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 new or transfer athletes are required to have a physical exam. This may be done by your primary care physician or a physician of your choice. It must be done before you report to campus and done at your expense. The ***Athlete Medical History Form*** must be completed in its entirety and signed by you and your physician.

All forms in this packet must be completed. Incomplete forms will not be accepted. Please read each form carefully and provide the required information. . **All signatures must be hand-written, do not electronically sign forms.** 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 on **single sided pages BEFORE YOUR FIRST DAY ON CAMPUS or no later than July 15th**. If a status change occurs after you turn this in please notify your respective sports medicine staff member. You may return your forms to the Al McGuire Sports Medicine Center, 770 N. 12th Street, Milwaukee, WI, 53233 or fax to 414-288-6477. Failure to return your completed forms will result in a delay in your clearance for participation. If you have any questions, please contact Danielle Armstrong (414)288-0341. We look forward to seeing you in the fall.

Sincerely,

Brandon Yoder, ATC
Director of Sports Medicine

Danielle Armstrong, ATC
Athletic Trainer

Aaron Doering, ATC
Athletic Trainer

Mary Wieczorek, ATC
Athletic Trainer

Marquette Sports Medicine

Athlete Information

Demographics

Name: _____ Sport: _____

Age: _____ Date of Birth: _____

SSN# or Passport #: _____ MU ID#: _____

Local/ On Campus Information

Address: Cell Phone: _____

_____

_____ E-Mail: _____

_____

Permanent/ 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

Are you currently being treated for an injury? Y ☐ N ☐

If so, what? _____

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? _____

_____

Have you ever worn orthotics? Y ☐ N ☐

If so, for what reason? _____

_____

Have you ever been hospitalized for medical or psychiatric reasons? Y ☐ N ☐

If yes, please explain: _____

_____

Indicate the dates and types of surgical operations you have had: _____

_____

Are you being followed by a physician for any medical problems? Y ☐ N ☐

If yes, please explain: _____

_____

The National Collegiate Athletic Association (NCAA) restricts the use of banned substances by student athletes. Student-athletes must inform the sports medicine staff of all medications or supplements that they are taking. Please list all medication (prescription and over the counter), vitamins and/or supplements that you are taking. List the name and the amount:

_____

_____

_____

Marquette Sports Medicine

Medical History

Name:_____ Sport:_____

Please indicate below if you have ever experienced any of these problems by checking "YES". If you are currently experiencing any of these problems, please check "CURRENTLY". Please give the date of occurrence if you answer "YES" to any question.

Marquette University respects the privacy of your personal health information. Please see www.marquette.edu/hipaa for a complete explanation of Marquette's health care privacy policy and practices.

EYE	Yes	Currently
Corrective Lenses/Contacts	☐	☐
Disabling loss of vision	☐	☐
Other _____		
Remarks_____		

EAR, NOSE, THROAT	Yes	Currently
Ear Problems	☐	☐
Recurrent Sinusitis	☐	☐
Allergies/Hay Fever	☐	☐
Recurrent Nosebleeds	☐	☐
Other _____		
Remarks_____		

HEART DISEASE	Yes	Currently
High blood pressure	☐	☐
Heart palpitations	☐	☐
Heart Murmur	☐	☐
Marfan's Syndrome	☐	☐
Kawasaki Disease	☐	☐
Other _____		
Remarks_____		

RESPIRATORY	Yes	Currently
Asthma	☐	☐
Exercise-induced asthma	☐	☐
Other _____		
Remarks_____		

ABDOMINAL	Yes	Currently
Irritable bowel syndrome	☐	☐
Inflammatory bowel disease	☐	☐
Reflux esophagitis	☐	☐
Hernia	☐	☐
Hepatitis/Jaundice	☐	☐
Other _____		
Remarks_____		

ENDOCRINE	Yes	Currently
Diabetes	☐	☐
Thyroid Disorder	☐	☐
Other _____		
Remarks_____		

URINARY	Yes	Currently
Kidney Stones	☐	☐
Urinary Tract Infections	☐	☐
Undescended testicle	☐	☐
Testicular mass/lump	☐	☐
Other _____		
Remarks_____		

HEMATOLOGICAL/ ONCOLOGICAL	Yes	Currently
Anemia	☐	☐
Cancer	☐	☐
Immune Disorder	☐	☐
Sickle Cell Trait	☐	☐
Other _____		
Remarks_____		

NEUROLOGICAL	Yes	Currently
Seizures	☐	☐
Headaches/Migraines	☐	☐
Fainting/Dizziness	☐	☐
Head Injury/Concussion	☐	☐
Other _____		
Remarks_____		

PSYCHOLOGICAL	Yes	Currently
Depression	☐	☐
Anxiety/Panic Disorder	☐	☐
ADD/ADHD	☐	☐
Eating Disorder	☐	☐
Other _____		
Remarks_____		

Marquette Sports Medicine

GYNECOLOGICAL	Yes	Currently
Irregular Periods	☐	☐
Severe Cramps	☐	☐
Ovarian Cyst	☐	☐

Other _____

Remarks_____

INFECTIOUS DISEASE	Yes	Currently
Mononucleosis	☐	☐
Chicken Pox	☐	☐
Tuberculosis	☐	☐
Rheumatic Fever	☐	☐

Other _____

Remarks_____

During the past year:

Have you often been bothered by feeling down, depressed, or hopeless?

____ yes ____ no

Have you often been bothered by little interest in pleasure doing things?

____ yes ____ no

MUSCULOSKELETAL	Yes	Currently
Bone fractures	☐	☐
Stress fractures	☐	☐
Joint dislocation/subluxation	☐	☐
Foot/ankle injury	☐	☐
Knee Injury	☐	☐
Hip Injury	☐	☐
Shoulder Injury	☐	☐
Osgood Schlatter's Disease	☐	☐
Shin splints	☐	☐
Scoliosis	☐	☐
Back pain/problems	☐	☐

Other _____

Remarks_____

_____

_____

SUPPORTING DOCUMENTATION

Check if you have ever had any testing/imaging related to sports or physical activity:

X-ray ☐

MRI ☐

CT Scan ☐

EKG or Echocardiogram ☐

Surgery ☐

Currently in physical therapy ☐

Any other medical test: _____

***If yes, you must provide results from supporting documentation before you are cleared**

Social History

Alcohol Use:

How often do you have a drink? ☐ Never ☐ ≤ once a month ☐ 2-4 times a month ☐ 2-3 times a week ☐ ≥ 4 times a week

How many drinks at a time? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ ≥ 10

How often do you have: 4 or more drinks (for women) or 5 or more drinks (for men)

☐ Never ☐ < Monthly ☐ Monthly ☐ Weekly ☐ Daily

Tobacco Use:

Do you use tobacco? ____ yes ____no Are you interested in quitting? ____ yes ____ no

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

Physical Exam
(To be completed by healthcare provider)

Please review the patient's history and complete this form.
Please comment on all positive answers.

Patient's Name:_____

Blood pressure: ____/____ Height:_____inches Weight:_____lbs

	Normal	Abnormal	Comments
EENT			
Mouth/Teeth Gums			
Neck/Thyroid			
Lungs/Chest			
Heart			
Abdomen			
Lymph Nodes			
Skin			
Neuro			
Musculoskeletal/ Extremities			
Back/Spine			

Physician Information:

Name: _____
Address: _____
_____
_____
Phone: _____
Fax #: _____

Is this patient medically qualified to participate in intercollegiate athletics? ☐**Yes** ☐**No**

Clinician's Signature: _____

Clinician's Printed Name: _____

Date exam was completed: _____

Marquette Sports Medicine

Personal Insurance Information

Student-Athlete Name: _____ **Date of Birth:** _____

Insurance Company

Name: _____

Policy #:_____ Group #: _____

Insurance Address: Insurance Phone #: _____

_____ Date Effective: _____

_____

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 your 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

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 your child be injured as a result of participating in intercollegiate athletics at MU, the following information will be useful and pertinent.

1. All student-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 treatment or any medical referral that is not a direct result of you /your child's athletic participation at Marquette University.

3. All student-athletes are *required* to have private medical insurance for routine medical and health treatment such as sickness etc. Student-athletes are required to submit a copy of their private health insurance card to the MU Sports Medicine Staff.

4. Any medical procedures needed to establish medical clearance for an incoming student-athlete is the financial responsibility of the student-athlete.

A. Explanation of Insurance Coverage for medical treatment related to MU sports participation.

i. Marquette University provides secondary insurance coverage for all sports related treatments authorized by athletic trainers for all student-athletes. Sports related medical bills should be submitted to the student-athlete's primary coverage provided by Marquette if related to athletic injury or illness. Any excess will then be submitted to MU's secondary insurance. There are some instances when a medical procedure is related to health issues and not as a direct result of sports participation, such as hernia's, appendectomy and a few surgical procedures not directly related to a sports injury.

When applicable, medical bills should be submitted to the MU insurer within 90 days. If you or your child receive medical bills or explanation of benefits (EOB's) related to a sports injury or sickness, please send them to a staff athletic trainer or have your provider contact us for proper submission of charges to the insurer. Any bills submitted after 90 days of injury may not be accepted by the secondary insurer.

ii. Treatment of injury or illness not related to athletics will not be paid by Marquette's athletic insurance and should be billed to the student's primary insurance. Please keep us informed of any changes in your insurance and make sure we have a photo copied version of the student's insurance card.

iii. MU's insurance coverage is a **secondary** insurance policy and is excess of private insurance coverage. However, this secondary policy covers only sport-related injuries and/or illness as described in the medical referral policy.

iv. All insurance claims must be reported within 90 days and treatment provided within one calendar year of each specific injury for payment. If approved as sports related, treatment cost billed from providers will be honored for two years. If this is not followed, the athlete and/or family may be responsible for any remaining bills.

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 MAY NEED INVESTIGATION AND MAY BE THE RESPONSIBIILTY OF THE STUDENT-ATHLETE AND/OR THE STUDENT-ATHLETE'S PARENT(S)/GUARDIAN(S). The coverage provided by MU requires prompt reporting within 90 days of injury or onset of symptoms for bills to be paid by the insurer in a timely manner and medical bills must be submitted as soon as received.**

****** Any questions concerning your child's insurance coverage can be directed to: Danielle Armstrong, 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.

_____ _____

Student -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 _____

Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

College Address _____ College Phone (_____) _____

Home Address _____ Home Phone (_____) _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name _____

Social Security No. _____

Date of Birth _____

Address _____

_____

Employer _____

Address _____

_____

Telephone (_____) _____

Medical Insurance
Company or Plan _____

Address _____

_____

Policy Number _____

Telephone (_____) _____

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Mother's Name _____

Social Security No. _____

Date of Birth

Address _____

_____

Employer _____

Address _____

_____

Telephone (_____) _____

Medical Insurance
Company or Plan _____

Address _____

_____

Policy Number _____

Telephone (_____) _____

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ 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.

I understand that I, or my authorized representative, is entitled to receive a copy of this authorization upon request

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older) Date

Signature of Authorized Representative or Next of Kin Date

Relationship of Authorized Representative or Next of Kin to Claimant

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.

_____ _____

Student-Athlete's signature Date

_____ _____

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

_____ _____

Witness 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.

_____ _____

Student -Athlete's signature Date

_____ _____

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

Marquette Sports Medicine

HIPPA Policy

It is the policy of Marquette University Sports Medicine to implement the following policies and procedure to ensure patient policy rights in accordance with the HIPPA Privacy Rules:

Marquette University Sports Medicine will maintain the privacy of your health records as required by law.

Access, inspection, and copying of health information

- With a few exceptions, patients have the right to inspect and obtain a copy of their health information. However, this right does not apply to psychotherapy notes or judicial proceedings.

Requesting restrictions on certain uses and disclosures

- The patient has the right to object to, and ask for restrictions on how his or her health information is used or to whom the information is disclosed.
- Marquette University Sports Medicine will not make any other uses or disclosures of your health information unless you sign a written Authorization to Disclose Medical Information form unless authorized by law.

- I hereby acknowledge the receipt of Marquette University's Sports Medicine Notice of Health Information Privacy Practices:

_____
Athlete's Name (print)

_____ _____
Athlete's signature Date

_____ _____
Parent/guardian signature (if under 18 yrs old) 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 Date

_____ _____

Parent/guardian signature (if under 18 yrs old) Date

Marquette Sports Medicine

Concussion Fact Sheet- Student-Athletes

Head injuries (concussions and traumatic brain injuries) account for a significant percentage of injuries sustained during participation in collegiate athletics. A concussion can occur from any blow to the head, face or neck and results in a variety of symptoms listed below. Getting "knocked out" or being unconscious does not always occur with a concussion. Certain sports have been identified by the NCAA injury surveillance studies as having a relatively higher risk of head injury occurrence than other sports. Marquette University sponsors some of these higher risk sports, at the varsity level (men's basketball, women's basketball, men's soccer, women's soccer, and pole vault). It is important to understand that traumatic head injury can occur in any sport, during all types of activity (games, practices, conditioning, etc.), and with relatively minor trauma. Head injuries are often difficult to detect. The assessment, management, and return-to-play decision associated with these injuries are among the most difficult responsibilities facing Marquette University's sports medicine staff. An additional challenge is that student-athletes suffering from an acute head injury often underreport their injury, minimize the injury symptoms, or do not recognize that an injury has even occurred.

Signs & Symptoms of Concussion

- Amnesia (can't recall events before or after hit)
- Confusion
- Headache
- Balance problems or dizziness
- Vision problems (double/blurry)
- Sensitivity to light or noise
- Nausea
- Do not "feel right"
- Feel sluggish, hazy, or foggy

What Should I do if I think I have a concussion?

REPORT IT! Do not ignore a blow to the head, face or neck. If you have any of the above symptoms tell your athletic trainer and coach immediately. Do not wait a few minutes for the symptoms to go away. Tell your athletic trainer or coach if you think a teammate may be suffering from a concussion, as well. Your athletic trainer and team physician will be able to evaluate you, and will determine your return to play. A concussion can affect your class performance, your ability to do every day activities, your reaction time, your sleep, your mood and your balance.

What do I do if I am diagnosed with a concussion?

Allow yourself time to heal. Your brain, like any other injury, needs time to heal. While your brain is still healing, you are much more likely to sustain another concussion. In rare cases, repeat concussions can cause permanent brain damage or even death. Your athletic trainer and team physician will tell you what to do and will determine when you are cleared to play.

Marquette Sports Medicine

Marquette University
Student-Athlete Concussion Statement

☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

☐ I have read and understand the *Marquette University Concussion Fact Sheet*.

After reading the Marquette University Concussion fact sheet, I am aware of the following information:

_____ A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.
Initial

_____ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.
Initial

_____ You cannot see a concussion, but you might notice some of the symptoms right away. 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 team physician or athletic trainer.
Initial

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

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

_____
Printed name of Student-Athlete

_____ _____
Signature of Student-Athlete Date

_____ _____
Parent/Guardian Signature (if under 18) Date

Marquette Sports Medicine

Female Athlete History Questionnaire

Name: _____ Sport: _____

Have you had a menstrual period? _____

If Yes, How old were you when you had your first menstrual period? _____

When was your last period? _____

Do you have monthly menstrual cycles? _____

How many periods have you had in the past 12 months? _____

How many periods have you had in the past 6 months? _____

Have you ever missed 3 or more consecutive months of your menstrual periods? _____

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

Do you have trouble with heavy bleeding? _____

Do you experience cramps during your period? _____

If Yes, Do they affect your ability to practice/compete? _____

How do you treat them? _____

Have you ever had a pelvic exam? _____

Date of last exam: _____

Have you ever had an abnormal Pap smear? _____

If yes, what was the date? _____

How was it treated? _____

Have you ever been treated for anemia (low hemoglobin or low iron)? _____

Do you have a family history of Osteoporosis (thinning of bones)? _____

Are you currently taking birth control medication or hormones? _____

If Yes, Were they prescribed for (circle below):

Irregular periods/ No periods/ Painful periods/ Birth control

Marquette Sports Medicine

Nutrition Questionnaire

Name: _____ Sport: _____

How tall are you? _____ What is your current weight? _____

Are you happy with your present weight? _____ Circle: Do you want to weigh MORE or LESS?

Does your weight affect the way you feel about yourself? _____

In the last year, what has been your lowest weight? _____ Highest weight? _____

Do you worry about your weight or body composition? _____

Do you gain or lose weight to meet the demands of your sport? _____

Do you currently or have you ever suffered from an eating disorder? _____

Have you ever tried to lose weight by using any of the following? _____

If Yes, Circle: Vomiting/ Laxatives/ Diuretics/ Diet Pills/ Excessive exercise/ Food Restriction

Has anyone recommended that you change your weight or eating habits? _____

If Yes, Specify: _____

Have you ever followed a particular "diet"? _____

Do you eat breakfast daily? _____

How many meals do you eat a day? _____ How many snacks do you eat a day? _____

Do you ever eat in secret? _____

Do you worry that you have lost control over the amount you eat? _____

Are there certain food groups that you refuse to eat? _____

If Yes, Circle: Meat/ Bread/ Dairy/ Sweets Other?_____

Do you ever limit your food intake to control your weight? _____

If Yes, Do you (circle): Decrease the amount of food you eat during the day/ Skip meals/ Limit calorie intake/ Limit carbohydrate intake/ Limit fat intake/ Cut out snack items

Do you regularly exercise outside of your normal practice schedule? _____

Do you take nutritional or performance enhancement supplements? What type? How often? _____

_____

Have you ever been treated for a stress fracture? _____

If Yes, please list body part(s) involved and corresponding injury date(s)? _____

_____

How was the diagnosis made? (circle one) X-ray/ bone scan/ CT scan/ MRI

Marquette Sports Medicine

Dear incoming Marquette University student-athlete,

As of recent years, the NCAA has become stricter in applying its Medical Exemption policy with regards to banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD). The NCAA bans certain substances because they can harm student-athletes and create unfair competitive advantage. However, they do realize that some banned substances are legitimate medications that are beneficial to improve the general health and academic performance of student-athletes. The NCAA allows exemption for use of these substances for individuals with a documented medical history demonstrating the need for regular use of such a drug.

If you have been diagnosed with ADD/ADHD and are taking stimulant medication to treat it, your home prescribing physician MUST provide documentation to the athletic department/ sports medicine staff that contains the information on the next available page.

Included with this letter is a guideline for documentation that you should provide to the prescribing physician so that he/she includes all required information. Additionally, the sports medicine staff will need to have a current prescription on file for the medication.

If you have not received formal testing or completed rating scales for ADHD, this must be included as part of the evaluation. It is your responsibility to obtain and pay for any necessary testing. Marquette University is NOT responsible for payment of any testing required as part of the necessary documentation.

<u>This required documentation must be turned in to the Head Athletic Trainer by August 25, 2014 (the 1st day of classes.)</u>

If the required documentation is not provided and you are subsequently selected for testing and test positive, you will not be able to receive a medical exemption and could lose your eligibility to compete in intercollegiate athletics.

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
and Treatment with Banned Stimulant Medication

• Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
• Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting).

To be completed by the Institution:

Institution Name:_____

Institutional Representative Submitting Form:
Name_____
Title_____
Email_____
Phone_____

Student-Athlete Name_____
Student-Athlete Date of Birth_____

To be completed by the Student-Athlete's Physician:

Treating Physician (print name):_____
Specialty:_____
Office address_____
Physician signature:_____ Date_____

Physician documentation (letter, medical notes) to include the following information:
• Diagnosis.
• Medication(s) and dosage.
• Blood pressure and pulse readings and comments.
• Note that alternative non-banned medications have been considered, and comments.
• Follow-up orders.
• Date of clinical evaluation: _____
• **Attach written report summary of comprehensive clinical evaluation:**
o The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores.
o The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.

Marquette Sports Medicine

SICKLE CELL POLICY

NCAA states: "All athletes at Division I and II schools are required to be tested for the trait before competing. This is to make coaches and athletic trainers aware that some athletes may need to take precautions."

Sickle cell disease is an inherited blood condition that can be found in a wide variety of ethnic backgrounds. If a person receives a sickle cell gene from *both* parents, they will inherit sickle cell disease. If he/she inherits only *one* sickle cell gene, then they are said to have "sickle cell trait".

Persons with the sickle cell trait do not have sickle cell disease and typically have no problems *with the exception that they can be at a higher risk when exercising with high exertion and decreased recovery periods in hot conditions for heat illness problems and even death*.

All newborn babies are tested for sickle cell disease and the trait when they are born. If you present proof of your status for sickle cell trait (usually on record with whoever was your doctor when you were born) then the test does not need to be repeated here. If you cannot provide documentation then the simple blood test will need to be performed at the time of your sports physical. Test results are typically returned after 72 hours, **no student athlete will be cleared for participation until results are documented.**

All incoming student athletes must provide documentation of their sickle trait status prior to medical clearance for participation. A note from your physician stating you do not have sickle cell trait will not be accepted, lab results are required.

<u>For athletes who carry the sickle cell trait the following simple steps will be taken</u>:

1. The student athlete will watch the NCAA educational video about sickle cell trait and athletic participation.

2. The athlete will meet with a team physician to answer any questions and make sure the athlete understands the issue and the steps he or she needs to take to make remain safe while participating (staying hydrated, recognize early symptoms of heat illness/sickle crisis, and report them to sports medicine staff and coaches immediately).

3. Sport and strength/conditioning coaches will be notified of the student athlete's trait status. This will ensure that the student athlete is allowed access to fluids as needed, sport/conditioning drills are modified, adequate rest periods are provided, slowly acclimated to heat and any student athlete with complaints of exhaustion are taken seriously and activity stopped until evaluation by sports medicine staff is completed.

4. Sports medicine staff present at official practices and workouts will monitor the student athlete's status closely and encourage adequate hydration. The sports medicine staff will also monitor environmental conditions and possibly limit or halt exercise if risk is determined to be high.

Marquette Sports Medicine

Incoming Student Athlete Packet Check-List

- ☐ Athlete Information
- ☐ Medical Information
- ☐ Medical History (2 pages)
- ☐ Physical Exam **(filled out by physician)**
- ☐ Personal Insurance Information
- ☐ Medical/ Insurance Policy Statement Acknowledgment
- ☐ 1st Agency – Parent/Guardian/Student Information Form (2 pages)
- ☐ Acknowledgement of Assumption of Risk ☐ Witness Signature
- ☐ Medical Treatment Consent Form
- ☐ HIPPA Policy
- ☐ Personal Information Disclosure Consent Form
- ☐ Student Athlete – Concussion Statement
- ☐ Female Athlete History Questionnaire (if applicable)
- ☐ Nutrition Questionnaire
- ☐ ADD/ADHD Treatment Documentation (if applicable)
- ☐ Sickle Cell Disease/Trait Test Results (**REQUIRED for EVERY Student-Athlete)**

All signatures must be hand-written – DO NOT electronically sign forms

Please submit all completed forms printed on **front side of paper only BEFORE YOUR FIRST DAY ON CAMPUS or no later than July 15th**. If anything occurs after you turn this in please notify your respective sports medicine staff member. You may mail your forms to the: Al McGuire Sports Medicine Center, 770 N. 12th Street, Milwaukee, WI 53233 or fax to: 414-288-6477.