



Counseling, Health & Wellness Services HEALTH CENTER

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Club Sports Pre-participation Medical Examination Information 2022-23 Academic Year

Dear New Athletes and Families,

On behalf of the Department of Athletics & Recreation and the PLU Counseling, Health and Wellness Center, it is a pleasure to welcome you to PLU. We're glad to have you here, and we will do everything we can to ensure that you have a safe, successful, and enjoyable athletic experience. **Please read through the following information carefully and prior to completing the medical history form.**

As you prepare to join PLU Athletics, you will need to complete a pre-participation medical evaluation. In the past, this has been done at the PLU Health Center. This year, due to COVID-19, Health Center services have been curtailed and we are requesting you complete your physical with your healthcare provider, who knows you and your medical history, or at an urgent care clinic. You will need to schedule a brief phone visit at the Health Center, prior to the start of practice, to review the form with one of the providers. **Regardless of where you have the physical, it must be completed on the PLU physical form. If not, you will be asked to repeat the physical exam when you arrive on campus. This may delay your ability to participate in practices.**

In order to serve each incoming athlete as easily as possible, we ask that you schedule your sports physical phone review as soon as possible. To schedule an appointment, you need only call **253-535-7337 option 2**.

■ Why should I complete my physical as soon as possible?

In the event that your pre-participation exam identifies a health issue that warrants further testing, we like to allow adequate time to obtain medical records and tests so that there are no delays in starting athletic practice.

■ Where else can I have this done?

As noted above, you may choose to have this done with your primary care provider at home. **If you choose to have your exam done with your provider, the PLU physical exam form is still required and may be requested by calling the health center. Physical forms completed by an off-campus provider need to be reviewed during an appointment with a PLU Health Center provider.**

■ How much time do I have?

Due to the high volume of new athletes each year our deadlines for your pre-participation exam are very important to remember! If you are having your physical done at the Health Center please be sure to have this completed **2-3 weeks before the start of your practice** This applies to Fall club sports.

■ Will I need to do this every year?

No. Most athletes undergo an examination only once. Athletes who are absent from the athletic program or who have certain health conditions may be asked to follow-up with the PLU Health Center on an annual basis.

■ Do you accept my insurance?

Almost all visits to the PLU Health Center are free of charge. For this reason, it is not necessary to bring an insurance card; we will not bill your insurance since there is no charge for the visit

■ What do I need to bring with me to my appointment?

Please carefully review your personal and family medical history with your family. Accurate health information at the time of your visit will help avoid delays in starting practice.

- Completed Pre-participation Examination Questionnaire (enclosed).** This form must be completed in ink, not pencil.
- The PLU Health History and Consent,** if you have not already sent this in to the Health Center.
This form must be signed by a parent or guardian if you are not yet 18 years old.
- Your **complete vaccination records and sickle cell trait (SCT) test results.** See below for more info on the SCT. You can have the SCT test done at the Health Center for \$15.00 if you're unable to obtain this record from your birth state.
- A list of any **medications** you are taking, **including the dose and reason that you take them** (bring the bottle(s))

- with you if you aren't sure).
- A list of any **allergies** to medications, including the type of medication and type of reaction.
 - Please wear your eyeglasses or contact lenses.
 - Any prior records regarding tests pertaining to your heart, particularly if you have undergone an ultrasound (**echocardiogram**) in the past.
 - Please **do not take any "pre-workout" or energy supplements**. These can affect your heart rate and blood pressure.

■ Special Health Conditions

• Attention Deficit Hyperactivity Disorder (ADHD)

The NCAA has specific regulations regarding the use of stimulant medications for ADHD. PLU Club Sports follows these regulations. These include amphetamine drugs such as Ritalin, Adderall, Vyvanse, Daytrana, methylphenidate, dextroamphetamine, and others. You will be required to provide proof of medical necessity to take these medications. This includes prior medical records and documentation of formal testing for ADHD. **We also recommend that you review the PLU Health Center Stimulant Medication Policy on our website.**

If you require ongoing prescriptions for ADHD medications while at PLU, the Health Center can prescribe these for you under most circumstances *if you provide the above documentation*.

• Chronic Illnesses: Asthma, Acne, Anxiety, Depression, High Blood Pressure, etc.

The PLU Health Center is happy to serve as your "medical home" while you are here. We can prescribe medications for common chronic illnesses while you are a student at PLU. We have an in-house pharmacy or we can send prescriptions to any other pharmacy, also.

• Heart Valve Disease and Heart Murmurs

If you have a history of a heart murmur or heart valve disease, please bring a copy of your echocardiogram. We do not require actual visual images of your heart, just a written, dated report of the echocardiogram, **indicating you are cleared to participate in college-level sports.**

If you have any questions or concerns, do not hesitate to contact the Health Center at [253-535-7337](tel:253-535-7337).

• Orthopedic Surgery

If you have undergone orthopedic surgery during the past year, you will be required to present a statement from the surgeon stating that you may participate in competitive athletics without restriction.

We look forward to welcoming you to campus!

■ What if I need additional tests?

In the event that your medical history or physical exam indicates a need for further testing, we will make every effort to arrange for this in a timely fashion. We will work with you and your family to review insurance coverage and convenient access to care. This is why it is always best to come in for your pre-participation examination as early as possible. This will prevent delays in beginning your participation in PLU athletics & recreation.

Elizabeth Hopper, MN, ARNP
Director, PLU Health Services

Pacific Lutheran University Health Services
Club Sports Pre-Participation Medical History
 2022-23 Academic Year

Date of exam: _____

Name _____ PLU ID: _____

Age _____ Sport(s): _____

■ Medicines and Allergies

Please list all of the prescription and over-the counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? Yes No If yes, please identify specific allergies below:

- Medicines Pollen Food Stinging insects

Explain all "Yes" answers below. Circle any question to which you do not know the answer. Please review these questions with your parent/guardian/healthcare provider so that you can answer with as much detail as possible.

■ General Questions	Yes	No
1. Has a healthcare provider ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify them below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections <input type="checkbox"/> Other _____		
3. Have you ever spent the night in the hospital		
4. Have you ever had surgery?	Yes	No
■ Heart Health Questions <u>About You</u>		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a healthcare provider ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other _____		
9. Has a healthcare provider ever ordered a test for your heart (such as an ECG/EKG or echocardiogram)?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
■ Heart Health Questions <u>About Your Family</u>	Yes	No
13. Has any family member or relative died of heart problems, or had an unexpected or unexplained sudden death <u>before age 50</u> (including drowning, unexplained car accident, or sudden infant death syndrome?)		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		

Name _____	PLU ID _____	
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
■ Bone and Joint Concerns	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required an x-ray, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray to check for neck instability, atlantoaxial instability? (Down syndrome or dwarfism?)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		
■ Other Medical Questions		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	Yes	No
27. Have you ever used an inhaler or taken asthma medicine?		
28. Does anyone in your family have asthma?		
29. Were you born without—or are you missing—a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain, or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the past month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you ever had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of a seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps while exercising?		
42. Do you or does anyone in your family have sickle cell trait or sickle cell disease?		

Name _____	PLU ID _____	
43. Have you ever had any problems with your eyes or vision? (Other than wearing glasses or contacts)		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying—or has anyone recommended—that you gain or lose weight?		
49. Are you on a special diet, or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the healthcare provider today?		
■ Mental Health		
52. Are you currently or have you ever been treated for mental health concerns, such as depression and anxiety?		
53. Would you like information about counseling services on campus?		
■ Females Only	Yes	No
54. Have you ever had a menstrual period?		
55. How old were you when you had your first menstrual period?		
56. How many periods have you had in the past 12 months?		

Please explain any “yes” answers here.

COVID-19 Screening - Please complete the attached questionnaire and provide supporting documentation for any tests, releases to participate and/or proof of COVID-19 vaccination.

Sickle Cell Trait Screening

Student-athletes must do one of the following in order to participate in intercollegiate activities: 1) be tested for sickle cell trait or 2) provide results from a previous sickle cell trait test. Sickle Cell Trait Test waiver is no longer allowed. All student athletes must provide this test result. Please check with your birth hospital records department or the Department of Health in the state in which you were born, if you choose to submit a copy of your results. This [link](#) will also provide access to birth SCT test results. The record can be faxed to the Health Center at 253-536-5042.

■ Attestation and Consent

I hereby state that—to the best of my knowledge, my answers to the above questions are complete and correct.

As a student and/or parent or legal guardian, I consent to a comprehensive medical examination, electrocardiography, and laboratory testing as required for athletic participation.

I also consent to have the information in this form shared with the PLU Athletic Department, as well as subsequent medical information that may affect my ability to participate in my sport for the duration of my participation at PLU in this Club sport. This may involve illness or injuries that occur both on and off the sports field.

There are no charges for the medical examination. There is a \$15.00 charge for a SCT test done at the Health Center.

Student Signature _____

Date _____

Student printed name _____

PLU ID# _____

Parent/Guardian Signature (if student is under 18) _____

Date _____

Name _____

PLU ID _____

NCAA Pre-participation COVID-19 Screening Questionnaire:

Have You Ever Been Diagnosed With COVID-19? YES NO If "Yes", when? _____

Did You Experience Symptoms As A Result Of COVID-19? YES NO

If "Yes", how long did you have symptoms and when? _____

Fever or Chills YES NO

Cough or Sore Throat YES NO

Shortness Of Breath or Difficulty Breathing YES NO

New Loss Of Taste or Smell YES NO

Muscle Or Body Aches YES NO

Congestion, Runny Nose or Headache YES NO

Nausea, Vomiting, or Diarrhea YES NO

Have You Ever Been Evaluated By A Doctor For COVID-19? YES NO

Were Any Diagnostic Tests Performed? (Provide Documentation From Tests Performed) YES NO (check all that apply)

Chest X-ray Blood Test (Troponin) EKG/ECG ECHO Cardiac MRI Antibody Test

Other

Have You Ever Been Hospitalized Due To COVID-19? YES NO

Have You Ever Been Advised Not To Participate In Athletic Activities Due To COVID-19? YES NO

Have You Been Cleared To Return To Activity Following Your Diagnosis of COVID-19?(Please provide documentation) YES NO

Have You Received A COVID-19 Vaccination? YES NO

◆ What Vaccine? _____ Date Of Vaccine(s): _____

If you answered "Yes" please describe and include dates where necessary.
