NEW ATHLETE
PRE-PARTICIPATION FORMS

ST. THOMAS UNIVERSITY
ATHLETICS DEPARTMENT

Name of Student-Athlete:	**Sport:**

Dear Student-Athletes & Parents:

We would like to welcome you to the St. Thomas University Athletics family. The following is a checklist to better assist you in making the process of completing physicals easier. Please make sure to have all of the necessary paperwork completed prior to arriving on campus. The waivers will be accessed online and must be completed prior to the date of physicals. Instructions on how to complete the profile can be found on page 1. Any paperwork completed the day of or after the date of physicals may potentially delay initial clearance to participate in athletics. Should you have any questions or concerns, please contact the St. Thomas University Athletic Training Staff.

Please note: If you are under 18, a parent or legal guardian must sign required forms both on physical and online.

_____ Follow the instructions on page 1 to complete SportsWare Profile

_____ Complete and sign SportsWare waivers

- ____ HIPAA
- ____ Consent for Participation
- ____ Athlete Attestation and Releases
- ____ Insurance
- ____ Secondary Insurance Explanation
- ____ Drug and Alcohol Policy
- ____ Concussion Acknowledgement Form
- ____ Sickle Cell Form

_____ Clear front and back copy of primary insurance card

_____ Completely fill out pages 2-5 prior to entering physicals

STAFF USE ONLY

- ☐ Pgs. 2-5 Complete
- ☐ SportsWare Profile Complete
- ☐ SportsWare Waivers Complete
- ☐ Insurance Card Copy (front and back)

Reviewed By:_____

Thank you,

George Fernandez, MS, ATC/LAT E: gfernandez5@stu.edu O: 305-628-6533
Head Athletic Trainer

NEW ATHLETE
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ST. THOMAS UNIVERSITY
ATHLETICS DEPARTMENT

SPORTSWARE REGISTRATION INSTRUCTIONS

PLEASE READ AND FOLLOW THE FOLLOWING INSTRUCTIONS. THIS IS NECESSARY TO COMPLETE YOUR ATHLETE PROFILE.

Joining SportsWareOnline:

1. Go to www.swol123.net.
2. Scroll to the middle of the screen and click the **Join SportsWare** button.
3. Enter your **School ID – STU Bobcats**
4. Enter your First Name, Last Name, STU Email address and click the Send button. Your request to join SportsWare will then be sent to the Athletic Trainer for review.
5. Once your request is accepted you will receive an e-mail with the Subject *"SportsWare request accepted"*.
6. Open the e-mail and click the www.swol123.net link to continue to SportsWareOnLine.

Setting Up Your Password:

1. Go to www.swol123.net
2. Enter your Email Address and click the Reset Password button.
3. You will receive an e-mail with the Subject "SportsWareOnLine Password Request".
4. Open the e-mail and click on the link to reset your password. Enter your e-mail address, new password and click the Save button.

Updating Your Information:

1. Go to www.swol123.net.
2. Enter your Email Address and password, click the Login button.
3. Select My Info: Update your address, emergency contact and insurance information school.
4. Once done with My Info go to:
   - **Med History:** Complete a Medical History questionnaire.
   - **Forms:** View/complete required paperwork. Note: SportsWare will also display "*You have 8 forms to complete/download"*.

** For questions: please contact Kat (kavalos@stu.edu) or Erica (ealvarez-rosario@stu.edu)

NEW ATHLETE
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ST. THOMAS UNIVERSITY
ATHLETICS DEPARTMENT

Player Information and Contact Sheet

Student-Athlete Name: _____ **Date of Birth:** _____
(Last, First, MI)

Sport(s): _____ **STU I.D.#:** _____

STU Email Address: _____ **Expected Grad. Year:** _____

Last Four Digits of Social Security #: ***-**-_____ **If no SSN**: ☐ International Student

☐ Live On Campus ☐ Live Off Campus – Local Address: _____

Permanent Home Address: _____

City, State, Zip Code: _____

Cell Phone #: _____ **Home Phone #:** _____

Father/Legal Guardian Name: _____

Use as Emergency Contact? ☐ YES ☐ NO **Cell Phone #:** _____

Home Phone #: _____ **Work Phone #:** _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

Mother/Legal Guardian Name: _____

Use as Emergency Contact? ☐ YES ☐ NO **Cell Phone #:** _____

Home Phone #: _____ **Work Phone #:** _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

<u>Other Emergency Contact</u>

Name: _____

Relationship to Student-Athlete: _____

Home Address: _____

City, State, Zip Code: _____

Cell Phone #: _____ **Alternate Phone #:** _____

NEW ATHLETE
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ATHLETICS DEPARTMENT

Primary Insurance Information Sheet

Name of Student Athlete: _____ Sport: _____

If a student will be using their own primary insurance, the following information needs to be completed in full and returned to the St. Thomas University Athletic Training Staff along with a front and back copy of the primary insurance card. If a student will be using the St. Thomas University Primary insurance, please indicate and sign below.

*** PLEASE NOTE: THIS IS NOT A WAIVER FOR THE STU STUDENT INSURANCE PLAN!**

Will you be using the primary insurance provided by St. Thomas University?

☐ YES If yes, STU ID#: _____

☐ NO If no, please complete below.

Primary Insurance Holder's Full Name: _____

Primary Insurance Company Name: _____

Address: _____

Phone #: _____

Group # (if applicable): _____

Policy # (if applicable): _____

Member ID # (if applicable): _____

I certify that, to the best of my knowledge, the information provided above is complete and correct. Should any changes in insurance or demographic occur, it is my responsibility to notify the St. Thomas University Athletic Training Staff immediately. **Failure to do so may result in incurring out-of-pocket expenses. St. Thomas University will not be responsible for any medical bills resulting from the lapse or cancellation of a student athlete's primary insurance coverage.**

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____

ALL information provided will be stored in private files in the St. Thomas University Athletic Training Department and will only be disclosed if required by insurance company to file a claim.

NEW ATHLETE
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ST. THOMAS UNIVERSITY
ATHLETICS DEPARTMENT

MEDICAL HEALTH HISTORY

Name: **Date:** **Sex:** ☐ **Male** ☐ **Female**

ALLERGIES/DRUGS, OTHER

ALLERGIC TO ANY OF THE FOLLOWING?

☐ Ibuprofen ☐ Sulfa ☐ Food: _____ ☐ NO KNOWN ALLEGRIES
☐ Penicillin ☐ Codeine ☐ Insect or pet allergy? Type? _____
☐ Aspirin ☐ Other drugs/allergy:

MEDICATIONS

PLEASE LIST ANY CURRENT MEDICATIONS, DOSAGES, AND REASON FOR TAKING. A COPY OF THE PRESCRIPTION MUST BE TURNED IN TO THE ATHLETIC TRAINING ROOM. ☐ NONE

_____
_____
_____

PERSONAL HISTORY

	Yes	No	Date, if yes		Yes	No	Date, if yes
Anemia	☐	☐		Hepatitis	☐	☐	
Asthma	☐	☐		High blood pressure	☐	☐	
Bleeding disorder	☐	☐		Kidney disease	☐	☐	
Blood clots	☐	☐		Loss of consciousness	☐	☐	
Blood in stool/urine	☐	☐		Ovarian cyst	☐	☐	
Breast mass	☐	☐		PID	☐	☐	
Cancer	☐	☐		Seizures/convulsions/epilepsy	☐	☐	
Depression	☐	☐		Sickle cell disease or trait (circle one)	☐	☐	
Diabetes mellitus	☐	☐		Thyroid disease	☐	☐	
Eating disorder	☐	☐		Tuberculosis or positive PPD	☐	☐	
Fibroid	☐	☐		Ulcer	☐	☐	
Heart Murmur	☐	☐		Other:			

ANY HOSPITALIZATION/SURGERIES? ☐ NONE

_____
_____

FAMILY MEDICAL HISTORY

Any **close relatives** have…?	Yes	No	If yes, who?
Cancer	☐	☐	
Diabetes	☐	☐	
Heart disease	☐	☐	
Stroke	☐	☐	
Sudden death (under 50)	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
Alcoholism	☐	☐	

I, the undersigned, hereby acknowledge, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18 years of age): _____ Date: _____

NEW ATHLETE
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ATHLETICS DEPARTMENT

Pre-Participation Medical History

Name: **Sport:**

Instructions: Please check all appropriate boxes. All YES answers **must** include detailed comments

MEDICAL HEALTH QUESTIONNAIRE

Have you ever had or do you now have…?	Yes	No	Comments
Chest pain with or after exercise?	☐	☐	
Dizziness with or after exercise?	☐	☐	
Passing out with or after exercise?	☐	☐	
Wheezing/coughing with exercise?	☐	☐	
Weakness/fatigue with or after exercise?	☐	☐	
Heat exhaustion or intolerance?	☐	☐	
Racing of the heart/irregular rhythm?	☐	☐	
Hearing loss or perforated eardrum?	☐	☐	
Headaches or migraines?	☐	☐	
Dental plate or orthodontic work?	☐	☐	
Impaired vision, wear glasses/comntacts?	☐	☐	
Unequal Pupils? If yes, R or L larger?	☐	☐	
Anemia?	☐	☐	
High blood pressure?	☐	☐	
Rheumatic heart fever or heart murmur?	☐	☐	
Infections (Staph/MRSA)?	☐	☐	
Frequent anxiety, depression, insomnia?	☐	☐	
Hernia?	☐	☐	
Loss of function or absence of paired organ?	☐	☐	
Weight problem (or recent weight gain/loss)?	☐	☐	
Do you have sickle cell trait or been diagnosed with sickle cell anemia?	☐	☐	
Are you currently taking medication for ADD/ADHD? Rx:	☐	☐	
Are you currently taking medication for asthma? Rx:	☐	☐	

ORTHOPEDIC QUESTIONNAIRE

Instructions: Please check all appropriate boxes. All YES answers **must** include as much detail as possible including date of injury, sport, if surgery was needed, and time lost from play.

Have you ever had a…?	Yes	No	Comments
Head injury?	☐	☐	
Neck injury?	☐	☐	
Back injury?	☐	☐	
Shoulder injury?	☐	☐	
Elbow injury?	☐	☐	
Wrist/hand/finger injury?	☐	☐	
Hip injury?	☐	☐	
Knee injury?	☐	☐	
Ankle/foot/toe injury?	☐	☐	
Have you ever had a stress fracture?	☐	☐	
Have you ever been treated for a mental condition? If yes, specify when, where, and nature of condition?	☐	☐	

I, the undersigned, hereby acknowledge, affirm, and represent that all of the above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (if under 18 years of age): _____ Date: _____

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ATHLETICS DEPARTMENT

PRE-PARTICIPATION PHYSICAL EXAMINATION

Name:		Date:	☐ Male	☐ Female	Sport:
Height:	Weight:	Blood Pressure:	/	Pulse:	
Vision: R 20/	L 20/	Corrected? ☐ Y ☐ N	If corrected, circle one: Glasses/Contacts?		

MEDICAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat • Pupils equal, reactive to light		
Lymph nodes		
Heart • Murmurs		
Lungs		
Abdomen		
Skin • HSV, tinea corporis, lesions suggestive of MRSA • Scars/Incisions		
Neurologic		
MUSCULOSKELETAL		
Neck		
Shoulder		
Elbow		
Wrist/Hand/Digits		
Back		
Hip		
Knee		
Ankle		
Foot/Toes		
Reflexes		
Functional • Hop, jump, squat • Duck/toe/heel walk		

PARTICIPATION STATUS

_____ Full Unlimited Participation in Intercollegiate Sports

_____ Conditionally Cleared with the Following Exceptions: _____
_____

_____ Participation withheld until: _____
_____

_____ Disqualifications (explain): _____
_____

General Medical Physician Signature:_____ Date: _____

Orthopedic Physician Signature:_____ Date: _____

Reviewed By: _____ Date: _____
(STU Staff Certified Athletic Trainer)

PHYSICIAN STAMP HERE IF OUTSIDE PROVIDER