

CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Membership Procedure

As stated in the Sport Club Officer's Manual under Membership (Pg. 3), Capital University Athletic Dept. must have on file the following completed forms (Sport Club Participation Packet) before a Sport Club member can participate in any club activities:

1. Acknowledgment of Participation and Release, 2. Medical History, 3. Emergency Information, 4. Athletic Training Services. 5. Physical Form

These forms constitute a legal standard that require accurate filing and management by an administrative body, Capital University Athletic Department. To help both the Sport Club officers and Capital ensure that the Sport Club Program meets this legal standard, the following procedures have been developed:

1. Sport Club members may pick up the Sport Club Participation Packet at either the Club Sport Office, or from their respective Sport Club officer.
2. Sport Club members must complete all sections of the forms. Omitting any section may result in CSD returning the form via mail or campus mail, delaying the member's opportunity to participate. It is highly recommended to submit copies of member's health insurance card, driver license, and auto insurance regardless of whether he/she plans to travel as a just-in-case measure.
3. Once a member submits the completed forms, the Club sports director will make copies of the Medical History and the Emergency Information and get them to the Sport Club officer(s) in charge of safety. Once the Sport Club officer(s) in charge of safety receives the copied Medical History and Emergency Information, that member may participate.
4. The Sport Club officer(s) in charge of safety must keep the copies of the Medical History and the Emergency Information with the FA Kit, all of which should be on location at any club practices and/or events. At no time should a member participate who does not have his/her Medical History and Emergency Information on location.

Additionally, if a member plans to travel for any club activities, both Club sport director and the club's safety officer must also have a copy of his/her health insurance card. As traveling with the club is the standard method of travel, members wishing to travel outside the club's plans (ie. driving self) must request an exception from the Sport Club Director by submitting a Travel Release at least three days prior to the date of travel and meeting with the Sport Club Director to discuss the nature of the exception.

CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Acknowledgment of Participation and Release

Participants in the Sport Club Program at Capital University, under the supervision of the Intramural and Recreational Activities Department, should be aware of the possible risks that are inherent in the nature of some of the activities. These risks include, but are not limited to, the potential for accidents or illness while traveling to and from club activities. Participants should realize that risks cannot be eliminated completely. However, if participants meet minimum physical and mental conditioning and follow safety procedures, the potential for mishaps is reduced.

I, _____, a member of _____,
a student organization recognized by the Student Affairs Council of Capital University and
organized by Capital Athletic Department, affirm that I am aware of my physical condition,
that participation in this sport club may result in possible injury as a result of the sport clubs
nature, and that I am assuming any risk that may be involved by participating in the sport club.

In addition, I do hereby release Capital University, its faculty and staff members, and the CSD
of any responsibility of liability in case of any personal injury sustained by me or damage
to property of others caused by me while participating in the activities of the aforementioned
sport club. Such participation will include practice, club functions, competition, and travel to
and from all sport club activities.

I further acknowledge that I am aware of insurance policies that are available to me through
private or institutional means, that I know and understand club and University policies and
procedures, and that I will represent the club and the University in such a manner that is
expected. I have read and understand the above statements and will carry them out.

Signature

Date

Printed Name

CU ID #

CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Medical History

NAME: _____ DATE: _____

(Last) (First) (MI)

LOCAL ADDRESS: _____ LOCAL PHONE: _____

DATE OF BIRTH: _____ AGE: _____ CU ID.# _____ SPORT CLUB : _____

PARENT INFORMATION

FATHER: _____ MOTHER: _____

ADDRESS: _____ ADDRESS: _____
(street) (street)

(city, state, zip code) (city, state, zip code)
PHONE: (H) _____ (W) _____ PHONE: (H) _____ (W) _____

PHYSICIAN INFORMATION

FAMILY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____
(Street) (City, State, Zip Code)

FAMILY HISTORY

Has anyone in your family had any of the following? (Please circle and give relation)

Heart Disease _____	Diabetes _____
High Blood Pressure _____	Heart Disease _____
Sickle Cell _____	Other _____
Cancer _____	Explanation _____

RECORD OF ILLNESS

(Check those that you have had; star those that you have had during past year)

___ Allergies	___ Hay Fever	___ Mononucleosis
___ Appendicitis or	___ Heart Disease or	___ Mumps
___ Appendectomy	___ Heart Trouble	___ Poliomyelitis
___ Arthritis	___ Heat Exhaustion	___ Pneumonia
___ Asthma	___ Hepatitis	___ Rheumatic Fever
___ Bronchitis	___ Hernia or Rupture	___ Scarlet Fever
___ Chickenpox	___ Hives	___ Smallpox
___ Convulsions or Fits	___ Influenza	___ Tonsillitis or
___ Diabetes	___ Kidney Disease or	___ Tonsillectomy
___ Diphtheria	___ Bladder Problem	___ Tuberculosis
___ Epilepsy	___ Malaria	___ Ulcer
___ Frequent Colds	___ Measles	___ Whooping Cough
___ Bone & Joint Diseases	___ Other _____	___ Other _____
___ Skin Diseases	<i>List Other Illnesses By Name:</i>	___ Other _____

(continued on back of page)

RECORD OF SYMPTOMS

(Check those that you have had; star those that you have now)

☐ Aching Eyes	☐ Blood in Urine	☐ High Blood Pressure
☐ Sties	☐ Sugar in Urine	☐ Frequent/Painful Urination
☐ Blurred Vision	☐ Gall Bladder Trouble	☐ Heart Murmur
☐ Inflamed Eyelids	☐ Abdominal Pain	☐ Toothaches
☐ Ringing in Ears	☐ Diarrhea	☐ Swollen or Painful Joints
☐ Difficulty in Hearing	☐ Jaundice	☐ Backache
☐ Ear Fluid Discharge	☐ Vomiting	☐ Leg Pains - Cramps
☐ Ear Infections	☐ Fluid Retention	☐ Constipation
☐ Nasal Discharge	☐ Indigestion	☐ Insomnia
☐ Sinus Infection	☐ Boils	☐ Motion Sickness
☐ Nosebleed	☐ Acne	☐ Recent Weight Gain/Loss
☐ Sore Throat	☐ Eczema	☐ Tumor, Growth, Cyst
☐ Cough (Prolonged)	☐ Hemorrhoids	☐ Shortness of Breath
☐ Hoarseness(Laryngitis)	☐ Painful Urination	☐ Chest Pains
☐ Headaches	☐ Swelling of Ankles	☐ Palpitation/Pounding Heart
☐ Blackouts		☐ Fainting Spells/Dizziness

If you check or star any of the above, please explain in detail: _____

EYES

Yes ___ No ___ Do you consider your vision to be normal in each eye without corrective lenses?

Yes ___ No ___ Had eye exam in past two years?

Yes ___ No ___ Do you have a peripheral vision problem?

Yes ___ No ___ Do you wear contact lenses?

If yes, what type? Hard ___ Soft ___ Extended Wear ___

Yes ___ No ___ Do you wear glasses?

Yes ___ No ___ Are you near-sighted?

Yes ___ No ___ Do you have a "lazy eye"?

Yes ___ No ___ Are you color blind?

Yes ___ No ___ Have you ever had eye surgery?

Yes ___ No ___ Have you ever had an eye injury?

If yes, what type? _____

ALLERGIES

Please check or list and specify:

Do you have any allergies? Yes ___ No ___

Hay Fever _____

Poison Ivy or Oak _____

Drugs or medications _____

Adhesive Tape _____

Foods _____

Other _____

TONSILS

Present ___ Removed ___ Have frequent sore throats? _____

MEDICATION/TREATMENT

Are you taking any medication at the present time? Yes ___ No ___

List all drugs or medicine with daily or regular doses: _____

Have you required any special adhesive taping, wrapping or protective services (braces for participation in athletic competition)?

Yes ___ No ___ Please specify in detail and for what part of the body these items are needed: _____

CERTIFICATION

I certify that the medical history above is accurate and complete, to the best of my knowledge.

Date: _____

Signature: _____

CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Emergency Information

NAME: _____ YEAR: FR / SO / JR / SR BIRTHDATE: _____
SPORT(S): _____ CU ID #: _____ LOCAL PHONE: _____
LOCAL ADDRESS: _____ DORM: _____ ROOM#: _____
FATHER _____ MOTHER _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE:(home) _____ (Work-Father) _____ (Work-Mother) _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____
PHONE: _____

PRIVATE INSURANCE: (PRIMARY)

IS THIS PRIMARY INSURANCE A: HMO? OR PPO?

NAME: _____
MAILING ADDRESS: _____
CITY, STATE, ZIP: _____
PRE-AUTHORIZATION PHONE: _____
GROUP #: _____
POLICY #: _____
OTHER #: _____
EMPLOYEE: _____

BASIC HEALTH INFORMATION

KNOWN ALLERGIES: _____
CURRENT MEDICATION(S): _____
SPECIAL MEDICAL PROBLEMS: _____
OTHER IMPORTANT INFORMATION: _____

MEDICAL RELEASE FOR TREATMENT

I authorize _____ or other Capital University faculty/staff person or sport club representative to
Name of Coach or Athletic Trainer
authorize on my behalf all appropriate medical treatment which may be required in the event of an illness or injury to
_____ resulting in any manner
Name of Student + CU ID #
from participating in Capital University's Sport Club Program. This authority is intended to cover any illness or injury
sustained while traveling to, from, or while participating in any sport club event, practice session, or other event
associated in any way with my participating in the Sport Club Program.

DATE

STUDENT'S SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE IF STUDENT IS UNDER 18

CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Athletic Training Services

- 1) To the best of his/her ability, the athletic trainer will provide each Capital University sport club member with opportunities for immediate first aid care and follow-up therapy or treatment for all injuries sustained at scheduled practices or games. Necessary referrals to appropriate physicians or medical services will be made as approved by the athletic trainer.
- 2) **A comprehensive physical examination is recommended for all students who are participating in their first year. Additionally, a medical history form is required for all sport club members each year.** The primary intent of these requirements is to create a medical history of the sport club member that can be referred to in case of injury/emergency. The secondary function of these requirements is to assist the club members in determining whether their own level of fitness is appropriate for participation in strenuous physical activity.
- 3) No sport club member will be allowed to participate in a club's activities (practices or games) without first having completed and signed current medical forms.
- 4) **It is the responsibility of each sport club member to report athletic injuries to the Sport Club Director (a sport club accident report must be turned in to document all injuries).** Also, coaches and club officers should send any sport club member to the athletic trainer if he/she feels medical attention is needed.
- 5) Sport Club Members should utilize posted walk-in or appointment times when needing athletic training services.
- 6) Both men and women will be treated equally in all matters of health care, treatment of injuries, and access to the athletic training facility.

The undersigned, herewith

1. Has read, understood and promises to abide by the above policies.
2. Understands that by not following these policies he/she may not qualify for the University's "Excess" athletic insurance policy.
3. Acknowledges and understands that participation in all physical activity has inherent dangers and risks that include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to any or all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of the body, general health and well-being.

PRINT NAME: _____

CLUB MEMBER SIGNATURE: _____ DATE: _____

CAPITAL UNIVERSITY CLUB SPORTS**PHYSICAL EXAMINATION**

Capital University
Athletic Training Department
1 College and Main
Columbus, OH 43209
Phone (614) 236-6558
Fax (614) 236-6624

(Please type or print)

Athlete's Name _____ **Birth Date** _____
Last First Middle Initial

Capital University Club Sport: Men's / Women's _____

(Please Circle)

Height _____ **Weight** _____ **Pulse** _____ **BP** ____/____

VA: 20/ 20/ 20/ **Corrected:** Y N
(right eye) (Left eye) (Both eyes)

Normal		Abnormal Findings	Description
MEDICAL			
HEENT			
Neck			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Neuro			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

☐ Not cleared for: _____ Reason: _____

Recommendations:

I certify that I have on this date examined this athlete and that, on the basis of the examination requested by Capital University authorities and the athlete's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this athlete to participate in supervised athletic activities. **(Note exceptions above).**

Physician's Name and Address (stamp or print)

Examiner's Signature

Date

Examiner's Telephone Number

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name & address of collaborating physician or physician group:

NOTE: Medical History and Consent Must be Completed Prior to Physical Examination