



LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_

SPORT \_\_\_\_\_

Circle year entering: FR SOPH JR SR

## **Intercollegiate Athletics Health Information Booklet**

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

#### **1.a 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 College in 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 College in Maryland carries an **excess insurance policy** that only covers the balance after your personal insurance company pays first.

#### **1.b 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 15.

#### **5. Health Screening Form**

Please complete before obtaining physical assessment and explain any previous injuries/ illnesses under Additional Medical Concerns.

#### **6. 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.

#### **7. Immunization Records**

Please obtain information from family physician.

**PLEASE RETURN IN PROVIDED ENVELOPE BY AUGUST 15.**

#### **Please Mail To:**

Athletic Training Room  
Loyola College in 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
Fax: 410.617.5626	

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 _____
College Address _____	College 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 College Athletic Training Staff, Loyola College Health Center, or the Loyola College Team Physician. Loyola College in 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 College 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 College Athletic Training Room staff to release my medical records to Loyola College personnel who have legitimate educational interests, including seeking payment for medical care provided to me. I further authorize Loyola College 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 College in 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 College in 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



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

**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 College 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.**

**6. 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 College in Maryland Department of Athletics neither approves of nor condones the use of Supplements;

b) I have been informed of the Loyola College in 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 College in 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 College in 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

**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)

**(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)

**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. \_\_\_\_\_

DOSE 2 - After 1980 \_\_\_\_\_  
**c. RUBELLA      Date**  
 Has report of immune titre: Specify date (copy of report required) \_\_\_\_\_  
 Vaccine at age 12 mos. or older \_\_\_\_\_

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

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

**(4) TUBERCULOSIS TEST      Date**  
 PPD (Mantoux) test within the past 12 mos. \_\_\_\_\_

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

**(5) HEPATITIS B (OPTIONAL)**  
 Vaccine series dates:  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

**(6) MENINGOCOCCAL (Menomune)      Date**  
 Dosage 0.5ml \_\_\_\_\_  
 Required by Maryland State Law

**(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: \_\_\_\_\_

**8. Additional Medical Concerns**

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Please make notes:

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