

Dear Student-Athlete:

Welcome to Marquette University Athletics. The Sports Medicine Staff wants to ensure that you have a safe and successful career while an athlete at Marquette University. As such, there are several steps you **must** take and forms you **must** complete before you will be allowed to participate in **any** Marquette University athlete team workout, practice or game. The Marquette University Sports Medicine Staff will issue final medical clearance for participation.

**All returning athletes are required to complete a *Pre-Season Health Questionnaire*.**

**All forms in this packet must be completed. Incomplete forms will not be accepted.** Please read each form carefully and provide the required information. Some forms may require multiple signatures. The *Assumption of Risk Form* requires a witness signature in addition to your signature. Any individual over the age of 18 qualifies as a witness. Your parent or guardian must also sign the forms if you are under the age of 18. The accurate completion of these forms is very important. **All new and returning athletes are required to submit a new set of forms every year.**

Please submit all completed forms **no later than July 27<sup>th</sup>**. You may return your forms to the Al McGuire Sports Medicine Center, 770 N. 12<sup>th</sup> Street, Milwaukee, WI, 53233. Failure to return your completed forms will result in a delay in your clearance for participation. If you have any questions, please contact a member of our sports medicine staff at (414) 288-0329. We look forward to seeing you in the fall.

Sincerely,

Jeremy Johnson, ATC  
Head Athletic Trainer

Aaron Doering, ATC  
Assistant Athletic Trainer

**MARQUETTE UNIVERSITY SPORTS MEDICINE  
PRE-SEASON HEALTH QUESTIONNAIRE**

**Name:** \_\_\_\_\_

**Sport:** \_\_\_\_\_

**Local Address:** \_\_\_\_\_  
\_\_\_\_\_

**Local Phone:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

Please indicate below if you experienced any of the following injuries listed since the END of your season at Marquette by circling "YES". If you are currently experiencing any of these problems, please circle "CURRENTLY". Please give the date of occurrence and any treatment received if you answer "YES" to any question.

<b>HEAD/FACE</b>		
Head Injury/Concussion	Yes	Currently
Eye Injury	Yes	Currently
Nasal Fracture	Yes	Currently
Jaw Injury	Yes	Currently
Other _____		
Remarks _____		

<b>LOWER EXTREMITY</b>		
Gluteal muscle injury	Yes	Currently
Hip Injury	Yes	Currently
Groin Pain/Injury	Yes	Currently
Hamstring Injury	Yes	Currently
Quadricep/Thigh Injury	Yes	Currently
Knee Injury	Yes	Currently
Calf Injury	Yes	Currently
Shin Pain/Injury	Yes	Currently
Achilles Injury	Yes	Currently
Ankle Injury	Yes	Currently
Foot Injury	Yes	Currently
Toe Injury	Yes	Currently
Other _____		
Remarks _____		
_____		

<b>UPPER EXTREMITY</b>		
Shoulder Injury	Yes	Currently
Upper Arm Injury	Yes	Currently
Elbow Injury	Yes	Currently
Forearm Injury	Yes	Currently
Wrist Injury	Yes	Currently
Hand/Finger Injury	Yes	Currently
Other _____		
Remarks _____		

<b>CHEST</b>		
Clavicle Injury	Yes	Currently
Sternum Injury	Yes	Currently
Rib Injury	Yes	Currently
Other _____		
Remarks _____		

<b>SPINE</b>		
Neck injury		
Mid-back pain/injury		
Low-back pain/injury		
Sacroiliac pain/injury		
Other _____		
Remarks _____		

<b>ABDOMEN</b>		
Abdominal muscle strain	Yes	Currently
Hernia	Yes	Currently
Spleen injury	Yes	Currently
Other _____		
Remarks _____		

**QUESTIONS**

1. Since the end of your season, have you been hospitalized for medical or psychiatric reasons?  
\_\_\_\_ YES \_\_\_\_ NO. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
2. Since the end of your season, have you had any surgeries? \_\_\_\_ YES \_\_\_\_ NO. If yes, explain  
type, body part and date of surgery. \_\_\_\_\_  
\_\_\_\_\_
3. Since the end of your season, did you have any illnesses that required you to see a physician?  
\_\_\_\_ YES \_\_\_\_ NO. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Are you taking any medication, vitamins or supplements? \_\_\_\_ YES \_\_\_\_ NO. If yes, please list  
name and dosage. Please include both prescription and non-prescription medication. \_\_\_\_\_  
\_\_\_\_\_
5. Do you have any known allergies to medications? \_\_\_\_ YES \_\_\_\_ NO. If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
6. Do you, your parents or your physician believe that there should be any limitation to your full  
sports participation this season? \_\_\_\_ YES \_\_\_\_ NO. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
7. Please list any conditions or problems that you are currently having that may not have been  
mentioned above. If none, please write "NONE" on the lines below. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I, \_\_\_\_\_, agree that the above information is accurate and that  
falsification or omission on my part would relieve Marquette University of being obligated for  
any condition that results from falsification or omission.**

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (if under 18 years of age): \_\_\_\_\_ Date: \_\_\_\_\_

# Marquette University Department of Athletics

Revised 5/06

## Medical Policy Statement

This is to inform you of particular procedures that pertain to health care of you/your son and/or daughter while they are participating in their respective sport(s) for Marquette University (MU). Please keep the information handy. Should you/your child be injured as a result of participating in athletics at MU, the following information will be useful and pertinent.

1. All athletes receive the same care whether they are Male, Female, Scholarship Athletes, Non-scholarship Athletes, Revenue Sport or Non-Revenue Sport.
2. The National Collegiate Athletic Association (NCAA) does not allow MU, or any other NCAA school, to pay for health insurance or any medical referral that is not a direct result of you /your child's athletic participation.
3. All athletes are ***required*** to have medical insurance. Athletes are required to submit a copy of their insurance card to the MU Sports Medicine Staff.
4. MU's accident insurance for athletes is designed as a secondary provider.

### **A. Explanation of Insurance Coverage**

a. The *primary* source of payment is the individual health insurance coverage of the athlete or of the athlete's parents. **YOUR INSURANCE WILL BE BILLED FIRST.** We may occasionally ask you to check on or obtain referrals or authorization through your insurance prior to non-emergency injury treatment. It is the **ATHLETE'S RESPONSIBILITY** to obtain proper authorization and/or verify coverage with his/her insurance company. If your insurance company procedures are not followed, (i.e. authorization, obtain referral, etc.), MU will be unable to pay your claims.

b. If you follow all of your insurance company's procedures and your insurance policy does not fully cover the charges, MU will pay the balance. It is the **ATHLETE'S RESPONSIBILITY** to send us the necessary paperwork from your insurance company to process the claim. The following items are needed to process any claim: 1. Explanation of Benefits or Denial. 2. Itemized Bill.

c. MU's insurance coverage is a **secondary** insurance policy. This policy covers only sport-related injuries and/or illness as described in the medical referral policy.

d. All insurance claims must be resolved within one calendar year of each specific injury. If this is not followed, the athlete and/or family may be responsible for any remaining bills.

### **B. Physician Referrals/Consultations**

- a. All student-athletes **must** be evaluated by a MU staff athletic trainer before referral to a physician will be made. A MU staff athletic trainer must authorize and properly refer all student-athletes for care administered by a physician or medical consultant (except in the event of a sport-related medical emergency).
- b. If a student-athlete seeks medical care from a physician/medical consultant and/or receives any medical evaluation or treatment **without** prior authorization (including a signed medical referral form), the student-athlete and/or the parent(s)/guardian(s) will be financially responsible for any and all medical bills incurred.

### **C. Medical Bills**

- a. In the event that a student-athlete and/or parent(s)/guardian(s) should receive a bill/statement for medical care associated with an injury/illness that occurred as a direct result of participation in intercollegiate athletics at Marquette University, the student-athlete must submit the bill/statement to his/her staff athletic trainer **within 30 business days of receipt.**

**\*\*BILLS RECEIVED AFTER 30 BUSINESS DAYS WILL BE THE RESPONSIBILITY OF THE STUDENT-ATHLETE AND/OR THE STUDENT-ATHLETE'S PARENT(S)/GUARDIAN(S). \*\***

**Any questions concerning your child's health care can be directed to:  
Jayd Grossman, ATC – Head Athletic Trainer  
Marquette University  
(414)288-3067**

**Any questions concerning your child's insurance coverage can be directed to:  
Jeremy Johnson, ATC – Assistant Athletic Trainer  
Marquette University  
(414)288-0328**

.....  
**PLEASE KEEP THIS MEDICAL POLICY  
INFORMATION PACKET FOR YOUR RECORDS.**  
.....

**Medical/Insurance Policy Statement Acknowledgement**

I, \_\_\_\_\_, have read and understand the stated Marquette University procedures concerning health care and insurance coverage for injuries that may occur to myself/my son/my daughter while participating in intercollegiate athletics for Marquette University.

\_\_\_\_\_  
Athlete's Name (print)

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature (if under 18 yrs old)

\_\_\_\_\_  
Date

## Athlete Information Form

### Demographics

Name: \_\_\_\_\_ Sport: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Local Address: \_\_\_\_\_ Local Phone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Emergency Contact Information

1. Parents/Guardian Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

2. Parents/Guardian Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Miscellaneous

Allergies: Y / N

(if yes please specify): \_\_\_\_\_

## **Insurance Information Form**

Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Policy Holder's SSN: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

\*Does this company require authorization prior to treatment? **Y / N**

\*Do you have prescription insurance coverage? **Y / N**

If yes, please provide a copy of the prescription card along with the medical card below.

**YOU MUST PROVIDE A COPY OF YOU INSURANCE CARD(S) – FRONT & BACK**

**FRONT**

**BACK**

---

By my signature, I agree that the above information is accurate and that falsification or omission on my part would relieve Marquette University of any obligation that may result from this falsification or omission.

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if under 18 yrs. of age)

\_\_\_\_\_  
Date

## **Personal Information Disclosure Consent Form**

Under the Family Education Right and Privacy Act, personally identifiable information about a student may not be released to a third party without the written permission of the student. Therefore, it is necessary for the Athletic Department to have your written release before we can share the following kinds of information with the news media and/or other interested parties.

For each item you **DO NOT** want made public, you need to:

1. Write the phrase "Do not release"
2. Initial the corresponding phrase

**REGARDLESS OF WHETHER OR NOT YOU OBJECT TO ANY OR ALL OF THE BELOW LISTED INFORMATION, PLEASE PRINT YOUR NAME, SIGN AND DATE THIS FORM WHERE INDICATED.**

-----

I hereby consent to and agree that Marquette University may release, to any third party or representative of the news media, information concerning me of the following nature:

1. Directory information (e.g. name, address, year, major, height, weight, etc.)
2. Marital status (e.g. single, married, divorced, spouse's name, etc.)
3. Academic performance record (e.g. cumulative GPA, semester GPA, academic eligibility, etc.)
4. Athletic performance record (game, season, career, etc.)
5. Current Health/Injury Status
6. General outcomes of any disciplinary action that might occur while I am a team member (specific details will not be released without my consent)

\_\_\_\_\_  
Athlete's Name (print)

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature (if under 18 yrs old)

\_\_\_\_\_  
Date

## **Acknowledgment of Assumption of Risk**

I, \_\_\_\_\_, hereby expressly and affirmatively state that I wish to participate in the sport of \_\_\_\_\_ at Marquette University. I realize that my participation in this activity involves risks of injury, including, but not limited to severe sprains, strains, fractures, head and neck injuries, the possibility of paralysis or death.

I also recognize that there are many other risks of injury or illness including serious disabling injuries which may arise due to my participation in this activity and that it is not possible to specifically list each individual injury/illness risk. However, knowing the material risks and appreciating, knowing and reasonably anticipating that other injuries and death are possibilities, I hereby assume all of the delineated risks of injury, all other possible risk of injury, and death which could occur by reason of my participation.

I have had an opportunity to ask questions. Any questions I had have been asked and answered to my complete satisfaction. I understand the risks of my participation in this activity. Knowing and appreciating these risks, I voluntarily choose to participate, assuming all risks of injury or death due to my participation.

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if under 18 yrs. of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## **Medical Treatment Consent Form**

I, \_\_\_\_\_, hereby grant permission to Marquette University, its team physicians, Athletic Trainer(s), and other Marquette representatives to provide the needed emergency treatment prior to admission to a medical facility.

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if under 18 yrs. of age)

\_\_\_\_\_  
Date



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

**PARENT/ GUARDIAN/STUDENT INFORMATION FORM**

**RETURN FORM WHEN COMPLETE TO** → Name of College/University \_\_\_\_\_

Attention \_\_\_\_\_

This form is to be completed by the  
 Parents, Guardians or Student.

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.**  
 If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown)

Name of Athlete \_\_\_\_\_ Sport \_\_\_\_\_

Social Security No. or Passport No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

College Address \_\_\_\_\_ College Phone (\_\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**FATHER/ GUARDIAN INFORMATION**

**MOTHER/ GUARDIAN INFORMATION**

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Social Security No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

Medical Insurance  
 Company or Plan \_\_\_\_\_

Medical Insurance  
 Company or Plan \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

Is this plan an HMO or PPO?  Yes  No

Is this plan an HMO or PPO?  Yes  No

Is pre-authorization required to obtain treatment?  Yes  No

Is pre-authorization required to obtain treatment?  Yes  No

Is a second opinion required before surgery?  Yes  No

Is a second opinion required before surgery?  Yes  No

**PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM**



**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 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.

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 or Next of Kin

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Authorized Representative or Next of Kin to Claimant

# PRE-ADMISSION FORM

DATE OF PROCEDURE / TREATMENT / EXAM
--------------------------------------

## PATIENT INFORMATION

NAME: (Last, First, MI)		
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:
MARITAL STATUS:	MAIDEN / FORMER NAME:	DATE OF BIRTH:
RACE / ETHNICITY: (REQUIRED BY STATE OF WIS.)	NAME OF PROCEDURE / TREATMENT / EXAM	
ADMITTING PHYSICIAN:	SOCIAL SECURITY NUMBER:	
EMPLOYER:	OCCUPATION:	
EMPLOYER ADDRESS:	LENGTH OF EMPLOYMENT:	EMPLOYMENT STATUS FT   PT   UNEMPLOYED
CITY:	STATE:	ZIP CODE:
ALLERGIES: (SPECIFY) YES   NO	RELIGION:	PLACE OF WORSHIP:
PRIMARY CARE PHYSICIAN: (IF DIFFERENT FROM ADMITTING PHYSICIAN)		

## PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL ARRANGEMENTS

NAME:		DATE OF BIRTH:
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:	RELATIONSHIP:	
EMPLOYER:	OCCUPATION:	
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:
LENGTH OF EMPLOYMENT:	EMPLOYMENT STATUS: FT   PT   UNEMPLOYED	

## INSURANCE INFORMATION

PRIMARY	SECONDARY
NAME AND ADDRESS OF INSURANCE: <i>(If on card)</i>	NAME AND ADDRESS OF INSURANCE: <i>(If on card)</i> Guarantee Trust Life Ins.
	First Agency, Inc.
	5071 W. H Avenue
	Kalamazoo, MI 49009-8501
SUBSCRIBER / POLICY HOLDER:	SUBSCRIBER / POLICY HOLDER Marquette University
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
SUBSCRIBER NUMBER:	SUBSCRIBER NUMBER:
GROUP NUMBER:	GROUP NUMBER:
GROUP NAME:	GROUP NAME: Marquette

## PERSON TO CONTACT

NAME:			
ADDRESS:			
CITY:		STATE:	ZIP CODE:
PHONE #	ALTERNATE PHONE #		
RELATIONSHIP TO PATIENT:			

### NOTE:

1. Please call (414) 219-6054 if you have any questions about completing this form.
2. Some insurance companies require pre-certification authorization for hospital admittance. Please be sure to contact your insurance company to inform them that you may be admitted to Aurora Sinai Medical Center. This is the best way to confirm your coverage.
3. This form is designed to make your admission faster and easier. Though we have this information, we do need you to bring your insurance card(s) when being admitted.
4. Please return this form to:

**Aurora Sinai Medical Center**  
 Attention: Admitting Department  
 945 N. 12th Street.  
 P.O. Box 342  
 Milwaukee, WI 53201-0342