

Date \_\_\_\_\_

BOWDOIN COLLEGE ATHLETIC TRAINING

# IMPORTANT

## **PARENTS & STUDENT ATHLETE:**

Welcome to Bowdoin College Athletics. In this letter you will find an Emergency Contact and Medical History Information Sheet. This form is vital to the operation of our Athletic Training Department. Please fill out **COMPLETELY** and return it to the following address:

**BOWDOIN COLLEGE  
ATT: ATHLETIC TRAINING  
9000 COLLEGE STATION  
BRUNSWICK, MAINE 04011**

If this form is not completed and returned by the start of athletic participation, the student athlete **WILL NOT** be able to practice or compete in any contest at Bowdoin College. The student athlete **WILL BE REINSTATED** when the Emergency Information form is completed and returned to the Athletic Training Department. Thank you for your cooperation. If we can be of any assistance please feel free to call.

## **FIRST TIME ATHLETES AT BOWDOIN COLLEGE:**

A completed physical exam / health history and immunization records from your primary care physician must take place in the 6 months prior to the beginning of classes. These forms will be sent in a separate college mailing and returned to Health Services. Questions regarding these forms should be directed to the Health Services (207-725-3779).

Dan Davies M.Ed., A.T.C., C.S.C.S.  
Head Athletic Trainer  
Bowdoin College  
207-725-3018

Date \_\_\_\_\_

BOWDOIN COLLEGE ATHLETIC TRAINING EMERGENCY INFORMATION

Year of Graduation \_\_\_\_\_

NAME OF ATHLETE \_\_\_\_\_ SPORT \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_  
S.S# \_\_\_\_\_  
SCHOOL ADDRESS \_\_\_\_\_ HOME PHONE#( ) \_\_\_\_\_  
RM# \_\_\_\_\_ BOX \_\_\_\_\_ CELL PHONE# \_\_\_\_\_  
BOWDOIN ID# \_\_\_\_\_ CAMPUS PHONE# \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME \_\_\_\_\_ HOME PHONE( ) \_\_\_\_\_  
ADDRESS \_\_\_\_\_ WORK PHONE( ) \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_

**MEDICAL INFORMATION:**

ARE YOU ALLERGIC TO ANY MEDICINE? YES / NO  
IF YES, (LIST ALL).

DO YOU HAVE ANY OTHER ALLERGIES? YES / NO  
IF YES, (LIST ALL).

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CORRECTIVE LENSES	YES / NO	SICKLE CELL ANEMIA	YES / NO
ASTHMA	YES / NO	DIABETES	YES / NO
EPILEPSY	YES / NO	SEVERE CONCUSSION	YES / NO
HIGH BLOOD PRESSURE	YES / NO	HEADACHES	YES / NO
LOW BLOOD PRESSURE	YES / NO	UNPAIRED ORGANS	YES / NO
HEAT EXHAUSTION	YES / NO	BLEEDER TENDENCY	YES / NO
HEAT STROKE	YES / NO	HEAT CRAMPS	YES / NO

PREVIOUS INJURY / SURGERY THAT KEPT YOU OUT OF PRACTICE / GAME.  
(SPECIFY TYPE OF INJURY / SURGERY AND DATE OF OCCURRENCE).

PROTECTIVE DEVICES, BRACES, ORTHOTICS, ETC. (SPECIFY).

**INSURANCE INFORMATION**

NAME OF POLICY HOLDER \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
D.O.B \_\_\_\_\_ SS# \_\_\_\_\_  
INSURANCE COMPANY NAME \_\_\_\_\_  
CARRIER / ID # \_\_\_\_\_ POLICY# \_\_\_\_\_  
ADDRESS INSURANCE CO. \_\_\_\_\_  
INSURANCE COMPANY PHONE # ( ) \_\_\_\_\_ / 1-800- \_\_\_\_\_

**\*COPY OF THE INSURANCE CARD (front/back) MUST ACCOMPANY THIS FORM\***

Date \_\_\_\_\_

**BOWDOIN COLLEGE**  
**Athletic Screening Questionnaire**

NAME \_\_\_\_\_ SS# \_\_\_\_\_ SPORT \_\_\_\_\_  
CAMPUS PHONE \_\_\_\_\_ BOWDOIN ID# \_\_\_\_\_ CLASS YEAR \_\_\_\_\_

**Have you ever**

Had a head injury Y    N  
Seen a doctor/hospital due to a head injury Y    N  
Been diagnosed with a heart murmur, if yes when Y    N  
Been diagnosed with any heart abnormalities Y    N  
Please explain \_\_\_\_\_

Experienced any chest pain, if yes when Y    N  
Experienced shortness of breath, if yes when Y    N  
Experienced dizziness or fainting during activity, if yes when Y    N  
Had a history of heart disease or Marfan syndrome in your family Y    N  
Please explain \_\_\_\_\_

Had any sudden deaths in family members 50 or younger for non-traumatic reasons Y    N  
Please explain \_\_\_\_\_

Been found to have only one organ of usually paired organs Y    N  
Have you had feelings of depression or mood change? Y    N  
Does anyone in your family have an eating or weight problem? Y    N  
Have you seen a dentist in the last 12 months? \_\_\_\_\_ Y    N  
Have you ever been diagnosed / under treatment for ADD / ADHD? Y    N

Do you have any medical conditions such as:

seizure/convulsions	high blood pressure	hair/skin changes
fatigue	amenorrhea	dizziness/fainting
vomiting blood	constipation	sickle cell anemia
diabetes	Asthma, what type, _____	

Had allergies to food, drugs, insect bites or stings, other \_\_\_\_\_ Y    N

Do you require daily medication? Y    N  
Please state type \_\_\_\_\_

Do you have unequal pupils? Y    N  
Please explain \_\_\_\_\_

Have you ever had an injury or surgery, missed a game or practice, or seen a physician or therapist for any of the following: Please circle

**\*Returning Student-Athletes report only those injuries that have occurred within the past 12 months\***

Back    Shoulder    Elbow    Wrist    Hand    Hip

Knee    Foot    Ankle    Leg    Neck

**^Any Injury/Illness/Surgery in past 12 months from end of last playing season and had loss of playing time will need letter of clearance from MD^**

**FEMALES ONLY** - Have you had any changes in your periods in the last year? Y    N  
aver. cycle length \_\_\_\_\_ LMP \_\_\_/\_\_\_/\_\_\_

Please be sure that you have read and completed this form in its entirety. Upon your signature, this form will give consent for the sports medicine staff to evaluate and treat all injuries that occur while you are attending Bowdoin College.

Athlete's Signature \_\_\_\_\_ Date \_\_\_\_\_

