Athlete Name: _____________________

Sport: Cheerleading  Squad: _____________________________

Please fill out all information in PEN

Stephen F. Austin
State University

Old / Returning Athlete

Due: June 1, 2012
STEPHEN F. AUSTIN STATE UNIVERSITY
ATHLETE DEMOGRAPHICS

Last Name: _________________________________________  First Name: _________________________________________

Middle Name: _______________________________________  Nickname: ______________________________________

SS#: ________ - ______ - __________  Campus ID # ________________________________  Sport: Cheerleading

Birth Date: ______ / ______ / __________  Age: ______  Sex: _____  Marital Status: S / M / D

Preferred Email Address: ____________________________________________________________@____________________

Current SFA Classification:       ______ Incoming Freshman       ______ Sophomore

                   ______ Junior       ______ Senior       ______ Graduate Student

Local / Campus/  Dorm / Apt.

Dorm / Apt. Address: ____________________________________________________________  Phone: (_____) ______ - _________

City: Nacogdoches  State: Texas  Zip: 7596  Mobile Phone: (_____) ______ - _________

Father / Guardian: ________________________________________________________________

Home Address: ____________________________________________________________  Home Phone: (_____) ______ - _________

City: _________________________  State: __________  Zip: __________  Mobile Phone: (_____) ______ - _________

Email Address: ________________________________________________________________  Work Phone: (_____) ______ - _________

Mother / Guardian: ________________________________________________________________

Home Address: ____________________________________________________________  Home Phone: (_____) ______ - _________

City: _________________________  State: __________  Zip: __________  Mobile Phone: (_____) ______ - _________

Email Address: ________________________________________________________________  Work Phone: (_____) ______ - _________

Contact Person in Case of an Emergency (Non-Relative):  Home Phone: (_____) ______ - _________

Name: __________________________  Relationship: __________________________  Mobile Phone: (_____) ______ - _________

Family Physician: ____________________________________________________________  Phone: (_____) ______ - _________
**Athlete’s Name** ___________________________  **Sport** CHEERLEADING

**Social Security Number (Athlete)** ___________ - ___________ - ___________

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**Parent/Guardian Information**

<table>
<thead>
<tr>
<th>Father/Guardian Name</th>
<th>Mother/Guardian Name</th>
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</table>

Address

Telephone

Email Address:

**Is Father employed? Yes / No**

Employer

Emp. Address

Emp. Telephone

**Is Father insured? Yes / No**

If "No", please sign here:

Insurance Company Plan

Policy Number

Group Number

*I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits, either to myself, or to the party who accepts assignments below. I authorize payment of medical benefits to physicians or suppliers of medical services.*

Signature of **Insured** (Parent)

Date

Social Security Number of **Insured** (Parent)

Birth Date of **Insured** (Parent)

My insurance company requires special forms to be filled out:  Yes _____ No _____

*Please attach a copy of the front and back of your insurance card(s)*

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<table>
<thead>
<tr>
<th>Mother/Guardian Name</th>
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</thead>
<tbody>
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</table>

Address

Telephone

Email Address:

**Is Mother employed? Yes / No**

Employer

Emp. Address

Emp. Telephone

**Is Mother insured? Yes / No**

If "No", please sign here:

Insurance Company Plan

Policy Number

Group Number

*I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits, either to myself, or to the party who accepts assignments below. I authorize payment of medical benefits to physicians or suppliers of medical services.*

Signature of **Insured** (Parent)

Date

Social Security Number of **Insured** (Parent)

Birth Date of **Insured** (Parent)

My insurance company requires special forms to be filled out:  Yes _____ No _____

*Please attach a copy of the front and back of your insurance card(s)*

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Concussion Notification and Agreement Policy

I, ______________________________________________, acknowledge and affirm that I have been educated on concussions and the importance of notifying an athletic trainer as soon as I am aware that I may have developed signs and/or symptoms of a concussion. I understand and affirmatively accept full responsibility for my safety and health while participating in intercollegiate athletics at Stephen F. Austin State University, including reporting any injury or illness to athletic training staff, and am duly aware of the dangers in continued participation with any such injury or illness and that I will not allow my desire to play impede my judgment or cause me to give false information to the evaluating athletic trainer.

I also HEREBY give my permission for the athletic trainer and/or physician to make all return to play decisions on my concussion status. I also understand that I will fully cooperate with the athletic training staff and physicians in the management of my concussion(s).

This agreement will remain in effect for the duration of my intercollegiate career at Stephen F. Austin State University.

________________________________  ________________  __________________
Student-Athlete Signature Date Parent/Guardian (if under 18)
Student-Athlete Authorization/Consent for Disclosure of Protected Health Information for NCAA-Related Research Purposes

I, ________________________________ hereby authorize _________________________

Name of Student-Athlete  Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation regarding any injury, illness, treatment or participation related to or affecting my training for participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA), and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used by the NCAA, and authorized third parties to receive such information for the purpose of using injury, relevant illness and participation information collected from multiple student-athletes and institutions in a manner that does not identify myself or my school. The information is provided to NCAA committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate the effectiveness of health and safety rules and policy, and the study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns and help develop education on student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPPA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the director of athletics of my institution. I understand that a revocation takes effect on its date and does not affect any action taken prior to that date.

____________________________________  _____________________________
Printed Name of Student-Athlete  Signature  Date
Please be reminded of the medical policy of **No Visible Jewelry** for all practices and events. Visible jewelry is defined as any items that are readily visible in your normal practice or game uniform. If your typical practice attire does not include a shirt and you have a belly button ring, it must be removed. Items that are always visible and therefore must be removed are *earrings, necklaces, watches, fingers rings, brow rings, belly button rings, nose rings, and tongue piercing*.

This policy is for the safety you, the athlete, and for the safety of your teammates.

Five typical injuries can happen while wearing these items.

5. Direct blow to the pierced area resulting in a laceration to you or to your opponent/teammate.

4. Opponent/teammate catches the article and rips it from your body. Usually this results in the jewelry being damaged. If a teammate catches a 'ring of some sort with a finger, etc., the ring will be forcibly ripped from your body resulting in probable damage of the item and guaranteed damage to your body; not to mention the damage to your teammate's finger (It's called a tendon avulsion and requires surgery to repair.).

3. Swallowing of the items. Internal organs do not like objects with points on the end. An Esophageal piercing is not very pretty. No one will notice your statement.

2. Tooth damage by biting down on such items and breaking a tooth. Most dental plans will not pay for this type of dental repair and neither will the SFA Athletic Department.

1. And the most life threatening way to injury yourself while wearing a tongue ring is **asphyxiation**. Should the tongue ring remove itself from your tongue and you breathe it into your lungs, it becomes a life threatening emergency that will require your immediate removal from the game/practice and its immediate removal from your lungs.

At all pre-season meetings I addressed this situation and it seemed like you (the athlete) understood the athletic training room's opinion. By the repeated actions of some athletes, it is obvious that you did not understand that opinion. Let me be blunt:

**NO VISIBLE JEWELRY OF ANY TYPE WILL BE ALLOWED DURING ANY PRACTICE OR PERFORMANCE.**  
**THE JEWELRY WILL BE REMOVED OR YOU WILL BE REMOVED FROM THE PRACTICE OR PERFORMANCE.**

The Athletic Training Staff has been instructed to inform you that you need to remove it and then inform your coach if you do not remove the problematic item. If you refuse, you will be removed from practice and will not return until it is removed.

Covering is not removing. It just doesn't work.

Thank you for your cooperation in keeping yourself and your teammates as injury free as possible.

I have read the above policy _________________________________________
The enclosed is for your protection and for the protection of your unborn child, should the situation occur. I cannot force you to inform the medical staff that you have become pregnant; but I hope you will do what is in the best interest of you and your unborn child - inform us so we can protect the health of both of you.

Table 29-2
American College of Obstetricians and Gynecologists (ACOG)
Guidelines for Exercise During Pregnancy (Feb. 1994)

An exercise prescription in pregnancy should be individualized and should include a health assessment. It must be emphasized that none of these recommendations has a firm basis in prospective, randomized, clinical trials.

These guidelines follow from a critical analysis of the available physiologic data regarding exercise and pregnancy and represent reasonable extrapolations from such knowledge.

Recommendations for Exercise in Pregnancy and Postpartum

There are no data in humans to indicate that pregnant women should limit exercise intensity and lower target heart rates because of potential adverse events. For women who do not have any additional risk factors for adverse maternal or prenatal outcome, the following recommendations may be made.

1. During pregnancy, women can continue to exercise and derive health benefits even from mild-to-moderate exercise routines. Regular exercise (at least three times per week) is preferable to intermittent activity.

2. Women should avoid exercise in the supine position after the first trimester. Such a position is associated with decreased cardiac output in most pregnant women; because the remaining cardiac output will be preferentially distributed away from splanchnic beds (including the uterus) during vigorous exercise, such regimens are best avoided during pregnancy. Prolonged periods of motionless standing should also be avoided.

3. Women should be aware of the decreased oxygen available for aerobic exercise during pregnancy. They should be encouraged to modify the intensity of their exercise according to maternal symptoms. Pregnant women should stop exercising when fatigued and not exercise to exhaustion. Weight-bearing exercises may under some circumstances be continued at intensities similar to those prior to pregnancy throughout pregnancy. Non-weight-bearing exercises such as cycling or swimming will minimize the risk of and facilitate the continuation of exercise during pregnancy.

4. Morphologic changes in pregnancy should serve as a relative contraindication to types of exercise in which loss of balance could be detrimental to maternal or fetal well-being, especially in the third trimester. Further, any type of exercise involving the potential for even mild abdominal trauma should be avoided.

**copied from ACSM’s Handbook for the Team Physician**

I have read the recommendation of the American College of Obstetricians and Gynecologists.

Please sign here
Shared Responsibility for Sport Safety

Participation in sport requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them. Periodic analysis in injury patterns lead to refinements in the rules and other safety decisions. However, to legislate safety via a rule book and to rely on officials to enforce compliance with the rule book is an insufficient as to rely on warning labels to produce compliance with safety guidelines. “Compliance” means respect on everyone’s part for the intent and purpose of a rule or guideline.

This annual form must be completed and returned before the student-athlete will be permitted to practice or play. The National Collegiate Athletic Association's policies recommend that all student-athletes have a qualifying intercollegiate athletic physical and an annual “health-state” review. Stephen F. Austin State University supports this NCAA policy. Further medical evaluations may be required for specific matters.

Date of initial medical evaluation: ___ / ___ / _______
Date of the most recent medical update: ___ / ___ / _______

CIRCLE

YES  NO 1. Have you been hospitalized or had a major illness since your last Health History Re-examination at SFASU?
YES  NO 2. Are you currently ill or injured in any way?
YES  NO 3. Have you had a major injury (including cerebral concussion) since your last Health History Re-examination at SFASU?
YES  NO 4. Do you currently have any incompletely healed injury?
YES  NO 5. Are you taking any medication on a regular or continuing basis?
YES  NO 6. Are you currently taking any short-course medication for a specific current illness, injury, etc.?
YES  NO 7. Have you had any operations or surgery since your last Health History Re-examination at SFASU?
YES  NO 8. Have you had any accidents and/or fractures since your last Health History Re-examination at SFASU?
YES  NO 9. Have you seen a physician for any reason in the last year?
YES  NO 10. Do you know of, or do you believe there is, any health reason why you should not participate in Stephen F. Austin State University’s intercollegiate athletic programs at this time?
YES  NO 11. Would you like to discuss your current health with the team physician?

Please explain in you answered yes to any of the above questions. ___________________________ ___________________________
____________________________________________________________________________
___________________________________________________________________
___________________________________________

The undersigned, herewith:

A. Understand that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.

B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluation did not find a medical reason to disqualify him or her at the time of said examination.

C. Certifies that the answers to the questions above are correct and true.

SIGNATURE: ___________________________ DATE: ___________________________
TO BE COMPLETED BY STEPHEN F. AUSTIN STATE UNIVERSITY MEDICAL STAFF

Comments: __________________________________________________________
_______________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Athlete needs to be referred to: Orthopedic ________________________________
General Medicine _______________
Medical Specialist ________________

Referred to: __________________________________________________________


EXAMINATION:

[ ] CLEARED
[ ] PRIOR TO PARTICIPATING,

ATHLETE REQUIRES _______________________________________________________

[ ] NOT CLEARED

PHYSICIAN SIGNATURE: ________________________________________________ DATE: ______________

Height: _________ Weight: ________ Blood Pressure: _________ Pulse:

2012 – 2013 ACADEMIC YEAR