CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Membership Procedure

As stated in the Sport Club Officer’s Manual under Membership (Pg. 3), Capital University Athletic Dept. must have on file the following completed forms (Sport Club Participation Packet) before a Sport Club member can participate in any club activities:


These forms constitute a legal standard that require accurate filing and management by an administrative body, Capital University Athletic Department. To help both the Sport Club officers and Capital ensure that the Sport Club Program meets this legal standard, the following procedures have been developed:

1. Sport Club members may pick up the Sport Club Participation Packet at either the Club Sport Office, or from their respective Sport Club officer.

2. Sport Club members must complete all sections of the forms. Omitting any section may result in CSD returning the form via mail or campus mail, delaying the member’s opportunity to participate. It is required to submit copies of member’s health insurance card, driver license, and auto insurance regardless of whether he/she plans to travel as a just-in-case measure.

3. Once a member submits the completed forms, the Club sports director will make copies of the Medical History and the Emergency Information and get them to the Sport Club officer(s) in charge of safety. Once the Sport Club officer(s) in charge of safety receives the copied Medical History and Emergency Information, that member may participate.

4. The Sport Club officer(s) in charge of safety must keep the copies of the Medical History and the Emergency Information with the FA Kit, all of which should be on location at any club practices and/or events. At no time should a member participate who does not have his/her Medical History and Emergency Information on location.

Additionally, if a member plans to travel for any club activities, both Club sport director and the club’s safety officer must also have a copy of his/her health insurance card. As traveling with the club is the standard method of travel, members wishing to travel outside the club’s plans (ie. driving self) must request an exception from the Sport Club Director by submitting a Travel Release at least three days prior to the date of travel and meeting with the Sport Club Director to discuss the nature of the exception.
Participants in the Sport Club Program at Capital University, under the supervision of the Intramural and Recreational Activities Department, should be aware of the possible risks that are inherent in the nature of some of the activities. These risks include, but are not limited to, the potential for accidents or illness while traveling to and from club activities. Participants should realize that risks cannot be eliminated completely. However, if participants meet minimum physical and mental conditioning and follow safety procedures, the potential for mishaps is reduced.

I, __________________________________________, a member of __________________________________________, a student organization recognized by the Student Affairs Council of Capital University and organized by Capital Athletic Department, affirm that I am aware of my physical condition, that participation in this sport club may result in possible injury as a result of the sport clubs nature, and that I am assuming any risk that may be involved by participating in the sport club.

In addition, I do hereby release Capital University, its faculty and staff members, and the CSD of any responsibility of liability in case of any personal injury sustained by me or damage to property of others caused by me while participating in the activities of the aforementioned sport club. Such participation will include practice, club functions, competition, and travel to and from all sport club activities.

I further acknowledge that I am aware of insurance policies that are available to me through private or institutional means, that I know and understand club and University policies and procedures, and that I will represent the club and the University in such a manner that is expected. I have read and understand the above statements and will carry them out.

__________________________________________    ______________________
Signature                                      Date

__________________________________________    ______________________
Printed Name                                  CU ID #
CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Medical History

NAME: ________________________________________________ DATE: ______________________

(Last) (First) (MI)

LOCAL ADDRESS: ___________________________________ LOCAL PHONE: ______________________

DATE OF BIRTH: __________ AGE: __ CU ID.# __________________ SPORT CLUB: ______________________

PARENT INFORMATION

FATHER: ___________________________ MOTHER: ___________________________

ADDRESS: ___________________________ ADDRESS: ___________________________

_____________________________ (street) _______________________________ (street)

_____________________________ (city, state, zip code) _______________________________ (city, state, zip code)

PHONE: (H) __________________ (W) __________ PHONE: (H) __________________ (W) __________

PHYSICIAN INFORMATION

FAMILY PHYSICIAN: __________________________________ PHONE: ________________________

ADDRESS: ____________________________________________

_____________________________ (Street) _______________________________ (City, State, Zip Code)

FAMILY HISTORY

Has anyone in your family had any of the following? (Please circle and give relation)

- Heart Disease
- Diabetes
- High Blood Pressure
- Heart Disease
- Sickle Cell
- Other
- Cancer
- Other

RECORD OF ILLNESS

(Check those that you have had; star those that you have had during past year)

- Allergies
- Appendicitis or Appendectomy
- Arthritis
- Asthma
- Bronchitis
- Chickenpox
- Convulsions or Fits
- Diabetes
- Diphtheria
- Epilepsy
- Frequent Colds
- Bone & Joint Diseases
- Skin Diseases
- Hay Fever
- Heart Disease or Heart Trouble
- Heat Exhaustion
- Hepatitis
- Hernia or Rupture
- Hives
- Influenza
- Kidney Disease or Tonsillitis or Tonsillectomy
- Bladder Problem
- Malaria
- Measles
- Other
- Other

List Other Illnesses By Name: ___________________________

(continued on back of page)
### RECORD OF SYMPTOMS
(Check those that you have had; star those that you have now)

<table>
<thead>
<tr>
<th>Symptom</th>
<th></th>
<th>Symptom</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aching Eyes</td>
<td></td>
<td>Blood in Urine</td>
<td></td>
</tr>
<tr>
<td>Sties</td>
<td></td>
<td>Sugar in Urine</td>
<td></td>
</tr>
<tr>
<td>Blurred Vision</td>
<td></td>
<td>Gall Bladder Trouble</td>
<td></td>
</tr>
<tr>
<td>Inflamed Eyelids</td>
<td></td>
<td>Abdominal Pain</td>
<td></td>
</tr>
<tr>
<td>Ringing in Ears</td>
<td></td>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>Difficulty in Hearing</td>
<td></td>
<td>Jaundice</td>
<td></td>
</tr>
<tr>
<td>Ear Fluid Discharge</td>
<td></td>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>Ear Infections</td>
<td></td>
<td>Fluid Retention</td>
<td></td>
</tr>
<tr>
<td>Nasal Discharge</td>
<td></td>
<td>Indigestion</td>
<td></td>
</tr>
<tr>
<td>Sinus Infection</td>
<td></td>
<td>Boils</td>
<td></td>
</tr>
<tr>
<td>Nosebleed</td>
<td></td>
<td>Acne</td>
<td></td>
</tr>
<tr>
<td>Sore Throat</td>
<td></td>
<td>Eczema</td>
<td></td>
</tr>
<tr>
<td>Cough (Prolonged)</td>
<td></td>
<td>Hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>Hoarseness(Laryngitis)</td>
<td></td>
<td>Painful Uirination</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td>Swelling of Ankles</td>
<td></td>
</tr>
<tr>
<td>Blackouts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you check or star any of the above, please explain in detail:

---

### EYES

Yes__ No__ Do you consider your vision to be normal in each eye without corrective lenses? Yes__ No__ Are you near-sighted?

Yes__ No__ Had eye exam in past two years?

Yes__ No__ Do you have a "lazy eye" problem?

Yes__ No__ Do you wear contact lenses?

If yes, what type? Hard___ Soft___ Extended Wear___

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### ALLERGIES

Please check or list and specify:

Do you have any allergies? Yes__ No__

Adhesive Tape________________________________

Hay Fever____________________________________

Foods________________________________________

Poison Ivy or Oak____________________________

Other________________________________________

Drugs or medications__________________________

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### TONSILS

Present_____ Removed_____ Have frequent sore throats?_______

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### MEDICATION/TREATMENT

Are you taking any medication at the present time? Yes__ No__

List all drugs or medicine with daily or regular doses:_________________________________________

Have you required any special adhesive taping, wrapping or protective services (braces for participation in athletic competition)?

Yes__ No__ Please specify in detail and for what part of the body these items are needed:________

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### CERTIFICATION

I certify that the medical history above is accurate and complete, to the best of my knowledge.

Date:________________________  Signature:________________________
CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Emergency Information

NAME:________________________ YEAR: FR / SO / JR / SR BIRTHDATE:__________
SPORT(S):__________________ CU ID #:________________________ LOCAL PHONE:__________
LOCAL ADDRESS:________________ DORM:__________ ROOM#:_____
FATHER________________ MOTHER________________
ADDRESS:________________________________________________
CITY:__________________ STATE:___________ ZIP:__________
PHONE:(home)______________ (Work-Father)______________ (Work-Mother)____________
EMERGENCY CONTACT:________________ RELATIONSHIP:________________
PHONE:________________

PRIVATE INSURANCE: (PRIMARY)
IS THIS PRIMARY INSURANCE A: HMO? OR PPO?
NAME:________________________
MAILING ADDRESS:________________
CITY, STATE, ZIP:________________
PRE-AUTHORIZATION PHONE:__________
GROUP #:________________________
POLICY #:________________________
OTHER #:________________________
EMPLOYEE:______________________

BASIC HEALTH INFORMATION
KNOWN ALLERGIES:______________________________________________
CURRENT MEDICATION(S):________________________________________
SPECIAL MEDICAL PROBLEMS:________________________________________
OTHER IMPORTANT INFORMATION:________________________________________

MEDICAL RELEASE FOR TREATMENT
I authorize _________________________or other Capital University faculty/staff person or sport club representative to
Name of Coach or Athletic Trainer
authorize on my behalf all appropriate medical treatment which may be required in the event of an illness or injury to
_________________________________________ resulting in any manner
Name of Student + CU ID #
from participating in Capital University's Sport Club Program. This authority is intended to cover any illness or injury
sustained while traveling to, from, or while participating in any sport club event, practice session, or other event
associated in any way with my participating in the Sport Club Program.

_________________________________________ STUDENT'S SIGNATURE
_________________________________________ PARENT/GUARDIAN SIGNATURE IF STUDENT IS UNDER 18
CAPITAL UNIVERSITY
INTRAMURAL & RECREATIONAL ACTIVITIES
SPORT CLUB PROGRAM

Athletic Training Services

1) To the best of his/her ability, the athletic trainer will provide each Capital University sport club member with opportunities for immediate first aid care and follow-up therapy or treatment for all injuries sustained at scheduled practices or games. Necessary referrals to appropriate physicians or medical services will be made as approved by the athletic trainer.

2) A comprehensive physical examination is required for all students who are participating in their first year. Additionally, a medical history form is required for all sport club members each year. The primary intent of these requirements is to create a medical history of the sport club member that can be referred to in case of injury/emergency. The secondary function of these requirements is to assist the club members in determining whether their own level of fitness is appropriate for participation in strenuous physical activity.

3) No sport club member will be allowed to participate in a club's activities (practices or games) without first having completed and signed current medical forms.

4) It is the responsibility of each sport club member to report athletic injuries to the Sport Club Director (a sport club accident report must be turned in to document all injuries). Also, coaches and club officers should send any sport club member to the athletic trainer if he/she feels medical attention is needed.

5) Sport Club Members should utilize posted walk-in or appointment times when needing athletic training services.

6) Both men and women will be treated equally in all matters of health care, treatment of injuries, and access to the athletic training facility.

The undersigned, herewith
1. Has read, understood and promises to abide by the above policies.
2. Understands that by not following these policies he/she may not qualify for the University's "Excess" athletic insurance policy.
3. Acknowledges and understands that participation in all physical activity has inherent dangers and risks that include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to any or all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of the body, general health and well-being.

PRINT NAME:________________________________________

CLUB MEMBER SIGNATURE:________________________ DATE:________________________