Loyola Marymount University Sports Medicine

Dear Incoming Student-Athlete:

On behalf of the LMU Sports Medicine Department, we would like to congratulate you on becoming a Lion. We want to welcome you to Loyola Marymount University Athletics and look forward to working with you this season. The Sports Medicine Staff wants to ensure that you have a safe and successful career while at Loyola Marymount University.

Yearly, medical physical examinations are required for all student-athletes who are participating on an intercollegiate athletics team at Loyola Marymount University. As such, there are several steps you must take and forms you and your parents/guardians must complete before you will be cleared to participate in any Loyola Marymount University athletic team weight training sessions, conditioning work-outs, practices or competitions. Your primary care physician or a physician of your choice may perform the medical physical examination. The Student-Athletes Health History Questionnaire and Physical Examination Form must be completed in its entirety and signed by a board certified physician only. We will not accept forms signed by nurses, physician assistants, chiropractors, etc. There will be no exceptions. All physical examination costs are the full financial responsibility of the student-athlete. If the LMU Sports Medicine Staff determines the need for any additional medical clearances, the student-athlete will be referred to the appropriate specialist(s) for further evaluations. The student-athlete will be responsible for any and all medical costs accrued from these additional medical evaluations.

If you sustain a significant injury or illness after your physical examination, but before the first sanctioned practice, you must submit a letter from a board certified physician informing the LMU Sports Medicine Staff that you are cleared and eligible to be evaluated by the LMU Athletic Department team physician(s) for final clearance to participate in intercollegiate sports with no restrictions.

IMPORTANT DUE DATES

Friday, May 6th – All First Session Summer School Enrollees

Friday, June 3th – Basketball (M&W), Volleyball, and Freshmen/Transfers Second Session Summer School Enrollees

Friday, July 15th – ALL Sports Fall Enrollees

All forms in this packet must be completed. Incomplete forms will not be accepted. Failure to return your completed forms will result in a delay in your clearance for participation. If you have any questions, please contact Keith R. Ellison at 310-338-2874 or via e-mail at kellison@lmu.edu. We are looking forward to meeting you, and again welcome to Loyola Marymount University.

Sincerely,

Keith R. Ellison

Assistant Athletics Director – Sports Medicine

Loyola Marymount University Sports Medicine

MEDICAL CLEARANCE PACKET
Freshmen / Transfer Student-Athletes

I agree that in order to participate as a student-athlete during the **2016 -2017** academic year at Loyola Marymount University, I must complete the following documents **within established guidelines**. I understand that if I fail to complete these forms properly, **I WILL NOT BE ELIGIBLE** to participate in either practice or competition with my team until these forms are **received and approved** by the Department of Sports Medicine in the LMU Athletic Department.

INCOMING FRESHMEN AND TRANSFERS – SUBMISSION POLICY

New student-athletes enrolled in the second session summer school (e.g. Basketball and/or Volleyball) are required to submit this packet by June 3rd.
New student-athletes enrolled for Fall 2016-17 (e.g. incoming freshmen and transfers) are required to submit this packet by July 15th.
I understand that I am responsible for submitting this packet for review and approval prior to being cleared to participate in weight training, conditioning, practice or competition.

REQUIREMENTS FOR COMPLETING THE PACKET

1. All forms included in the packet must be legible, accurate, and complete. Incomplete or inaccurate packets will not be approved and will cause a delay with your clearance to participate.
2. Forms must be approved by the LMU Sports Medicine Department prior to any student-athlete engaging in practice or competition activities.
3. Packets may be faxed, e-mailed, mailed, or hand-delivered to the LMU Athletic Training Room located in Gersten Pavilion.
4. **All medical history forms must be completed either prior to visiting a board certified physician or in the presence of a licensed physician, and must be reviewed by the physician completing the physical.**
5. Physician's signature **AND** stamp or business card is required on the Physician's Statement in the Medical Section.
6. Signatures of the student-athlete and a parent /legal guardian are required on the Acceptance of Risk, Authorization/Consent for Disclosure of Protected Health Information, Personal Insurance Statement, Health History Questionnaire and Concussion Statement **regardless of the age of the student-athlete**.
7. Proof of Insurance (Accident, Dental, Vision and Prescriptions) is required, which includes photo copies of the front and back of each card.

RETURNING THE PACKET

- **By Mail:** Use the business reply envelope provided to you or mail the packet to:
  Keith R. Ellison
  Assistant Athletics Director – Sports Medicine
  Gersten Pavilion, Athletic Training Facility
  1 LMU Drive
  Los Angeles, CA 90045
- **By Fax:** Fax the form to the LMU Athletic Training Room at **(310) 338-5191**
- **By Hand:** The LMU Athletic Training Room located in Gersten Pavilion.
- **By E-mail:** kellison@lmu.edu

Printed Name: _____ Sport(s): _____

Signature: _____ Today's Date:_____

Loyola Marymount University Sports Medicine

IMPORTANT INFORMATION ABOUT HEALTH INSURANCE PLEASE READ CAREFULLY

This letter is to provide information regarding insurance coverage for your son/daughter as a student-athlete at Loyola Marymount University. Prior to your son/daughter arriving for the fall semester, the LMU Athletic Department would like to provide you with some information regarding both a change in our insurance policy, as well as procedural information as to how the Department of Athletics will handle any medical issues that might arise due to athletics participation. It is **MANDATORY** that all student-athletes are required to show proof of medical insurance coverage and to provide this information before gaining clearance to participate in intercollegiate athletics. The LMU Athletic Department has a program that will assist parents and/or guardians if a student-athlete is injured during intercollegiate sports participation by providing **secondary** medical coverage. This insurance policy covers each student-athlete in the event of an accidental athletic-related injury due to participation in an organized and supervised practice, competition, strength training and conditioning. The student-athletes personal insurance policy will act as the **primary** medical coverage when an athletic related injury occurs. The student-athlete's primary insurance policy will be billed first in every circumstance. LMU secondary coverage only applies after the student's primary insurance coverage has been exhausted or denied. The secondary accident policy provided by LMU (AG Administrators) will reimburse for all deductibles and/or co-pays that are stipulated in your primary insurance policy.

Sicknesses or illnesses (ex. appendicitis), non-sport injuries (ex. car or biking accidents) or injuries not related to intercollegiate athletics are not covered by the Athletics Department secondary injury insurance policy. Parents/Guardian's should not discontinue their insurance coverage assuming that the LMU Department of Athletics will assume financial responsibility for all medical costs.

As mentioned above, medical insurance coverage is mandatory for all LMU students. A fee for the LMU Accident/Sickness Policy will be assessed at the beginning of each academic year as part of their registration fees. Students may waive out of this policy by providing proof of adequate medical insurance coverage that meets the University's minimum coverage requirements. The LMU Accident/Sickness Policy can only be waived online by October 1, 2016.

Student-athletes are solely responsible for waiving out of LMU Sickness/Accident policy (the LMU Athletic Department cannot not do it for them).

The Athletic Training Staff or the LMU Team Physician will make ALL medical referrals with regards to an intercollegiate athletic injury. Loyola Marymount University will not be responsible for any bills, malpractice, or second opinions in the event that a student-athlete does not follow the appropriate protocol for athletic related injuries. **In other words, if you decide to seek out your own medical treatment you will assume complete financial and legal responsibilities that you may incur.**

Loyola Marymount University Sports Medicine

In the event of an athletic injury to your son/daughter, medical bills will be sent directly to him/her at the address they provide (school or home). Once these bills are received, please forward them **immediately** to:

Keith R. Ellison
Assistant Athletics Director – Sports Medicine
Gersten Pavilion – Athletic Training Facility
One LMU Drive
Los Angeles, CA 90045

It is our sincere hope that your son/daughter will not be injured while participating in Loyola Marymount University athletics. Be assured that our staff will do its best to properly administer the best possible medical care if any injury should occur to your child. If you have any questions, please do not hesitate to call us at (310) 338-2874. We look forward to seeing you during the season!

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

GENERAL INFORMATION QUESTIONNAIRE

Today's Date (Month/Day/Year): _____ Sport(s): _____

Your Full Name: _____
First Middle Last Nickname

Ethnicity: _____ Date of Birth: _____ Sex: M F

Current Academic Year: Fr So Jr Sr Grad LMU ID Number: _____

Cell Phone: _____ Personal Email: _____ LMU Email: _____

Permanent Address:_____
Street City State Zip

Campus/Local Adress:_____
Street City State Zip

Birth Mother Information ☐ Emergency Contact

Last Name: _____ First Name: _____ MI: _____ Maiden Name: _____

Home Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ Home Fax: _____ Email: _____

Employer Name: _____ Job Title: _____

Employer Address: _____
Number/Street Floor/Suite City State Zip

Work Phone: _____ Work Fax: _____ Work Email: _____

Birth Father Information ☐ Emergency Contact

Last Name: _____ First Name: _____ MI: _____

Home Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ Home Fax: _____ Email: _____

Employer Name: _____ Job Title: _____

Employer Address: _____
Number/Street Floor/Suite City State Zip

Work Phone: _____ Work Fax: _____ Work Email: _____

Step Parent/Guardian/Other Information ☐ Emergency Contact

Last Name: _____ First Name: _____ MI: _____ Relationship: _____

Home Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ Home Fax: _____ Email: _____

Employer Name: _____ Job Title: _____

Employer Address: _____
Number/Street Floor/Suite City State Zip

Work Phone: _____ Work Fax: _____ Work Email: _____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

STUDENT-ATHLETE AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Release of Protected Health Information

I, _____, hereby authorize Loyola Marymount University Department of Sports Medicine to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the following parties:

a. LMU's team physicians;
b. Athletic trainers;
c. Coaching staffs;
d. Strength and conditioning staff;
e. Sports information staff;
f. Athletic department personnel;
g. Conference officer personnel;
h. Media representatives;
i. Insurance representatives; and/or
j. Health care personnel

I further authorize the Sports Medicine staff to disclose this information as they deem appropriate.

2. Purpose of the Release

I understand that information regarding my health will be used by the Sports Medicine staff and other identified personnel for the purpose of my care and ability to participate in intercollegiate athletics at Loyola Marymount University, and to provide related information to conference office personnel and media representatives.

3. Voluntary Waiver

I understand that signing this authorization/consent form is voluntary and that my institution will not condition any benefits (if applicable) on whether I provide the authorization/consent requested for the disclosure. I understand that I am not required to sign this authorization/consent form in order to be eligible for participation in intercollegiate athletics. This authorization/consent expires 380 days from the date of my signature below. I understand that I have the right to revoke it in writing at any time by sending written notification to the Assistant Athletic Director for Sports Medicine at Loyola Marymount University. I understand that a revocation is not effective to the extent action has already been taken in the reliance on this authorization/consent.

Student-Athlete's Printed Name: _____ Sport: _____

Student-Athlete's Signature: _____ Date: _____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

ACCEPTANCE OF RISK

Participation and involvement in intercollegiate athletics at Loyola Marymount University (LMU) will include, but may not be limited to: practice sessions (voluntary or required), weight lifting and conditioning (voluntary or required), travel and competition. **Participation in intercollegiate athletics places you, the athlete, at risk for potential illness or injury. As either a direct or indirect result, permanent disability and/or death may occur.** If you have any questions regarding this risk, you should contact the LMU Sports Medicine Department at (310) 338-2874.

I, _____ understand the inherent risk of participation in intercollegiate athletics will
(Student-athlete's full printed name, no nicknames)
include, but may not be limited to: practice sessions (voluntary or required), weight lifting and conditioning (voluntary or required), competitions, and travel to and from competitions. Practice, weight lifting and conditioning, and competition will occur at locations both on and off the LMU campus. I acknowledge those risks and I understand that permanent disability, and/or death may occur as a result of my participation in the above-stated activities. I voluntarily wish to participate in the above-stated activities and agree to comply with the regulations outlined below.

I acknowledge that LMU is permitting voluntary intercollegiate sports activities and that I am not required to participate in them. Furthermore, I understand that these activities are not associated with any LMU academic class and that my participation is elective.

I acknowledge that the above-stated activities may involve substantial risk to me or my property, including serious personal injury, permanent disability, and/or death. It may also result in damage to or loss of personal property as a result of my own or other's actions or failure to act.

I agree to comply with all the regulations and directions given to me by members of my coaching staff and/or athletic department or University officials.

Except for instances of LMU's gross negligence, I assume full responsibility of all risk of injury, death, damages, or loss which may result from participation in intercollegiate sports and all associated activities. I agree to release, discharge, and hold harmless LMU, its agents, volunteers, and employees from any claims or liabilities arising from or relating to my personal injury, death, and/or any and all losses whatsoever.

I acknowledge that I am covered by appropriate health and accident insurance and that I will not be adversely affected by participating in the above-stated activities.

MEDICAL TREATMENT AUTHORIZATION

I hereby authorize and give consent to the Loyola Marymount University Sports Medicine Staff or any licensed physicians, to perform or administer any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections and minor medical procedures. I further agree to hold harmless LMU for any and all actions taken by LMU to provide necessary emergency medical care to me that results from my participation in intercollegiate sports.

I acknowledge these risks and voluntarily choose to compete as an athlete at Loyola Marymount University. I further authorize medical treatment provided to me by Loyola Marymount University Medical Staff and/or any licensed physicians working in conjunction with LMU.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

(Required for ALL student-athletes regardless of age)

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

STUDENT-ATHLETE/PARENT OR GUARDIAN INSURANCE STATEMENT

I, _____, acknowledge that I have read and understand the following:

Prior to being certified and cleared by the Loyola Marymount University (LMU) Department of Sports Medicine to participate in practice, weight lifting and conditioning, or competition activities, I understand that I must first receive and sign for a copy of the LMU Sports Medicine Policies and Procedures Handbook. I understand that it is my responsibility for me and my parent(s) or guardian(s) to review this handbook. Included in this handbook is information that will assist my parents and I in the event of an injury. Additionally, the handbook is designed to help answer questions and provide guidance for me in order to receive the best medical care possible. In addition to the hardcopy I will receive at the first team meeting of each academic year, I understand this handbook may be found online at http://grfx.cstv.com/photos/schools/loyo/auto_pdf/Student-Athlete-Manual.pdf.

All student-athletes are required to provide proof of medical insurance coverage prior to being cleared for participation in intercollegiate athletic activities at LMU. This accident insurance will act as the **PRIMARY POLICY** for any injuries I might sustain during intercollegiate athletic activities that include but may not be limited to practice, weight training, conditioning, competition, etc. I understand that I must provide proof of this insurance to the Sports Medicine Department and the Compliance Office at LMU prior to being approved to engage in these activities. In addition to my primary coverage, I understand that LMU provides **SECONDARY** insurance coverage for student-athletes who suffer injuries sustained during training for and participation in intercollegiate athletic activities (e.g. practice, weight training, conditioning, competition).

In the event that I suffer an injury directly related to participation in intercollegiate activities at LMU, my **PRIMARY** accident insurance policy will first act upon and attempt to pay all charges related to medical care for the injury. Any charges not covered by my **PRIMARY** accident policy will be covered by the **SECONDARY** accident insurance policy secured by LMU. In addition, the **SECONDARY** accident policy provided by LMU will reimburse for all deductibles and/or co-pays that are stipulated in my **PRIMARY** accident policy. This means that I or my parent or guardian who holds the **PRIMARY** accident policy should not experience any out-of-pocket expenses for any sports-related injury that I suffer as part of participation in intercollegiate athletic activities at LMU.

If I have questions regarding the terms of my own accident insurance coverage, my parent(s) or guardian(s) and I should contact our insurance provider immediately. Further, I understand that my parent(s) or guardian(s) should ensure that we are aware of any exclusions in my accident policy regarding athletically related injuries.

I understand that I am responsible for notifying the LMU Department of Sports Medicine of any changes made to my own insurance policy. This includes, but is not limited to, change of insurance company, change in policy terms, and/or cancellation of policy. I also understand that LMU requires me to provide proof of insurance coverage for sickness or illness. If I do not have insurance coverage, I understand that I am required to purchase the sickness/illness insurance provided by LMU.
http://www.lmu.edu/about/services/controller/osfs/studentaccounts/sicknessinsurance.htm

I understand that the NCAA's Catastrophic Injury Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a $75,000 deductible and is supplemental coverage in the event of a catastrophic injury. I understand more information on this program may be found on the NCAA's website at http://t.co/NNZqihd.

Finally, I understand that failure to provide an accurate health history to the LMU Sports Medicine personnel may void the University's responsibility. I understand that if I experience a medical condition of any kind (e.g. injury, illness, etc.); it is my responsibility to immediately inform the LMU Department of Sports Medicine. I also understand that I must complete all insurance claims and that LMU is not responsible for any payment not covered by insurance.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

(Required for ALL student-athletes regardless of age)

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

Student-Athlete Health History Questionnaire Form

Athlete Name: _____ Sport: _____ Date of Exam: _____

CARDIOVASCULAR RISK FACTORS		Date(s)
1. Have you ever been told you have a heart murmur?	Y or N	_____
2. Have you ever experienced heart palpitations?	Y or N	_____
3. Has anyone in your family died suddenly or a heart attack, or had a heart attack at a young age?	Y or N	_____
4. Has a physician ever denied or restricted your participation in sports due to cardiovascular/heart problems?	Y or N	_____
5. Do you or anyone in your family have a history of high blood pressure?	Y or N	_____
6. Do you or anyone in your family have a history of high cholesterol?	Y or N	_____
7. Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart?	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

CHEST		Date(s)
8. Do you ever experience chest pain?	Y or N	_____
9. Have you ever felt dizzy or faint during or after exertional exercise or activity?	Y or N	_____
10. Do you have any shortness of breath with excessive or exertional activity or exercise?	Y or N	_____
11. Do you have a chronic cough, asthma, hay fever, wheezing, or bronchitis?	Y or N	_____
12. Do you use an inhaler of any kind?	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

HEAD INJURIES / CONCUSSIONS		Date(s)
13. Have you ever had a concussion or skull fracture?	Y or N	_____
14. How many concussions (including minor concussions) have you sustained?	*(Enter a number)*	_____
15. Have you ever been to the Emergency Room for a head injury / concussion?	Y or N	_____

16. Have you ever had any of the following tests performed for a head injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____

17. Have you ever been knocked unconscious, had loss of memory, and/or been hospitalized due to a head injury / concussion?	Y or N	_____
18. Have you ever been advised not to participate in athletic activities due to a head injury/concussion?	Y or N	_____
19. Do you or have you ever had any episodes of dizziness, seizures, or convulsions?	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

EYES	Date(s)

20. Do you have any problems with your eyes or vision? Y or N _____
21. Have you ever suffered an injury to your eye(s)? Y or N _____
22. Have you ever been diagnosed with an eye disease? Y or N _____
23. Do you wear: ☐ Contacts ☐ Glasses ☐ Protective Eyewear

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

EARS	Date(s)

24. Have you ever suffered an injury to your ear(s)? Y or N _____
25. Do you have any problems with your hearing? Y or N _____
26. Have you ever experienced any loss of hearing, infection, or swimmer's ear? Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

NOSE	Date(s)

27. Have you ever been diagnosed with a sinus problem? Y or N _____
28. Have you ever broken your nose? Y or N _____
29. Do you experience periodic nosebleeds? Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

MOUTH	Date(s)

30. When was your last dental exam? _____
31. Have you ever suffered an injury to your teeth, mouth, and/or jaw? Y or N _____
32. Do you have a bridge or false teeth? Y or N _____
33. Have you ever fractured a tooth? Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

NECK / CERVICAL SPINE	Date(s)

34. Have you ever suffered an injury to your neck or cervical spine? Y or N _____
35. Have you ever had a "Burner" or "Stinger" or other Brachial Plexus Injury? Y or N _____
36. Have you ever had a pinched nerve, or numbness or weakness in your arms and/or hands? Y or N _____
37. Have you ever had any of the following tests performed for a neck injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

38. Have you ever had an operation or surgery on your neck? Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

BECK / SPINE / SACROILIAC JOINT	Date(s)

39. Do you have a history of back problems? Y or N _____
40. Have you ever suffered a herniated, bulging, collapsed, or ruptured disc? Y or N _____
41. Have you ever been diagnosed with a stress fracture in your back? Y or N _____
42. Have you ever had a pinched nerve, or numbness or weakness in your arms, hands, and/or legs? Y or N _____
43. Have you ever experienced sciatica pain? Y or N _____
44. Have you ever had pain down your leg, numbness or weakness in your arms, hands, and/or legs? Y or N _____
45. Have you ever had an operation or surgery on your spine/back/sacroiliac joint? Y or N _____
46. Have you ever had any of the following tests performed for a back injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

HIP / GROIN	Date(s)

47. Have you ever suffered an injury to your hip/groin? Y or N _____
48. Have you ever suffered a hernia and/or sports hernia? Y or N _____
49. Have you ever had surgery or an operation on your hip or groin? Y or N _____
50. Have you ever had any of the following tests performed for a hip/groin injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

ABDOMEN / RIBS / THORAX / STERNUM		Date(s)
51. Have you ever sustained an injury to your abdomen, ribs, thorax, or sternum?	Y or N	_____
52. Have you ever had a fracture of a rib?	Y or N	_____
53. Have you ever had a fracture to your collarbone?	Y or N	_____
54. Have you ever fractured your sternum?	Y or N	_____
55. Have you ever had an operation or surgery on your abdomen, ribs, thorax, or sternum?	Y or N	_____

56. Have you ever had any of the following tests performed on your abdomen, ribs, thorax, or sternum? *(Check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

SHOULDER		Date(s)
57. Have you ever suffered an injury to your shoulder? *(For example: labrum or rotator cuff tear, ligament tear, tendonitis, impingement, or pain)*	Y or N	_____
58. Have you ever sustained a fractured bone in your shoulder?	Y or N	_____
59. Have you ever dislocated a joint in your shoulder?		
60. Have you ever subluxed your shoulder?	Y or N	_____
61. Have you ever had an A-C separation?	Y or N	_____
62. Have you ever had an operation or surgery on your shoulder?	Y or N	_____

63. Have you ever had any of the following tests performed for a shoulder? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

ELBOW/FOREARM		Date(s)
64. Have you ever suffered an injury to your elbow or forearm?	Y or N	_____
65. Have you ever sustained a fractured bone in your elbow or forearm?	Y or N	_____
66. Have you ever dislocated or subluxed your elbow?	Y or N	_____
67. Have you ever had an operation or surgery on your elbow or forearm?	Y or N	_____

68. Have you ever had any of the following tests performed on your elbow or forearm? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

HAND/WRIST/FINGERS	Date(s)

69. Have you ever suffered an injury to your hand, wrist, or fingers? Y or N _____
70. Have you ever sustained a fractured bone in your hand, wrist, or fingers? Y or N _____
71. Have you ever dislocated or subluxed you hand, wrist, or fingers? Y or N _____
72. Have you ever had an operation or surgery on your hand, wrist, or fingers? Y or N _____
73. Have you ever had any of the following tests performed on your hand, wrist, or fingers? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

THIGH	Date(s)

74. Have you ever suffered an injury to your thigh, quadriceps muscles, or hamstring muscles? Y or N _____
75. Have you ever had any of the following tests performed for a thigh, quadriceps, or hamstring injury? *(Check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

KNEE	Date(s)

76. Have you ever injured your knee, or had locking, clicking, giving way, or swelling in your knee? Y or N _____
77. Have you ever suffered a patellar (kneecap) dislocation or subluxation? Y or N _____
78. Have you ever had any ligament injuries in your knee (ACL, PCL, MCL, LCL)? Y or N _____
79. Have you ever had any cartilage injuries in your knee (meniscus tears, articular cartilage defects or tears)? Y or N _____
80. Have you ever had Jumper's Knee, Osgood-Schlatter's Syndrome, or stress fractures? Y or N _____
81. Have you ever had an operation or surgery on your knee? Y or N _____
82. Have you ever had any of the following tests performed for a knee injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

LOWER LEG / ANKLE / FOOT		Date(s)
83. Have you ever suffered any lower leg, ankle, or foot injuries?	Y or N	_____
84. How many ankle sprains have you sustained?	Right: _____	Left: _____
85. Have you ever had shin splints?	Y or N	_____
86. Have you ever fractured a bone or had a joint dislocation in your lower leg, ankle, or foot?	Y or N	_____
87. Have you ever had an operation or surgery on your lower leg, ankle, or foot?	Y or N	_____
88. Have you ever had instability, a feeling of giving out or weakness in your ankles?	Y or N	_____
89. Have you ever had injections or surgery for an ankle related trauma?	Y or N	_____
90. Has an ankle injury ever caused you to miss practice or games?	Y or N	_____
91. Have you ever had turf toe?	Y or N	_____

92. Have you ever had any of the following tests performed for a lower leg, ankle, or foot injury? *(Please check all that apply, and provide dates of tests)*

☐ X-Ray: _____ ☐ MRI: _____ ☐ CT/CAT Scan: _____ ☐ Physical Therapy:_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

NEUROLOGICAL		Date(s)
93. Have you ever had a seizure?	Y or N	_____
94. Have you ever been diagnosed with epilepsy?	Y or N	_____
95. Do you have headaches or migraines?	Y or N	_____
96. Do you have headaches or migraines with exercise?	Y or N	_____

If Yes, what is/was the name of the medication? _____

How often do you take this medication? _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

SKIN		Date(s)
97. Have you ever had any skin problems (e.g. eczema, rashes, itching, acne, warts, fungus, or blisters)?	Y or N	_____
98. Have you ever had any skin problems (ringworm, herpes, skin infection)?	Y or N	_____
99. Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body?	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

ALLERGIES **Date(s)**

100. Are you allergic to anything (medication, insect bites or stings, food, etc.)? Y or N _____
If yes, what are you allergic to? _____

101. Do you have any seasonal allergies that require medication? Y or N _____

102. Are you currently taking, or have you ever taken, allergy medication? Y or N _____
If Yes, what is/was the name of the medication? _____

How often do you take this medication? _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

DIABETIC HISTORY **Date(s)**

103. Have you or anyone in your family ever been diagnosed with diabetes? Y or N _____

104. Are you currently taking any diabetic medication? Y or N _____

If Yes, please provide the following information:

Name of Medication: _____

Dosage of Medication: _____

Frequency of Medication: _____

Form of Medication (oral, injectable, etc.):_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

HEAT-RELATED ILLNESSES **Date(s)**

105. Have you ever suffered from any of the following heat-related illnesses? *(Check all that apply and provide dates)*

☐ Heat Cramps Y or N _____

☐ Heat Syncope (fainting) Y or N _____

☐ Heat Exhaustion Y or N _____

☐ Heat Stroke Y or N _____

106. Have you ever been hospitalized for a heat-related illness? Y or N _____

If you answered, "Yes" to any of the above questions, please explain:

_____

_____

PERSCRIPTION MEDICATION

107. Please list all prescription and over-the-counter medications you are currently taking:

Medication	Purpose	Dosage	Frequency

Supplements / Ergogenic Aids

108. Please list **ALL** Supplements / Cryogenic Aids that you are **CURRENTLY** taking of **Have Taken** in the past two (2) tears and for **WHAT PURPOSE**:

Supplement	Purpose	Dosage	Frequency	Dates

GENERAL

		Date(s)
109. Have you ever been diagnosed with Hepatitis A, B, or C?	Y or N	_____
110. Have you ever been diagnosed with Mononucleosis, Tuberculosis, or Epstein-Barr?	Y or N	_____
111. Have you ever had an injury to any of your internal organs (liver, spleen, kidney, etc)	Y or N	_____
112. Have you ever experienced, or been treated for, exertional syncope (fainting)?	Y or N	_____
113. Do you have a family history of Marfan's Syndrome?	Y or N	_____
114. Have you ever had an examination of the femoral pulse?	Y or N	_____
115. Do you have any ongoing or chronic illnesses?	Y or N	_____
116. Have you ever been under the care of a psychiatrist or psychologist?	Y or N	_____
117. Have you ever had or do you have anorexia, bulimia, or an eating disorder?	Y or N	_____
118. Have you ever used laxatives, diuretics or diet pills for weight loss?	Y or N	_____
119. Have you ever had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?	Y or N	_____
120. Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?	Y or N	_____
121. Have you ever had any injury or illness other than those already noted?	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

ASTHMA

		Date(s)
122. Have you ever been diagnosed with asthma and/or exercise-induced asthma (EIA)?	Y or N	_____
123. Are you presently taking, or have you ever taken, asthma medication? If yes, what is/was the name of the medication? _____	Y or N	_____
124. Do you cough, wheeze or have difficulty breathing during or after exercise?	Y or N	_____
125. Do you currently use an inhaler? If yes, what is the name of the inhaler? _____	Y or N	_____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

_____

LOYOLA MARYMOUNT UNIVERSITY
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FEMALES ONLY	Date(s)

126. Have you ever gone three months or more without your menstrual cycle? Y or N _____

127. Does your menstrual cycle change with an increase/decrease in the intensity, frequency or duration of training Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

128. Have you ever been treated for anemia (low hemoglobin or low iron)? Y or N _____

If you answered, "Yes" to any of the above questions, please explain: _____

_____

129. Do you have a family history of Osteoporosis (thinning of bones)? Y or N _____

130. Are you currently taking birth control medication? Y or N _____
If yes, what is the name of the birth control medication? _____

131. Do you take any medications during your menstrual period? Y or N _____
If yes, what is the name of this medication? _____

If yes, were they prescribed for (circle below):
Irregular periods / No periods / Painful periods / Birth Control

If you answered "Yes" to any of the above questions, please explain:_____

_____

Immunizations / Vaccinations	Date(s)

132. Tetanus Booster Y or N _____

133. Hepatitis B Vaccination Y or N _____

134. MMR (Measles, Mumps, Rubella) Y or N _____

135. Tuberculosis Test Y or N _____

IMPORTANT:
Provide a written record of the immunizations from your health care provider.
If you don't have the record or have not received the vaccine, please do so before submitting your Medical Clearance Packet. ***You will be restricted from participation if this is not complete.***

********** REQUIRED SIGNATURES for ALL STUDENT-ATHLETES! *********

I verify that all the information is accurate and complete. I have the responsibility to report any changes in my health to LMU Sports Medicine Department. I understand that failure to disclose previous or current medical conditions may result in a medical disqualification. I understand that Loyola Marymount University is not responsible for expenses related to any previously existing conditions.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____
MUST BE AN MD

This Medical History Form MUST be signed by both the LMU Student-Athlete AND a Physician!

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

Student-Athlete Physical Examination Form

Must be completed by Physician only

Athlete Name: _____

Height: _____ Visual Acuity: Right…….20/ Hearing: Right ☐ Normal
Weight: _____ Left……..….20/ *(Using Finger Rub Test)* ☐ Decreased
Pulse Rate: _____ ☐ Uncorrected
Blood Pressure: _____ ☐ Glasses Left ☐ Normal
☐ Contacts ☐ Decreased

Please list all medications this athlete is currently taking:

1. _____ Reason: _____ Dosage/Freq: _____
2. _____ Reason: _____ Dosage/Freq: _____
3. _____ Reason: _____ Dosage/Freq: _____
4. _____ Reason: _____ Dosage/Freq: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Eyes	_____	_____	Musculoskeletal	_____	_____
Ears	_____	_____	Neurological	_____	_____
Respiratory	_____	_____	Lymph Nodes	_____	_____
Cardiovascular	_____	_____	Abdomen	_____	_____
Nose/Sinuses	_____	_____	Mouth/Teeth	_____	_____
Hernia	_____	_____	Skin	_____	_____
Chest/Lungs	_____	_____	Heart (Marfans)	_____	_____
Vessels	_____	_____	Joints	_____	_____
G.U.	_____	_____	Head/Neck	_____	_____
EKG	_____	_____	Spine	_____	_____

(Copy of EKG Report is Required)

Please list any health concerns for this athlete:

1. _____
2. _____
3. _____
4. _____

Please list any Recommendations/Limitations/Medications Prescribed:

1. _____
2. _____
3. _____
4. _____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

PHYSICIAN'S STATEMENT

I hereby certify that _____ medical history form was reviewed
Name of Student-Athlete

by me, and that he/she was examined by me on_____, and was found to have no previous
Date

history of problems, and is physically fit to engage in all NCAA Division I intercollegiate sports and activities, including strenuous

weight training, conditioning, practices and competitions without any restrictions or limitations.

Physician's Name (Print): _____

Physician's Signature: _____
MUST BE A MD – RNs AND PAs MAY NOT SIGN

Physician's Address: _____

Physician's Phone: _____

Please place the Physician's stamp or card in the space below:

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

Concussion Information

Loyola Marymount University Sports Medicine is committed to the safety and welfare of LMU student-athletes. In conjunction with the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS), the LMU Sports Medicine staff has implemented a concussion management plan to prevent, identify, evaluate, and manage concussions sustained by our student-athletes while participating in competitive sports. This management protocol provides the appropriate guidelines that should be followed in an event that a student-athlete suffers a concussion or traumatic brain injury (TBI). LMU student-athletes who sustain a concussion or traumatic brain injury (TBI) during a non-sports related activity will be managed in the same manner as those sustained during an athletic activity.

What is a Concussion?

The most common head injury in athletics is a concussion, which is a transient disturbance of neurologic function caused by trauma. A concussion is a brain injury that may be caused by a blow to any part of the body, most especially the head, face, and neck. This force is then transmitted through the body to the head, where there is a subsequent potential for injury to the brain. A concussion can also occur when an athlete collides with another hard object such as the ground, other players, or athletic equipment (e.g. bat, ball etc). It is important to remember that, because of the nature of a concussion, this type of head injury can occur in any sport. If a concussion is not managed correctly, there is the potential for serious complications. What appears to be a "little headache", or just a "little or minor ding" to the head has a high risk of catastrophic outcomes if the student-athlete is allowed to return to practice or competition too quickly. Studies have found that people who have received one concussion are at a higher risk to receive a concussion in the future.

Signs & Symptoms of Concussion

- Headache
- Dizziness or confusion
- Blurred or double vision
- Nausea (feeling that you might vomit)
- Extreme drowsiness or sleepiness
- Amnesia (memory loss)
- Feeling sluggish or groggy
- Concentration or memory deficits
- Sensitivity to light or noise
- Persistent ringing in the ears
- Fatigue or Low Energy
- Slowed reaction time

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, reading or video games may cause concussion symptoms (such as headache or feeling tired) to reappear or get worse.

What should I do if I think I have a Concussion?

REPORT IT to your Certified Athletic Trainer **immediately**, if you have any of the above symptoms. Do not ignore a blow to the head, neck or face. Do not wait for symptoms to go away. If your teammate may be suffering from any of the symptoms notify your certified athletic or coach. A concussion can affect your class performance, your ability to do every day activities, your sleep and your mood.

What do I if I am diagnosed with a concussion?

REST! Allow yourself to heal. Your brain, like any other injury, needs time to heal. While your brain is healing, you are much more likely to sustain another concussion. In rare cases, repeat concussions can cause permanent brain damage or even death. Your Certified Athletic Trainer and team physician (neurologist) will tell you what to do and will determine when you are cleared to return to play**. For more information and resources, visit wwwNCAA.org/health-safety and www.CDC.gov/Concussion.**

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

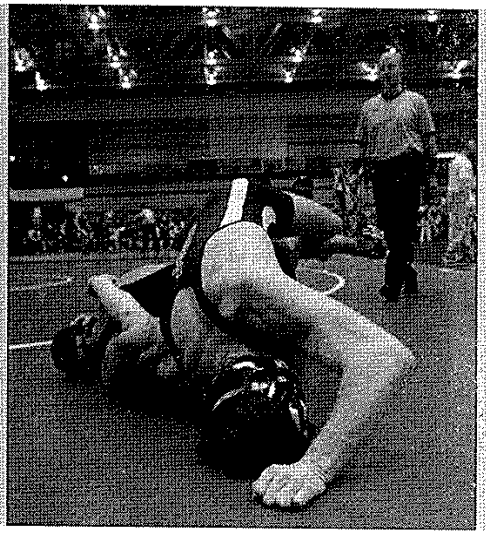
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

Student-Athlete Concussion Statement

☐ I understand that it is my responsibility to report **all injuries** and **illnesses** to my Certified Athletic Trainer and/or team physician.

☐ I have read and understand the *Loyola Marymount Sports Medicine Concussion Information Sheet*.

After reading the ***Loyola Marymount Sports Medicine Concussion Information Sheet***, I am aware of the following information.

_____ A concussion is a brain injury, which I am responsible for reporting to my Certified Athletic Trainer and/or team physician.
Initial

_____ I will not return to play in a game or practice if I have received a blow to the head, neck, face or body that results in concussion-related symptoms.
Initial

_____ You cannot see a concussion, but you might notice some of the symptoms right away, but other symptoms can show up hours or days after the injury.
Initial

_____ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my Certified Athletic Trainer and/ or team physician.
Initial

_____ A concussion can affect your class performance, your ability to do every day activities, your sleep and your mood.
Initial

_____ Following a concussion, the brain needs time to heal. You are much more likely have a repeat concussion if you return to play before your symptoms are resolved.
Initial

_____ Your Certified Athletic Trainer and team physician and/or neurologist will tell you what to do and will determine when you are cleared to return to play.
Initial

_____ In rare cases, repeat concussions can cause permanent brain damage, and even death.
Initial

_____
Print Name of Student-Athlete

_____ Date: _____
Student-Athlete Signature:

_____ Date: _____
Parent/Guardian Signature

(Required for ALL student-athletes regardless of age)

SICKLE-CELL TRAIT FORM

The NCAA recommends that member institutions confirm the Sickle Cell Trait status of **ALL** of their student-athletes if that information is not already known. The NCAA's recommendation follows the latest guidelines from the National Athletic Trainers Association and the College of American Pathologists who also recommend screening for the Sickle Cell Trait. In accordance with these recommendations, the LMU Sports Medicine Department requires that **ALL** LMU student-athletes provide official documentation of the results of Sickle Cell Trait testing, so that appropriate measures can be taken to protect them against potentially serious health risks.

Many states, including California test all newborns for the Sickle Cell Trait as part of standard screening. Incoming student-athletes may be able to obtain a copy of their test results either as part of their medical records or by contacting the public health agency in the state where they were born. Please note that obtaining test results from state governments can take up to a month and student-athletes may not participate in athletic activity including voluntary workouts until a test result is presented.

Name of Doctor/Facility who conducted the test: _____

Address of Doctor/Facility: _____

Phone Number of Doctor/Facility: _____

Date of Testing: _____

Results of Testing: ☐ Positive ☐ Negative

YOU MUST ALSO PROVIDE A COPY OF DOCUMENTATION, WHICH CLEARLY INDICATES THE RESULTS OF SICKLE CELL TRAIT TESTING.

PLEASE INCLUDE THE DOCUMENTATION ALONG WITH THIS MEDICAL PACKET!

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER FORM

☐ I **HAVE NOT** been diagnosed with Attention Deficit Disorder (ADD).Attention Deficit Hyperactivity Disorder (ADHD).

☐ I **HAVE** been diagnosed with Attention Deficit Disorder (ADD). Attention Deficit Hyperactivity Disorder (ADHD).

If you have been diagnosed with ADHD, you must obtain a letter from your physician which provides documentation to the LMU Athletics Department/Sports Medicine Staff regarding your ADHD diagnosis. This letter will be used in support of a NCAA Medical Exception request in the event that a positive drug test should result from the use of prescribed medications from your doctor.

The following must be included in this documentation:

1. Student-Athlete name
2. Student-Athlete date of birth
3. Date of clinical evaluation
4. Clinical evaluation components, including:
    - Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) and attach all supporting documentation.
    - ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary and attach all supporting documentation.
    - Blood pressure and pulse readings and comments.
    - Note that alternative non-banned medications have been considered, and comments.
    - Diagnosis
    - Medication(s) and dosage
    - Follow-up orders

5. Additional ADHD evaluation components should be included if available:
    - Report ADHD symptoms by other significant individuals.
    - Psychological testing results.
    - Physical exam date and results.
    - Laboratory/testing results.
    - Summary of previous ADHD diagnosis.
    - Other comments.

6. Documentation from prescribing physician must also include:
    - Physician name (Printed)
    - Office address and contact information.
    - Specialty.
    - Physician signature and date.

7. **Student-athlete will need to have an updated letter from the prescribing physician on file each year of their eligibility.**

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

PERSONAL MEDICAL INSURANCE INFORMATION

This form must be filled out completely. Incomplete or insufficient information will delay the processing of claims and the payments of medically related bills. If you have any questions regarding your ability to complete this form, please contact the LMU Athletic Training Room at (310) 338-2874.

Student-Athlete Full Name: _____

Date of Birth: ____/_____/_____ Sport: _____ Sex: M _____ F _____

Medical Insurance Company: _____

Address: _____

Medical Insurance Company Phone Number: _____

Medical Insurance Company Contact Person (if applicable): _____

Policy #: _____ Group #:_____

ID #: _____ Bin #: _____

This Medical Insurance is a *(check all that apply)*: ☐ HMO ☐ PPO ☐ POS ☐ Indemnity Plan

Does this insurance policy provide prescription drug coverage? Yes or No

Is your Son/Daughter covered by the above policy? Yes or No

Does this policy cover athletically related injuries? Yes or No

Policy Holder's Information

Policy Holder's Full Name: _____

Policy Holder's Date of Birth: ____/_____/_____ Policy Holder's Social Security #: _____

Policy Holder's Address: _____

Policy Holder's Home Phone: _____

Policy Holder's Place of Employment: _____

Policy Holder's Work Address: _____

Policy Holder's Work Phone: _____

I give my permission to LMU Sports Medicine to file claims for medical services with the above health care insurer.

I understand that it is my responsibility to notify the LMU Sports Medicine Department of any changes in my family's insurance coverage to avoid unnecessary complications in the event my son or daughter is injured.

Parent/Guardian Signature: _____ Date: _____

Parent Printed Name: _____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

DENTAL INSURANCE INFORMATION

This form must be filled out completely. Incomplete or insufficient information will delay the processing of claims and the payments of medically related bills. If you have any questions regarding your ability to complete this form, please contact the LMU Athletic Training Room at (310) 338-2874.

Dental Insurance Company: _____

Address: _____

Dental Insurance Company Phone Number: _____

Dental Insurance Company Contact Person (if applicable): _____

Policy #: _____ Group #: _____

ID #: _____ Bin #: _____

This Dental Insurance is a *(check all that apply)*: ☐ HMO ☐ PPO ☐ POS ☐ Indemnity Plan

Is your Son/Daughter covered by the above policy? Yes or No

I currently do not have dental insurance coverage. ☐

Policy Holder's Information

Policy Holder's Full Name:
_____

Policy Holder's Date of Birth: ____/_____/_____ Policy Holder's Social Security #: _____

Policy Holder's Address: _____

Policy Holder's Home Phone: _____

Policy Holder's Place of Employment: _____

Policy Holder's Work Address: _____

Policy Holder's Work Phone: _____

I give my permission to LMU Sports Medicine to file claims for medical services with the above health care insurer.

I understand that it is my responsibility to notify the LMU Sports Medicine Department of any changes in my family's insurance coverage to avoid unnecessary complications in the event my son or daughter is injured.

Parent/Guardian Signature: _____ Date: _____

Parent Printed Name: _____

LOYOLA MARYMOUNT UNIVERSITY
Department of Sports Medicine

VISION INSURANCE INFORMATION

This form must be filled out completely. Incomplete or insufficient information will delay the processing of claims and the payments of medically related bills. If you have any questions regarding your ability to complete this form, please contact the LMU Athletic Training Room at (310) 338-2874.

Vision Insurance Company: _____

Address: _____

Vision Insurance Company Phone Number: _____

Vision Insurance Company Contact Person (if applicable): _____

Policy #: _____ Group #: _____

ID #: _____ Bin #: _____

This Vision Insurance is a *(check all that apply)*: ☐ HMO ☐ PPO ☐ POS ☐ Indemnity Plan

Is your Son/Daughter covered by the above policy? Yes or No

I currently do not have vision insurance coverage. ☐

Policy Holder's Information

Policy Holder's Full Name: _____

Policy Holder's Date of Birth: ____/_____/_____ Policy Holder's Social Security #: _____

Policy Holder's Address: _____

Policy Holder's Home Phone: _____

Policy Holder's Place of Employment: _____

Policy Holder's Work Address: _____

Policy Holder's Work Phone: _____

I give my permission to LMU Sports Medicine to file claims for medical services with the above health care insurer.

I understand that it is my responsibility to notify the LMU Sports Medicine Department of any changes in my family's insurance coverage to avoid unnecessary complications in the event my son or daughter is injured.

Parent/Guardian Signature: _____ Date: _____

Parent Printed Name: _____

IMPORTANT

Please submit a front and back copy of MEDICAL INSURANCE, DENTAL/VISION and PRESCRIPTION CARDS. ALL ARE REQUIRED PRIOR TO PARTICIPATION. Please make sure the copy is legible.

Upon completion of this medical clearance packet, it will be reviewed and signed by a Staff Certified Athletic Trainer.

Signature: _____A.T.C., Date:_____