



## Marquette Sports Medicine

Dear Student-Athlete:

Welcome back 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. **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 **printed singled sided NO LATER THAN JULY 15th**. You may return your forms to the Al McGuire Sports Medicine Center, 770 N. 12<sup>th</sup> 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 a Danielle Armstrong at (414) 288-0341. We look forward to seeing you back in the fall.

Sincerely,

Brandon Yoder, ATC  
Director of Sports Medicine

Danielle Armstrong, ATC  
Assistant Athletic Trainer

Aaron Doering, ATC  
Assistant Athletic Trainer

Mary Wieczorek, ATC  
Assistant Athletic Trainer



## Marquette Sports Medicine

### Athlete Information

#### Demographics

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

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

SSN3 or Passport #: \_\_\_\_\_ MU ID: \_\_\_\_\_

#### Local Information

Address: \_\_\_\_\_ 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? _____		
_____		
Have you ever worn orthotics?	Y	N
If so, for what reason? _____		
_____		
Did you get injured over the summer or require an evaluation for an injury over the summer?	Y	N
If yes, what was/is the injury? _____		
_____		
Please list all medications and supplements that you take: _____		
_____		
_____		



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 and Marquette 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.

<b>HEAD/FACE</b>	<b>Yes</b>	<b>Currently</b>
Head Injury/ Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		
<b>UPPER EXTREMITY</b>	<b>Yes</b>	<b>Currently</b>
Shoulder Injury	<input type="checkbox"/>	<input type="checkbox"/>
Upper Arm Injury	<input type="checkbox"/>	<input type="checkbox"/>
Elbow Injury	<input type="checkbox"/>	<input type="checkbox"/>
Forearm Injury	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Injury	<input type="checkbox"/>	<input type="checkbox"/>
Hand/Finger Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		
<b>CHEST</b>	<b>Yes</b>	<b>Currently</b>
Clavicle Injury	<input type="checkbox"/>	<input type="checkbox"/>
Sternum Injury	<input type="checkbox"/>	<input type="checkbox"/>
Rib Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		

<b>ABDOMEN</b>	<b>Yes</b>	<b>Currently</b>
Abdominal muscle strain	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Spleen Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		
<b>LOWER EXTREMITY</b>	<b>Yes</b>	<b>Currently</b>
Gluteal muscle injury	<input type="checkbox"/>	<input type="checkbox"/>
Hip Injury	<input type="checkbox"/>	<input type="checkbox"/>
Groin Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Hamstring Injury	<input type="checkbox"/>	<input type="checkbox"/>
Quadriceps/Thigh Injury	<input type="checkbox"/>	<input type="checkbox"/>
Knee Injury	<input type="checkbox"/>	<input type="checkbox"/>
Calf Injury	<input type="checkbox"/>	<input type="checkbox"/>
Shin Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Achilles Injury	<input type="checkbox"/>	<input type="checkbox"/>
Foot Injury	<input type="checkbox"/>	<input type="checkbox"/>
Toe Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		
<b>SPINE</b>	<b>Yes</b>	<b>Currently</b>
Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Mid-back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Low-back Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Sacroiliac Pain/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Remarks _____		



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1. Since the end of your season, have you ever 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 injuries/illnesses that required you to see a physician? YES NO  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
4. Are you allergic to any medications, vitamins or supplements? YES NO  
If yes, please list name and dosage (please include both prescription and non-prescription medication):  
\_\_\_\_\_  
\_\_\_\_\_
5. Are you currently taking any medications, vitamins or supplements? 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  
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.



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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 RESPONSIBILITY 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	MOTHER/GUARDIAN INFORMATION
Father's Name _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____ _____	Address _____ _____
Employer _____	Employer _____
Address _____ _____	Address _____ _____
Telephone (_____) _____	Telephone (_____) _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____ _____	Address _____ _____
Policy Number _____	Policy Number _____
Telephone (_____) _____	Telephone (_____) _____
Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE 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.





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### 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  
Initial physician or athletic trainer.

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

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

\_\_\_\_\_ If I suspect a teammate has a concussion, I am responsible for reporting the  
Initial injury to my team physician or athletic trainer.

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

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

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

\_\_\_\_\_  
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 returning 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.

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

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](http://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 \_\_\_\_\_

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**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:**

○ 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.

○ 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

### Returning Student Athlete Packet Check-List

- Athlete Information
- Medical Information
- Pre-Season Health Questionnaire (2 pages)
- Insurance Information
- Medical/ Insurance Policy Statement Acknowledgment
- 1<sup>st</sup> 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)

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

Please submit all completed forms printed on **single sided paper NO LATER THAN JULY 15th**. 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.