

Rider University Athletics Re-Certification Form 2007-2008

This form is for **returning student-athletes only**. Please fill out and return at your designated physical session. You are required to report on your assigned date and time to have your height and weight taken and to undergo vital sign testing.

Name _____ Sport(s) _____

S.S.N. ____-____-____ D.O.B. __/__/__ Year Fr. So. Jr. Sr. 5th yr.

Failure to disclose pertinent medical information may invalidate your insurance coverage, and under NCAA rules, may cancel your eligibility to participate in intercollegiate athletics.

Please circle the correct response and provide further information where necessary.

1. Has there been any change in your family history over the past year (i.e. deaths related to cardiac arrest/disease of a family member)? **Yes** **No** If yes, please explain:

2. Have you had any illness or injury since your last season, which was not assessed or cleared by a physician? **Yes** **No** If yes, please explain:

3. List all of the medications and/or supplements that you are presently taking or have taken over the summer.

4. Would you like to discuss your current health status with the athletic training staff or with the physicians? **Yes** **No** If yes, please explain:

I understand that failure to disclose any medical information may invalidate my insurance coverage, and under NCAA rules, may cancel my eligibility. I have read and I understand the above. I/ We authorize the Rider University Sports Medicine Department to share information necessary for treatment with Rider team physicians, student health services, coaches, administrators, and parent(s)/ guardian(s). I have been informed that I have the right to revoke this authorization at any time. I understand that my medical records are kept secure and that I have the right to view those records upon request.

Student-Athlete Signature _____ Date _____

-----Office Use Only-----

Ht _____ Wt _____ BP _____ Pulse _____ Examiner's Init _____

Focused Exam: Certified Athletic Trainer _____ Physician _____

Clearance for participation: **Yes** **No**

Clearance pending completion of the following:
