



## MARQUETTE SPORTS MEDICINE

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 25<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

Ellie Rozumalski, ATC  
Assistant Athletic Trainer

Aaron Doering, ATC  
Assistant Athletic Trainer

Lauren Boyler, ATC  
Assistant Athletic Trainer



# MARQUETTE SPORTS MEDICINE

## Pre-Season Health Questionnaire

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

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

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.

HEAD/FACE		
Head Injury/Concussion	Yes	Currently
Eye Injury	Yes	Currently
Nasal Fracture	Yes	Currently
Jaw Injury	Yes	Currently
Other _____		
Remarks _____		
UPPER EXTREMITY		
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 _____		
_____		
CHEST		
Clavicle Injury	Yes	Currently
Sternum Injury	Yes	Currently
Rib Injury	Yes	Currently
Other _____		
Remarks _____		
ABDOMEN		
Abdominal muscle strain	Yes	Currently
Hernia	Yes	Currently
Spleen injury	Yes	Currently
Other _____		
Remarks _____		

LOWER EXTREMITY		
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 _____		
_____		
_____		
SPINE		
Neck injury	Yes	Currently
Mid-back pain/injury	Yes	Currently
Low-back pain/injury	Yes	Currently
Sacroiliac pain/injury	Yes	Currently
Other _____		
Remarks _____		



## MARQUETTE SPORTS MEDICINE

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 SPORTS MEDICINE

### Athlete Information

#### Demographics

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

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

SSN: \_\_\_\_\_ MU ID: \_\_\_\_\_

#### Local Information

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

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

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

\_\_\_\_\_

#### Home Information

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Emergency Contact Information

#### Primary:

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

E-Mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

#### Secondary:

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

E-Mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



## MARQUETTE SPORTS MEDICINE

### Pertinent Medical Information

Do you have any allergies?	Y	N
If so, what are you allergic to? _____ _____		
Do you have asthma?	Y	N
If so, how is it controlled? _____ _____		
Have you ever been diagnosed with Diabetes?	Y	N
If so, how is it controlled? _____ _____		
Have you ever been diagnosed with Sickle Cell Trait?	Y	N
If so, how is it controlled? _____ _____		
Please list all medications and supplements that you take: _____ _____ _____		



## MARQUETTE SPORTS MEDICINE

### 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

- i. 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 nonemergency 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.
- ii. 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.
- iii. 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.
- iv. 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.



## MARQUETTE SPORTS MEDICINE

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

- i. 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).
- ii. 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**

- i. 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 STUDENTATHLETE'S PARENT(S)/GUARDIAN(S). \*\***

Any questions concerning your child's health care can be directed to:  
Jeremy Johnson, ATC – Head Athletic Trainer  
Marquette University  
(414)288-0328

Any questions concerning your child's insurance coverage can be directed to:  
Ellie Rozumalski, ATC – Assistant Athletic Trainer  
Marquette University  
(414)288-0341

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



## MARQUETTE SPORTS MEDICINE

### 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



## MARQUETTE SPORTS MEDICINE

### 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



## MARQUETTE SPORTS MEDICINE

### Insurance Information

#### Insurance Company

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

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does this company require authorization prior to treatment? Y N

Do you have prescription insurance coverage? Y N

#### Policy Holder

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Relationship to Student-Athlete: \_\_\_\_\_

Employer: \_\_\_\_\_

Please provide a copy of the front and back of you insurance card and prescription card.

FRONT

BACK

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

\_\_\_\_\_

Student-Athlete Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Guardian Signature (if under 18)

\_\_\_\_\_

Date



## MARQUETTE SPORTS MEDICINE

### Female Athlete History Questionnaire

This form is strictly confidential and will only be reviewed by the team physician.

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

1. At what age did you have your first menstrual period? \_\_\_\_\_
2. When was your most recent menstrual period? \_\_\_\_\_
3. How many menstrual cycles have you had in the last year? \_\_\_\_\_
4. Are you currently taking oral contraceptives? \_\_\_\_\_
5. Have you ever taken oral contraceptives? \_\_\_\_\_  
If yes, when did you stop? \_\_\_\_\_
6. How tall are you? \_\_\_\_\_
7. Are you happy with your present weight? \_\_\_\_\_
8. At what weight do you perform best? \_\_\_\_\_
9. In the last year, what has been your lowest weight? \_\_\_\_\_
10. In the last year, what has been your highest weight? \_\_\_\_\_
11. Have you ever used any of the following methods to loose weight?  
(check all that apply)  
 Excessive Exercise       Food Restriction       Diuretics  
 Diet Pills       Laxatives       Binging/Purging
12. Have you ever or do you currently suffer from anorexia or bulimia? \_\_\_\_\_
13. Do you take any vitamin or mineral supplements (ex. Iron)? \_\_\_\_\_  
If yes, please list \_\_\_\_\_
14. Have you ever used a nutritional supplement to improve performance? \_\_\_\_\_  
In the last year? \_\_\_\_\_  
If yes, please list \_\_\_\_\_
15. Have you ever had a stress fracture? \_\_\_\_\_  
If yes, at what sites? \_\_\_\_\_
16. Do you have a family history of osteoporosis? \_\_\_\_\_



## MARQUETTE SPORTS MEDICINE

### Acknowledgement 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



## MARQUETTE SPORTS MEDICINE

### 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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date