TRYOUT APPROVAL REQUIREMENTS

A member institution may conduct a tryout of a prospective student-athlete only on its campus or at a site at which it normally conducts practice or competition beginning June 15 immediately preceding the prospective student-athlete’s junior year in high school and only under the following conditions (see Bylaw 17.02.14 for tryouts of currently enrolled students):

(a) Prior to participation in a tryout, a prospective student-athlete is required to undergo a medical examination or evaluation administered or supervised by a physician (e.g., family physician, team physician). The examination or evaluation shall include a sickle cell solubility test (SST), unless documented results of a prior test are provided to the institution or the prospective student-athlete declines the test and signs a written release. The examination or evaluation must be administered within six months prior to participation in the tryout. The medical examination or evaluation may be conducted by an institution’s regular team physician or other designated physician as part of the tryout;

   (1) Exception. A medical examination conducted or supervised by a physician within six months of the prospective student-athlete’s participation in practice, competition or out-of-season conditioning activities at his or her high school, prep school or collegiate institution may be used to satisfy the medical examination requirement provided it was accepted by the prospective student-athlete’s high school, prep school or collegiate institution for his or her participation in athletics during the academic year in which the tryout is conducted.

(b) The tryout may include tests to evaluate the prospective student-athlete’s strength, speed, agility and sport skills. Except in the sports of football, ice hockey, men’s lacrosse and wrestling, the tryout may include competition. In the sport of football, the prospective student-athletes shall not wear helmets or pads;

(c) Competition against the member institution’s team is permissible, provided such competition is considered a countable athletically related activity per Bylaw 17.02.1;

(d) The time of the tryout activities (other than the physical examination) shall be limited to the length of the institution’s normal practice period in the sport but in no event shall it be longer than two hours; and

(e) The institution may provide equipment and clothing on an issuance-and-retrieval basis to a prospective student-athlete during the period of the tryout.

Name:__________________________________________ Sport:____________________

All documents listed must be submitted and approved by the Sports Medicine Staff BEFORE the PSA is permitted to participate in a tryout per NCAA Bylaw 13.11.

Documentation of a physical within the past 6 months: [ ]

Signed sickle cell form: [ ]

Signed risk of liability form: [ ]

Completed athletic insurance questionnaire: [ ]

Copy of front and back of insurance card: [ ]

APPROVED:    YES      NO

Sports Medicine Staff Member Signature: ____________________________ Date: __________

Associate Athletic Director for Compliance: ____________________________ Date: __________

Athletics Department □ Northeast-10 Conference □ Phone 518.458.5158 □ Fax 518.458.5457 □ www.gogoldenknight.com
PHYSICAL EVALUATION

Name: ___________________________ Student ID: ___________________________
Address: ________________________ Phone: _________________________________
City: ____________________________ Cell: _________________________________
State: __________________________ Zip: ____________________ Date of Birth: __________

➢ To be completed within 1 year of arrival date on campus for International and Resident Students.
➢ To be completed within 6 months of arrival date on campus for Athletes.

Physical Evaluation must be completed by a Physician, Physician Assistant or Nurse Practitioner.

Practitioner please complete THIS form fully; other physical forms will NOT be accepted. EACH question must be answered or the document will not be accepted.

Date of Physical: ________________

Height: _______________ Blood Pressure: _______________ Vision (R) ___________ (L) ___________
Weight: _______________ Pulse Rate: _______________ Glasses/Contacts _______________

General Appearance □ Normal □ Abnormal □ Normal □ Abnormal
Skin □ Normal □ Abnormal □ Normal □ Abnormal
Eyes □ Normal □ Abnormal □ Normal □ Abnormal
Ears, Nose and Throat □ Normal □ Abnormal □ Normal □ Abnormal
Tonsils □ Normal □ Abnormal □ Normal □ Abnormal
Teeth and Gums □ Normal □ Abnormal □ Normal □ Abnormal
Thyroid □ Normal □ Abnormal □ Normal □ Abnormal

Explain abnormal responses above: ______________________________________________________

Any chronic or current illness: □ No □ Yes Explain: __________________________________________

Allergies to medications, foods, or stinging insects: □ NKDA □ Yes List: _______________________

Medications regularly taken or required: □ No □ Yes List: ___________________________________

Is student cleared for full athletic participation? □ Yes □ No Restriction(s): _______________________

________________________________________________________
Health Care Provider Signature & Stamp Required

Stamp  Signature ______________________________ Date: ______________________________

HEALTH SERVICES • 432 WESTERN AVE. • ALBANY, NY 12203 (518) 454-5244 • Fax (518) 454-2007

Rev. 05.2023
Assumption of Risk and Liability 2023-2024
The College of Saint Rose

1. I voluntarily assume all risks associated with my participation in intercollegiate athletics. I agree that The College of Saint Rose, its' agents, employees, officers, Board of Trustees, contractors and volunteers are not to be held responsible for any pre-existing medical condition(s) that I may have.

2. I certify that I have submitted a completed medical/physical examination to the Sports Medicine staff and Student Health Center as required.

3. I understand that having passed a physical examination does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me.

4. I understand that The College of Saint Rose Sports Medicine staff may review the health history questionnaire and physical examination and if necessary, require a follow-up examination or further evaluation for injury or illness that may interfere and/or affect athletic participation. If such injury or condition warrants, athletic activity may be restricted, limited or even discontinued at the discretion of The College of Saint Rose Sports Medicine staff and the Team physician.

5. I understand that all injuries, illnesses or medical conditions that occur during intercollegiate athletics must be reported to the Sports Medicine staff immediately for evaluation, treatment, care and/or rehabilitation. The Sports Medicine staff will perform the necessary medical services, which may include evaluation, treatment, care, and/or rehabilitation in accordance with the College’s applicable protocols. The Sports Medicine staff shall have the discretion to make a medical referral. If I choose to see another physician, I must inform the Sports Medicine staff PRIOR to that appointment.

6. I understand that I must refrain from practices, conditioning and/or games during medical treatment or rehabilitation until permitted or discharged from such care by both the Sports Medicine staff and/or our Team physician. The final decision to return to play for an injury, illness, and/or condition will be made by the Sports Medicine staff and the Team physician.

7. I understand and accept the risks of injury, permanent disability, and/or death inherent in my sport. By signing below, I pledge to do my best to reduce these risks by keeping in the best possible physical condition and following the advice of the Team physicians, The College’s Sports Medicine staff, and coach(es) concerning prevention, treatment and/or rehabilitation of athletic injuries.

8. I understand that even with the best of coaching, use of protective equipment, proper playing techniques, and strict observance of the rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in disability, total disability, paralysis, quadriplegia, or even death.

9. I hereby authorize any/all pertinent medical information regarding injury or illness that I may experience, to be freely communicated between the Sports Medicine staff, the Student Health Services staff and/or the Capital Region Orthopedics.

10. I grant permission to the Sports Medicine staff to hospitalize, provide care, and/or secure treatment for any injuries, illnesses or conditions that may occur. If I am currently under 18, my parent or legal guardian, by signing below, grants permission to the Sports Medicine staff to hospitalize, provide care, and/or secure treatment for any injuries, illnesses or conditions that may occur to me.

11. I understand that the Director of Athletics, or designee, may notify, in appropriate circumstances, my parent/legal guardian of serious injury and/or positive drug test results.

We/I the undersigned, have read and fully understand the preceding policy statements and warnings and agree to assume the risks and following the procedures required above. We/I hereby release The College of Saint Rose, its agents, employees, officers, Board of Trustees, contractors and volunteers from any liability caused by, or arising out of my athletic participation in The College of Saint Rose Intercollegiate Athletic Program.

Print Name: _______________________________ Sport: ______________

Athlete Signature: _______________________________ Date: ______________

Parent Signature (If under 18 years of age): _______________________________ Date: ______________

Scan & Upload to SportsWare: www.swol123.net
ATHLETIC INSURANCE QUESTIONNAIRE 2023-24
The College of Saint Rose

All blanks must be completed, in pen, including signature.

Athlete’s name: _________________________________ Sport: _________ Date of Birth: _____/_____/_______
Athlete’s local address: __________________________________ City: ____________________ Zip: ________
Residence Hall: _________________________________________ SS#: __________ -_______-___________
School Email: ____________________________________________________ Cell #: _____-_____-_______

**You MUST attach a copy of the front/back of your medical insurance cards**
My insurance is through my……_____Father   _____Mother    _____ Self   _____ Spouse   _____ Other

PLEASE READ AND SIGN!
I, ______________________________, hereby authorize The College of Saint Rose and their insurance carrier/claims administrator to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. I authorize The College of Saint Rose and their insurance carrier/claims administrator to pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by The College of Saint Rose. The information I have provided is correct to the best of my knowledge.

____________________________________________  ____/_____/_______
Signature of Student-Athlete                     Date

____________________________________________  ____/_____/_______
Signature of Parent/Guardian (If under 18 years of age) Date
Dear Incoming Student-Athlete:

A policy instituted by The College of Saint Rose and the NCAA is **mandatory sickle cell trait testing for ALL student-athletes**. We encourage you check with your primary care physician or pediatric medical records regarding your birth records to see if you were tested as an infant for sickle cell tested. If you were tested as an infant, there is no need to be tested again, as long as you provide us with documentation of the result of that test via the verification form enclosed.

If you were never sickle cell trait tested as an infant, we highly recommend that you schedule an appointment with your primary care physician as soon as possible during the summer vacation since this is a **mandatory** requirement for all student-athletes prior to being eligible to practice or compete in the fall. Please have your primary care physician complete and sign the attached **Sickle Cell Trait Status Verification Form** to be returned before **August 1, 2023**. If your **Sickle Cell Trait Status Verification Form** indicates you tested positive for the sickle cell trait, a member of The College of Saint Rose Sports Medicine staff will have an education session with you on living with the positive sickle cell trait.

**You will NOT be permitted to practice or compete in the fall until you submit the Sickle Cell Trait Testing Verification form so we advise you get this taken care of ASAP!**

Once this documentation is completed, please upload to SportsWare at www.swol123.net **no later than August 1, 2023**:

If you have any questions or concerns, please contact:
Lisa Geiger, MS, ATC, CSCS

*Attached is an informational sheet for student-athletes regarding the sickle cell trait and below is a link for an educational video from the NCAA.*

https://www.youtube.com/watch?v=sQvna_2sP6o
(copy and paste this link if hyperlink doesn’t load)
Name: ________________________________    Sport: ________________________________

Date of Birth: ________________________________

I verify that the all information is complete and accurate.

Patient’s signature: ________________________________    Date: ________________

*This section must be completed by a licensed physician*

**Required: Please attach supporting lab report**

Please list the date of the Sickle Cell Trait testing: ________________________________

Please list the result of the Sickle Cell Trait testing: ________________________________

Negative ________________________________

Positive ________________________________

Are there any restrictions to participation in intercollegiate athletics?

No restrictions: ________________________________

Restricted to: ________________________________

I verify that the above named individual has been tested for Sickle Cell Trait.

Physician’s signature: ________________________________    Date: ________________

Printed or Stamped Physician’s Name and Address: ________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Once completed, scan and upload to SportsWare @ www.swol123.net by August 1st.