _____
   City:_____ State: _____ Zip Code:_____

   DOB: _____ SS# _____

2. **Father/Guardian:** _____

   Address: _____

   Employer: _____

   Phone: _____ Social Security No._____

   Insurance Company: _____

   Address: _____

   Phone: _____ Policy No.:_____

3. **Mother/Guardian:** _____

   Address: _____

   Employer: _____

   Phone: _____ Social Security No._____

   Insurance Company: _____

   Address: _____

   Phone: _____ Policy No.:_____

I hereby authorize Olivet Nazarene University and NAHGA Claims Service 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 photo static copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the college/university or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college/university.

Parent's Signature_____

Student's Signature:_____

Olivet Nazarene University

Preparticipation Physical Evaluation(Page 1 of 2)

This completed form must be kept on file by the school.

Part 1. Student Information (to be completed by student or parent).

Student's Name: _____ Sex: _____ Age: _____ Date of Birth: _____ / _____ / _____
School: _____ Grade in School: _____ Sport(s):_____
Home Address: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____
Person to Contact in Case of Emergency: _____
Relationship to Student: _____ Home Phone Number: (_____) _____Work Phone Number: (_____) _____
Personal/Family Physician: _____City/State: _____ Office Phone: (_____) _____

Part 2. Medical History (to be completed by student or parent). Explain "yes" answers below, circle questions you don't know answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?		
2. Do you have an ongoing chronic illness?		
3. Have you ever been hospitalized overnight?		
4. Have you ever had surgery?		
5. Are you currently taking any prescription or nonprescription (overthe-counter) medications or pills or using an inhaler?		
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		
8. Have you ever had a rash or hives develop during or after exercise?		
9. Have you ever passed out during or after exercise?		
10. Have you ever been dizzy during or after exercise?		
11. Have you ever had chest pain during or after exercise?		
12. Do you get tired more quickly than your friends do during exercise?		
13. Have you ever had racing of your heart or skipped heartbeats?		
14. Have you had high blood pressure or high cholesterol?		
15. Have you ever been told you have a heart murmur?		
16. Has any family member or relative died of heart problems or sudden death before age 50?		
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
18. Has a physician ever denied or restricted your participation in sports for any heart problems?		
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
20. Have you ever had a head injury or concussion?		
21. Have you ever been knocked out, become unconscious, or lost your memory?		
22. Have you ever had a seizure?		
23. Do you have frequent or severe headaches?		
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
25. Have you ever had a stinger, burner, or pinched nerve?		
26. Have you ever become ill from exercising in the heat?		
27. Do you cough, wheeze, or have trouble breathing during or after activity?		
28. Do you have asthma?		
29. Do you have seasonal allergies that require medical treatment?		
30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
31. Have you had any problems with your eyes or vision?		
32. Do you wear glasses, contacts, or protective eyewear?		
33. Have you ever had a sprain, strain, or swelling after injury?		
34. Have you broken or fractured any bones or dislocated any joints?		
35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?		
If yes, check appropriate blank and explain below.		
___ Head ___ Elbow ___ Hip		
___ Neck ___ Forearm ___ Thigh		
___ Back ___ Wrist ___ Knee		
___ Chest ___ Hand ___ Shin/Calf		
___ Shoulder ___ Finger ___ Ankle		
___ Upper Arm ___ Foot		
36. Do you want to weigh more or less than you do now?		
37. Do you lose weight regularly to meet weight requirements for your sport?		
38. Do you feel stressed out?		
39. Record the dates of your most recent immunizations (shots) for:		
Tetanus:_____ Measles: _____		
Hepatitus B: _____ Chickenpox: _____		
FEMALES ONLY (optional)		
40. When was your first menstrual period? _____		
41. When was your most recent menstrual period? _____		
42. How much time do you usually have from the start of one period to the start of another? _____		
43. How many periods have you had in the last year? _____		
44. What was the longest time between periods in the last year? _____		

Expain "Yes" answers here:

_____

_____

_____

_____

_____

We hereby state, to the best of our knowledge that our answers to the above questions are complete and correct.

Signature of Student:_____ Date:_____

Olivet Nazarene University

Preparticipation Physical Evaluation(Page 2 of 2)

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Part 3. Physical Examination (to be completed by licensed physician)

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____, ____/____)

Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
MUSCULOSKELETAL			
1. Neck	_____	_____	_____
2. Back	_____	_____	_____
3. Shoulder/Arm	_____	_____	_____
4. Elbow/Forearm	_____	_____	_____
5. Wrist/Hand	_____	_____	_____
6. Hip/Thigh	_____	_____	_____
7. Knee	_____	_____	_____
8. Leg/Ankle	_____	_____	_____
9. Foot	_____	_____	_____

* – station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ ***Cleared without limitation.**

____ ***Not cleared for:** _____ **Reason:** _____

_____

____ ***Cleared after completing evaluation/rehabilitation for:** _____

____ ***Referred to** _____ **For:** _____

_____.

Recommendations:

_____

_____

_____

Name of Physician/Nurse Practitioner (print or type): _____ **Date:** _____

Address: _____

Signature of Physician/Nurse Practitioner:

_____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation.

____ Not cleared for: _____ Reason: _____

_____

____ Cleared after completing evaluation/rehabilitation for: _____

____ Referred to _____ For: _____

_____.

Recommendations: _____

_____

_____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____, MD or DO