These forms must be read and completed in entirety before an athlete can compete for a SJU Club Sport. This includes tryouts, team workouts and competitions. This packet must be completed every academic year and can be submitted to the club leader at tryouts.

Questions should be directed to:
Angie Nagle
Assistant Director of Recreation
610-660-2583
anagle@sju.edu
Saint Joseph’s University Club Sport Athlete
Assumption of Risk, Waiver, and Release from Liability

I understand that there are certain risks and that accidents and/or injuries may occur in the various activities offered by Saint Joseph’s University Campus Recreation. These risks may include but are not limited to bodily injury, including ankles, knees, shoulders, fingers, head, broken bones, back, neck, eye, paralysis, sprains, lacerations, contusions, loss of limbs, and even death. I further understand that certain activities require proper training and proper physical conditioning. Knowing the risks and conditions required for the activity in which I voluntarily participate, I hereby agree to assume those risks and release and hold harmless Saint Joseph's University and all those persons associated with the programming of such events.

In consideration for being allowed to participate in this activity, I the undersigned, hereby waive all claims for injury or accident or liability of any kind and do hereby release Saint Joseph's University, its staff, all managers, officials, or owners of the property on which the facility is located, from any claims, now or in the future, for such injury or accident.

_________________________________________  ______________________________
(Signature)  (Date)

_________________________________________
(Signature Of Parent/Guardian if Athlete is under 18 years of age)
IMPORTANT INFORMATION- PLEASE READ AND SIGN

1. All current club sport participants shall have physical and insurance forms completed and on file in the Recreation Office prior to play. Forms may be found on the web at http://www.sju.edu/recreation/clubsports/forms.html. Your physician must clear you and all information must be complete. You may email forms to anagle@sju.edu or fax to (610) 660-1715.

2. All injuries requiring a club participant to come off the ‘field of play’ or necessitating you stop practicing, should be reported to Club Sport Director within 24 hours of occurrence.

3. Injuries requiring medical attention (more than a band-aid and/or ice), i.e. needing follow-up care, going to the hospital, treatment by an ambulance crew or other on-site medical personnel should be reported by phone the day of the occurrence. Calls should be made to the Club Sport Director at (610) 660-2583 or (610) 660-1703 during business hours or at (610) 639-6094 after hours.

4. An injury form must be filled out and returned to the Club Sport Office. They may be found on our website at http://www.sju.edu/recreation/clubsports/forms.html. Forms can be emailed to anagle@sju.edu or faxed to (610) 660-1715.

5. Anyone injured and following above procedure may have access to the athletic trainer through the Club Sport office. This is to ensure that all paper work has been completed.

6. Once you have completed the necessary forms, the Club Sport Office will contact a member of the Sports Medicine Staff. They will assist you in coordinating medical services. This includes visits with an orthopedist or team doctor, priority scheduling for MRIs, x-rays, and PT etc.

7. There is a physical therapist that comes into the Sports Medicine office 3 times per week for the club sports. A member of the Sports Medicine staff will coordinate your visits.

8. Club sports are covered under the same insurance policy as the varsity athletes. In order to be covered under this policy you must follow the above instructions. If you fail to do so (i.e., get a pre-participation physical or fill out the proper injury form), the insurance company has the right to deny your claim and you will personally be responsible for all bills incurred from your medical treatment.

9. If an emergency or injury occurs after hours or on weekends, please go to the nearest emergency room or to Student Health Services.

I ________________________ have read the above information and understand that as a member of (Name of participant) the __________________________ Club, I am responsible to complete all appropriate documents.

____________________________
(Signature)  ______________________
(Date)
SJU Campus Recreation Concussion Policy

Any student who reports a suspected concussion (sport related or otherwise) is to be evaluated at Saint Joseph’s University Student Health. Students who sustain any degree of concussion will be removed from participation for a mandatory minimum of 3 weeks from date of injury (21 days). The Assistant Director of Campus Recreation should be notified and they will then notify the club coach or leader. Return to participation after 3 weeks is permitted only after clearance from SJU Student Health, at the discretion of the supervising physician. Any student who receives 2 concussions within the course of their season (sport related or otherwise) will be removed from participation for the remainder of that season and must be reevaluated at the start of the next season by SJU Student Health.

Acknowledgement of Responsibility To Notify

I, _________________________________ hereby acknowledge and accept the responsibility to report any injuries and illnesses to the Saint Joseph’s University medical staff, including signs and symptoms of a concussion. This includes both athletic and non-athletic related injuries / illnesses / medical conditions which might occur, and any medication, treatments, tests or treating facility notes which are needed in order to determine my health status.

I acknowledge that I have been presented information regarding concussions, including signs, symptoms, causes and complications of a concussion. I understand the importance of notifying the medical staff immediately if I suspect that I or another student-athlete has sustained a concussion.

I further affirm that I fully understand that my failure to notify the Sports Medicine staff of any injuries / illnesses / medical conditions in the proper fashion may put me at risk for further injury or exacerbation of my condition, and I voluntarily agree to release, discharge, indemnify and hold harmless Saint Joseph’s University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with this mandate.

_______________________________  __________________________  __________________________
Student – Athlete Signature                  Date                  Sport

_______________________________
Student – Athlete Print Name

_______________________________
SJUID #

_______________________________  __________________________
Parent/Guardian Signature (if under 18 years of age)                  Date

_______________________________
Parent/Guardian Print Name
SJU Club Sports
GPA Requirement and Hazing Compliance Form

Name: _______________________
Date: ______________________
SJU ID # _____________________
Club: ________________________

By signing, I understand that as a requirement of the Campus Recreation Club Sport program, my grades will be reviewed on a semester basis. A 2.0 minimum cumulative GPA is required to compete on a SJU club sport. Grades will be reviewed at the start of the Spring 2016 semester. If a student is below a 2.0 at the start of the Spring 2016 semester, a notice will be supplied to the student and their coach (if applicable) of their probationary standing. All students must have a 2.0 or above at the start of the Fall 2016 semester to participate as a club athlete at SJU.

Signature: ______________________________
Date: __________________________

----------------------------------------------------------------------------------------------------------------
Anti- Hazing Agreement

Hazing is defined as “any action or situation created intentionally, whether on or off campus premises, to produce mental or physical discomfort, embarrassment, harassment, or ridicule.” Saint Joseph’s University prohibits all forms of hazing. The Anti-Hazing Law of Pennsylvania states that any person who causes or participates in hazing commits a misdemeanor of the third degree. It also includes the willful destruction or removal of public or private property in its definition of hazing. Aside from the legal aspect of hazing, the University believes that hazing is contrary to the Christian teaching of human dignity and contradicts an environment of friendship, maturity and charity within its collegiate community. Individuals found responsible of hazing may be fined, placed on probation, suspended or dismissed. Likewise, organizations, clubs and teams may be fined, placed on probation or disbanded. Other sanctions may also be appropriately issued. Organizations, teams, or chapters may also face sanctions by University departments under which they function.

I have read the above definition and agree not to participate in any such activity.

Signature: ______________________________
Date: __________________________
# Insurance Coverage Information

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<tr>
<th>Name:</th>
<th>Sport</th>
<th>Date of Birth</th>
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Do you have dental insurance: Yes or No

Do you have a Prescription Plan: Yes or No

I hereby authorize Saint Joseph’s University as Administrators to release to and receive from other insurance companies, employers, unions, trusts, schools or associations, benefit information pertaining to this claimant.
ATHLETE INFORMATION QUESTIONNAIRE

NAME ______________________________ SPORT ____________________________

YEAR EXPECTED TO GRADUATE ___________ SJU # ____________________________

LOCAL at SCHOOL ADDRESS: HOME ADDRESS:

__________________________________

__________________________________

__________________________________

PHONE: PHONE:

__________________________________

__________________________________

PARENT/GUARDIAN NAME(S):

__________________________________

MEDICATION HISTORY

Please list any medication, supplements, etc. that you are currently taken or have taken in the last 30 days:

__________________________________-

__________________________________

__________________________________-

__________________________________

__________________________________

Do you have any of the following allergies?

Bee sting YES NO

Drug YES NO
If yes, _________________________
Please circle YES or NO and provide details as requested on BOTH sides of this form. All information is confidential.

1. Are you allergic to any medications or bee stings?
   NO   YES (list)

________________________________________________________________

2. Do you take any medication on a permanent or semi-permanent basis (steroids, Birth control pill, anti-inflammatory s, antibiotics, etc.)
   NO   YES (list)

________________________________________________________________

3. Have you ever had an epileptic seizure?
   NO   YES (date of last seizure)____________________________________

________________________________________________________________

4. Have you ever been told by a physician you have epilepsy?
   NO   YES (list)

________________________________________________________________

5. Have you ever been treated for diabetes?
   NO   YES (list)

________________________________________________________________

6. Have you ever been told by a physician that you are anemic?
   NO   YES (list)

________________________________________________________________

7. Have you ever been told by a physician you have sickle cell anemia?
   NO   YES (list)

________________________________________________________________

8. Have you ever been told by a physician you have sickle cell trait?
   NO   YES (list)

________________________________________________________________

9. Do you have or have you ever had high blood pressure?
   NO   YES (list)
10. Do you have or have you had any of the following diseases?
   - NO    YES (date) ________________________________ heart disease (heart murmur, rheumatic fever)
   - NO    YES (date) ________________________________ lung disease (pneumonia, tuberculosis)
   - NO    YES (date) ________________________________ kidney disease (infections)
   - NO    YES (date) ________________________________ liver disease (mononucleosis, hepatitis)

11. Have you ever been told by a physician you have asthma?
    NO    YES (medication)

12. Have you ever had a hernia
    NO    YES   Has it been repaired? (date)

13. Have you ever been “knocked out”?
    NO    YES
    (dates)

14. Have you ever had a concussion or head injury?
    NO    YES (dates)

15. Have you ever had to stay overnight in the hospital due to a head injury
    NO    YES (dates)

16. Have you ever had an neck injury involving bones, nerves or discs that disables you for a week or longer?
    NO    YES (dates)

17. Do you wear glasses or contact lenses
    NO    YES

18. Do you wear any of the following dental appliances?
    _____ permanent bridge  _____ permanent crown/jacket  _____ full plate
    _____ braces  _____ permanent retainer  _____ removable retainer

19. Have you had a broken bone or fracture in the last five years?
    NO    YES (dates)
20. Have you had a shoulder injury in the last five years?
   NO   YES (dates)

21. Have you ever had shoulder surgery?
   NO   YES (dates/kind)

22. Have you ever injured your back?
   NO   YES (dates)

23. Do you presently have back pain?
   NO   YES ___ seldom ___ occasionally ___ frequently ___ with vigorous exercise ___ with heavy lifting

24. Have you injured your knee in the last five years?
   NO   YES (dates)

25. Have you ever been told by a physician, trainer, or therapist that you injured:
   _______ cartilage/meniscus _______ ligaments

26. Have you ever had knee surgery?
   NO   YES (dates and kind)

27. Have you ever had a severe ankle sprain in the last five years?
   NO   YES (dates)

28. Do you have any metal implants in your body (screw, pin, plate, etc.)?
   NO   YES (dates, where)

29. Do you have any medical conditions we should be aware of
   NO   YES (details)

30. Is there any family history of chronic health problems
   NO   YES (specify)

31. Has anyone in your family died suddenly?
   NO   YES If YES, whom______________________________

⇒ PARTICIPANTS SIGNATURE ________________________________
DATE ________________
PHYSICAL EXAMINATION FORM (FRESHMAN DO NOT COMPLETE)
(TO BE COMPLETE BY A MEDICAL PROFESSIONAL ONLY)

NAME ______________________________________  D.O.B._______________________
SPORT __________________

BP ________   TEMP ____________   PULSE _____________   RESP _____________
HT ________   WT ________

VISION: OK ____  INVESTIGATION _____  ALLERGIES __________________

CURRENT MEDICATION
_____________________________________________________________________________

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Physician Signature_________________________________________   Date___________

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Physician Signature_________________________________________   Date______________