PAUL SMITH'S COLLEGE

Recreation & Athletics
P.O. Box 265, 113 Saunders Sports Complex
Paul Smiths, NY 12970 ◊ www.paulsmiths.edu
(518) 327-6286; Fax: (518) 327-6545

This medical form provides us with information required for the training and competition season for Intercollegiate Athletics and will prepare the supervisors with regards to your safety and emergency situations. By requesting medical history we do not imply that we have the expertise to assess your physical condition, or your ability to participate safely in Intercollegiate Athletics. This determination of ability to participate must be made by the participant in concert with their physician. Intercollegiate Athletics will demand strenuous exercise.
Some of the training may be in an outdoor or wilderness setting. Your training may include exposure to inclement weather as well as a variety of other hazards associated with being outdoors. Although safety is our first priority and we are trained to provide first aid in case of an incident, your participation in Intercollegiate Athletics indicates your acknowledgement and the assumption of inherent risk associated with being far from professional medical facilities. If you have any questions please call for further details.

In the interest of personal safety of the staff and your personal safety, please answer the following questions to the best of your knowledge.

Part One: Personal Information Sport(s): _____

Athlete's Name _____ Home Phone: _____ Yr(s) at PSC: _____

Home Address: _____
(Street Address) (City) (State) (Zip)
DOB:_____; Gender: _____

Primary Care Physician: _____ Phone Number:_____

PERSON(S) TO CONTACT IN CASE OF EMERGENCY (parent(s)/spouse, guardian, etc):

Name _____ Name:_____

Relationship to participant: _____ Relationship to Participant: _____

Phone (H) _____(W)_____ Phone (H) _____(W)_____

Address _____ Address _____
_____ _____

MEDICAL INSURANCE
Insurance Carrier: _____ Policy No._____
Address:_____
Phone:_____ Subscriber's Name:_____
Relationship:_____ (please complete the other side)

Part Two: Specific Medical History

Participant's Medical Information: please be candid; check any and all that apply:

☐ Cardiac problems ☐ Chest Pain ☐ Shortness of Breath ☐ Obesity ☐ High Blood Pressure
☐ Daily Use of Tobacco Products ☐ A family history of cardiac disease (heart attack < 50 years)
☐ Diabetes ☐ Asthma ☐ Seizures ☐ Sedentary/Inactive Lifestyle ☐ Kidney problems
☐ Bleeding or blood disorders ☐ Dizziness or fainting episodes ☐ Back problems/Spinal Injury
☐ Neurological Problems ☐ Other (please explain) _____

Medications – Please list and identify the condition they are for:

_____
_____

☐ Allergies. If yes, please describe: _____

Important Notes.

1. If you will be carrying prescription medication, you are advised to consult with your physician regarding secondary dosage in the event of possible loss or water contamination.
2. If you have ever had a systemic reaction to an insect sting, we recommend you consult your physician about carrying a personal Ana-kit or Epi-Pen. Even with no prior history it is possible for a person, for a variety of reasons, to develop a life-threatening systemic reaction. Because our activities are often far from professional medical care, we advise everyone to consult with their physician regarding a prescription for these kits. Due to New York State regulations, the coaching staff may not legally dispense controlled prescription drugs and will not be carrying group Ana or Epi devices.

☐ Past injuries/surgery/joint problems. If yes, please describe, including current status:

_____
_____

Environmental Emergencies (heat and cold conditions)

☐ frostbite ☐ Hypothermia ☐ circulatory problems ☐ heat stroke ☐ Raynard's syndrome

If yes, please describe: _____

☐ Special dietary requirements. If yes, please describe: _____

Please describe any other injuries or medical conditions not identified above: _____

Part Three: Swimming Assessment

Some of the training for Intercollegiate Athletics may involve activities in a water environment, which require basic swimming skills. We ask that participants self-assess their own comfort level in and around the water. We recommend that you do not register for a course involving water activities if you are a non-swimmer. Please rate your swimming ability below:

☐ Non-swimmer ☐ Recreational Swimmer ☐ Strong Recreational Swimmer
☐ Competitive Swimmer

Part Four: Signature

I have reviewed this entire medical form and verified that all information is given fully and truthfully. To the best of my knowledge, I am capable of safely participating in the sport(s) listed on the front of this form. In the event of an emergency, permission is given for any anesthesia and/or surgery at a medical facility that may become necessary for my immediate well-being.

_____	_____	_____
Participant's Signature	Participant's Name (print clearly)	Date
_____	_____	_____
Parent/Legal Guardian Signature (if participant is under 18 years old)	Parent/Legal Guardian Name (print clearly)	Date