



LAST NAME _____ FIRST _____

SPORT _____

Returning Student-Athlete Health Information

ONLY complete this booklet if you play 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.

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

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

3. Health-Status Questionnaire for Returning Student-Athletes

Please complete and explain any answers that require a "yes." If needed, please continue explanation on the back of the packet or on another piece of paper.

4. ADD/ADHD Medical Documentation

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

5. Student-Athlete Supplement Notification Form

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

6. 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.

2. 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

3. Health-Status Questionnaire for Returning Student-Athletes

Name: _____ Sport: _____ Date: _____

Athletic Class Entering: FR SO JR SR Age: _____ Birth date: _____

Sex: M F Height: _____ Weight: _____ BP: _____ Local / Cell number: _____

The NCAA policy states that all student athletes should have passed a complete physical examination upon initial entrance to the school where they will participate and then fill out an updated health-status questionnaire each year thereafter. Our policy is to adhere to these guidelines. This information will be screened along with your records and physician evaluations will be scheduled if necessary. Then, qualified athletes will be approved for participation in sports at Loyola University Maryland. Please read the following questions below. Then circle Y or N. If your answer is Y, please explain in detail and give the date for such answers.

- | | <u>Explain / Date</u> | |
|--|-----------------------|---|
| 1. Have you had any serious illness or injury which WAS NOT treated here at Loyola University Student Health Center, the Loyola University Athletic Training Room, or by a Loyola University team physician? | Y | N |
| 2. Have you visited a physician or hospital since last season (NOT including team physician)? | Y | N |
| 3. Have you experienced chest pain, fainting, lightheadedness, or shortness of breath due to exercise? | Y | N |
| 4. Have you developed or been made aware of a heart condition or high blood pressure in the past year? | Y | N |
| 5. Has a family member younger than 50 years of age been diagnosed with or died due to a cardiac condition in the past year? | Y | N |
| 6. Are you currently on any prescribed or over the counter medications? | Y | N |
| 7. Are you currently taking any supplements or performance enhancing drugs (creatine, protein powder, ephedrine, etc.)? | Y | N |
| 8. Have you developed any allergies (food, drug, insects, etc.) during the past year? | Y | N |
| 9. Have you lost or gained weight during the past year? How much? | Y | N |
| 10. Have you developed a stress fracture in the last year? | Y | N |
| 11. Females: Have your menstrual periods been regular and monthly during the past year? | Y | N |
- What was the date of your last pelvic exam? _____

Having reviewed the above student-athlete's records and this questionnaire, my impression is that this athlete *is* / *is not* able to fully participate in his/her sport activity.

Reviewed by: _____
Loyola University Certified Athletic Trainer Signature

Date: _____

4.

ADD/ADHD Medical Documentaion

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.*

5. ***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

6.

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: _____

7. Additional Medical Concerns

Please make notes:



**Union Memorial
Sports Medicine**
MedStar SportsHealth



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