



LAST NAME _____ FIRST _____

SPORT _____

Circle year entering: FR SOPH JR SR

Freshman/Transfer Student-Athlete Health Information

ONLY complete this booklet if you intend to play or try out for varsity men's or women's soccer, women's volleyball, men's golf, men's or women's swimming, men's or women's basketball, men's or women's tennis, men's or women's lacrosse, cheerleading, men's or women's crew, men's or women's cross country, or women's track.

DO NOT return this form if you intend to play a club sport or intramurals.

Please Complete This Checklist Before Returning.

1a. Personal/ Insurance Information.

Please be sure to include all information requested, i.e., addresses and phone numbers of insurance companies, emergency phone numbers, etc. The reason we are asking for the insurance information: Loyola University Maryland has an athletic insurance policy that covers each athlete while he or she is participating in an organized supervised practice or game in the event of an athletic related injury. **This does not include pre-existing or chronic conditions.** Loyola University Maryland carries an **excess insurance policy** that only covers the balance after your personal insurance company pays first.

1b. Photocopy of Insurance Card

2/3. Acceptance of Risk/Permission to Treat/Release of Medical Information/Disclosure Health Information Form

Please read and sign; if athlete is under age 18, parent or guardian signature is also required.

4. Physical Assessment

Athlete is responsible for obtaining their own physical exam, which is in this book, and returning it with this book before August 1st.

5. Health Screening Form

Please complete before obtaining physical assessment and explain any previous injuries/ illnesses under Additional Medical Concerns. You may use the back of this packet or another piece of paper to explain if necessary.

6. ADD/ADHD Medical Documentation

Athlete is responsible for reading, completing, and providing required documentation.

7. Student-Athlete Supplement Notification Form

Athlete is responsible for reading, completing, and signing; if athlete is under age 18, parent or guardian signature is also required.

8. Immunization Records

Please obtain information from family physician.

PLEASE RETURN IN PROVIDED ENVELOPE OR IN PERSON BY AUGUST 1st.

Please Mail To:

Athletic Training Room
Loyola University Maryland
4501 N. Charles Street
Baltimore, MD 21210-2699

Any Questions Please Contact:

Steve Austin:	Office: 410.617.5276
Kate Hill:	Office: 410.617.2757
Pam Sommerhauser:	Office: 410.617.2743

1.

Personal/Insurance Information

To be completed by the applicant or his/her parent or guardian

Athlete's Information:

(Please Print or Type)

Name of Athlete _____	Student ID# _____
Social Security No. or Passport No. _____	Date of Birth _____
School Address _____	School Phone () _____
Home Address _____	Home Phone () _____
City _____	State _____ Zip _____

Emergency Contact Information:

Contact Name: _____	Relation: _____
Address: _____	Home Phone: _____
_____	Work/Cell: _____
_____	_____

INSURANCE INFORMATION:

FATHER/GUARDIAN INFORMATION	MOTHER/GUARDIAN INFORMATION
Father's Name _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
Employer _____	Employer _____
Address _____	Address _____
Telephone () _____	Telephone () _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____	Address _____
Policy Number _____ GP/Plan Number _____	Policy Number _____ GP/Plan Number _____
Telephone () _____	Telephone () _____
Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please include a photocopy (front and back) of Athlete's Insurance Card.

One additional note: all referrals of injuries due to an intercollegiate athletic injury will be made by the Loyola University Athletic Training Staff, Loyola University Health Center, or the Loyola University Team Physician. Loyola University Maryland will not be responsible for any costs or expenses in the event an athlete is not seen by or referred by the Athletic Training Staff or designated Team Physician. In other words, if you decide to seek out your own medical treatment, you will assume complete financial responsibility for such treatment.



First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative of Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant

3. Acceptance of Risk/Permission to Treat/Release of Medical Information

I, the undersigned, hereby acknowledge and affirm the following:

A. Acceptance of Risk

I am aware of and accept the risk of injury associated with the intercollegiate sports in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible physical condition and to follow the advice of the team physician, athletic trainer, and/or coach concerning the prevention, treatment, and rehabilitation of athletic injuries.

B. Permission to Treat

Permission is hereby granted to Loyola University to proceed with any needed medical or minor surgical treatment, x-ray examinations, and immunizations for the undersigned student.

For students under age 18: In the event of serious illness, the need for major surgery, or significant injury, if the undersigned parent/guardian cannot be reached, the treatment necessary for the best interest of the below named student may be given.

C. Release of Medical Information

I authorize the Loyola University Athletic Training Room staff to release my medical records to Loyola University personnel who have legitimate educational interests, including seeking payment for medical care provided to me. I further authorize Loyola University to release my medical records to my parent(s)/guardian(s), and to other health care providers for the purpose of providing treatment to me. This authorization will remain in force and effective for 380 days from the date of my signature below, unless revoked as set forth in the following section.

D. Revocation of Authorization

I understand that I have the right to revoke this authorization, in writing, at any time by delivering the written notification to the athletic director at Loyola University Maryland. I understand that a revocation is not effective until the athletic director acknowledges in writing receipt of my notification and that such revocation is not effective to the extent that anyone, including Loyola University Maryland, has acted in reliance on this authorization to disclose medical information prior to an effective revocation of this authorization.

I have read and understood this packet in its entirety.

Student-Athlete Signature

Date

Print Student-Athlete Name

If Student-Athlete is under age 18:

Parent or Guardian Signature (if Student-Athlete is under 18)

Date

Print Parent/Guardian Name

4.

Physical Assessment

To be completed by a physician or a certified nurse practitioner. **SPORT:** _____

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Birth date: _____ Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____

PHYSICAL REVIEW:

Head and Scalp _____

Eyes: Visual Acuity R _____ L _____

Corrective Lenses _____

Ears _____

Nose, sinuses _____

Throat: Tonsils and adenoids _____

Thyroid _____

Teeth and gums _____

Dental carries _____

Chest _____

Respiration _____

Breast and nodes _____

Cardiovascular _____

Heart Rate and Rhythm _____

Murmurs _____

Size _____

Blood Pressure _____

Abdomen _____

scars, tenderness, masses _____

Buttocks _____

Hemorrhoids _____

Pilonidal cyst _____

Genitals _____

Hernia _____

Musculo-skeletal system _____

Injuries or defects _____

Spine; posture _____

Condition of feet and arches _____

Skin _____

Central Nervous System _____

Reflexes _____

Coordination _____

Has this patient ever been treated for an:

eating disorder? _____

anxiety/ stress disorder? _____

Comments on Health Screen (p 4):

Recommendations for lifestyle modification.

(i.e., stop smoking, lose weight)

General summary of physical examination findings:

Upon completion of a complete physical examination, I have found _____ to be in _____ health. In my opinion, he/she is:

_____ approved to participate in intercollegiate sports.

_____ NOT approved to participate in intercollegiate sports.

Recommendations and/or restrictions: _____

Reviewed by

Physician or Certified Nurse Practitioner signature

Date _____

Print Name _____

Telephone _____

Loyola University Certified Athletic Trainer Signature

Please explain any "YES" answers in the space provided.

	Yes	No		Yes	No
Do you want to talk to a doctor about a health problem or injury?	___	___			
Has anyone in your <u>close family</u> ever had:			Have you had or do you now have:		
Diabetes (high sugar in blood)?	___	___	Back injury or frequent backaches?	___	___
Allergies (hay fever/asthma)?	___	___	Knee injury (sprain) or recurrent pain?	___	___
Migraine headache?	___	___	Ankle injury (sprain) or recurrent pain?	___	___
Heart trouble?	___	___	Other joint trouble?	___	___
High blood pressure?	___	___	specify _____		
Has anyone <u>in your family</u> under age 50 died suddenly?	___	___	Bone infection? specify _____	___	___
Have <u>you</u> had or do <u>you</u> now have:			Have you ever had surgery?	___	___
High blood pressure?	___	___	(If yes, please explain) _____		
Cardiac problems/conditions?	___	___	Have you had or do you know have:		
Brain concussion (head injury)?	___	___	Diabetes (high sugar in blood or urine)?	___	___
Date: _____	___	___	Tendency to bleed or bruise easily?	___	___
Tendency to lose consciousness?	___	___	Anemic ("tired" blood)?	___	___
Skull fracture? Date: _____	___	___	Weight problems (under or overweight)?	___	___
Convulsions or epilepsy?	___	___	Hepatitis?	___	___
Neck injury?	___	___	Have you had or do you now have:		
Burners, stingers, numbness of neck shoulders or hand?	___	___	Asthma (wheezing)?	___	___
Have <u>you</u> had or do <u>you</u> now have:			Hay fever?	___	___
Very bad (impaired) vision in one eye?	___	___	Hives or rash?	___	___
Perforated ear drum?	___	___	Bee sting reactions (allergy)?	___	___
Discharge from an ear (recurrent infections)?	___	___	Reactions to medication (allergy)?	___	___
Sinus infections?	___	___	If yes, name: _____		
Dental plate (dentures)?	___	___	Do you:		
Orthodontia (teeth straightened)?	___	___	Smoke?	___	___
Pneumonia?	___	___	Take any medication regularly?	___	___
Infectious disease (please specify)?	___	___	If yes, name: _____		
Have you ever been found to have only one or two functioning organs, i.e. kidney, eye, testicle, ovary? _____	___	___	Take medication for emergency use?	___	___
Have you had or do you now have:			If yes, name: _____		
Hernia? Date: _____	___	___	Have you ever had mono? Date: _____	___	___
Kidney problems?	___	___	Have you had or do you now have:		
Blood in urine?	___	___	Recurrent rash?	___	___
(Boys) Loss of function or absence of testicles?	___	___	Fungus infection?	___	___
(Girls) Menstrual problems?	___	___	Athlete's foot?	___	___
Age of onset of menstruation _____	___	___	Recurrent boils (skin infection)?	___	___
Have you had or do you now have:			Do you experience frequent anxiety?	___	___
Bone fracture? specify _____	___	___	Do you experience frequent depression?	___	___
Joint dislocation? specify _____	___	___	Have you ever been treated for an emotional problem?	___	___
Foot problems?	___	___	If yes, explain: _____		
Shoulder injury?	___	___	Do you wish to discuss an emotional problem with a clinician?	___	___
Osgood-Schlatter?	___	___	Have you ever been told to give up any activity because of a health problem?	___	___
Osteomyelitis?	___	___	If yes, explain: _____		

Please make any further notes on the back page.

The NCAA bans classes of drugs because they can harm student-athletes and can create an unfair advantage in competition. Some legitimate medications contain NCAA banned substances, and student-athletes may need to use these medicines to support their academics and their general health. The NCAA has a procedure to review and approve legitimate use of medications that contain NCAA banned substances through a Medical Exceptions Procedure. The diagnosis of adult ADD/ADHD remains clinically based utilizing clinical interviews, symptom-rating scales, and subjective reporting from patients and others. Student-athletes diagnosed with ADD/ADHD require certain medical records on file in order to request an exception in the event of testing positive during an NCAA Drug Test.

Please answer the following questions by circling the correct response:

- | | | |
|--|-----|----|
| 1. Have you ever been diagnosed with ADD/ADHD? | Yes | No |
| 2. If so, were you diagnosed during childhood? | Yes | No |
| 3. Are you taking any medication for this condition? | Yes | No |
| a. If so, please list: _____ | | |

If you answered YES to any of the above questions please submit the following information:

- Description of the evaluation* process which identifies the assessment tools and procedures for this diagnosis.
- Statement of the diagnosis, including when it was confirmed.
- History of ADD/ADHD treatment (previous/ongoing).
- Statement that a non-banned ADD/ADHD alternative has been **considered** if a stimulant is currently prescribed.
- Copy of the most recent prescription (as documented by the prescribing physician).

All of the aforementioned information may be reported in the form of a dictated letter from your prescribing physician.

Student-athletes treated since childhood with stimulant medication but who do not have records of childhood assessments, or who are initiating treatment as an adult, must undergo a comprehensive evaluation to establish a diagnosis. These evaluations may be done off-campus. Disability Services has a list of doctors to refer student-athletes to.

**evaluations done during childhood include the Connors Grading Scale, ASRS, CAARS, and the DSM-IV ADHD Survey. Those diagnosed during adulthood have assessments that include the Connors Adult ADHD Grading Scale and the Adult ADHD Self-report Scale.*

7. ***Student –Athlete Supplement Notification Form***

Please read the following and sign below.

I, _____, acknowledge that I am currently taking and/or have taken (within the past six months) the following ergogenic aids, creatine powder, amino acids, protein supplements, or other similar substances, herein referred to as “Supplements”.

None

Supplement Name	Dosage	Main Ingredients	Comments

I understand and agree:

a) Loyola University Maryland Department of Athletics neither approves of nor condones the use of Supplements;

b) I have been informed of the Loyola University Maryland Department of Athletics, Metro Atlantic Athletic Conference (MAAC), National Collegiate Athletic Association (NCAA), and United States Olympic Committee (USOC) policies with regards to the use of Supplements, and have had any questions about these policies answered;

c) **The use of Supplements may result in serious injury to me, possible permanent harm to my health, and even death;**

d) I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance;

e) I must list all Supplements on the Chain of Custody Forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at anytime in the future any form of Supplements.

I further understand and agree that Loyola University Maryland, its officers, employees, and agents are not responsible for any injury and possible permanent harm to my health caused by my past, present, and/or future use of Supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release Loyola University Maryland its officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of Supplements.

I understand the statements in this form, and have had all questions about the information in this form answered to my satisfaction.

Student-Athlete’s Signature

Date

Parent/ Guardian’s Signature (if under 18 years old)

Date

8.

Immunization Record

Indicate your immunity by specifying relevant dates below.

(1) TETANUS/DIPHTHERIA DATE
Primary series of DPT completed _____
Tetanus booster _____
(Within last 10 years)

(3) POLIO Date
Completed vaccination series or last booster _____
Type of vaccine: _____
Oral Inactivated E-IPV _____

(2) a. M.M.R. (MEASLES, MUMPS, RUBELLA)
If you have had MMR vaccines, Omit (3) (4) (5)
Dose 1 (After 12 mos.) _____
Dose 2 _____
(Two Doses of measles required, One Dose after 1980)

(4) TUBERCULOSIS TEST Date
PPD (Mantoux) test within the past 12 mos. _____

OR
b. MEASLES (RUBEOLA) Date
Born before 1957 and therefore assumed immune _____
Has immune titre report; specify date _____
Immunized with live measles DOSE 1 - After 12 mos. _____

Results _____
Positive PPD: _____
Chest X-RAY required _____
Previous BCG – chest X-RAY require if PPD not done _____

DOSE 2 - After 1980 _____

(5) HEPATITIS B (OPTIONAL)
Vaccine series dates:
1. _____
2. _____
3. _____

c. RUBELLA Date
Has report of immune titre: Specify date (copy of report required) Vaccine at age 12 mos. or older _____

(6) MENINGOCOCCAL (Menomune) Date
Dosage 0.5ml _____
Required by Maryland State Law

d. MUMPS DATE
Has report of immune titre copy of report required _____
Vaccine at age 12 mos. or later _____

(7) VARICELLA (Chickenpox) Date
Had disease, confirmed by office record _____
Has report of positive immune titre. _____
Varicella Vaccine (2 doses required > 13 y.o.) _____

Please provide information regarding your personal health care provider.

Doctor/ Practice Name: _____ Telephone Number: (_____) - _____

Address: _____

Signature of Student: _____ Date: _____

9. Additional Medical Concerns

Please make notes:



**Union Memorial
Sports Medicine**
MedStar SportsHealth



PHYSICAL THERAPY FIRST
physicaltherapyfirst.com

PHYSICAL THERAPY FIRST

**Your First Choice for
Orthopedic and Sports Therapy**

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