



UMASS BOSTON SPORTS MEDICINE
NEW STUDENT ATHLETE SPORTS MEDICINE INFORMATION FORM

****Please attach a copy (front&back) of the student-athlete's medical insurance card****

Sport: _____

Date: _____

Personal Information

Name: _____ SS#: _____
DOB: _____ Year: Fr So Jr Sr Trans Age: _____ Sex: M F
Home Address: _____ Local Address: _____
Home Phone: _____ Local Phone: _____
Cell Phone: _____ Email: _____

Emergency Contact Information

Name: _____ Name: _____
Home Address: _____ Home Address: _____
Home Phone: _____ Home Phone: _____
Work/Cell Phone: _____ Work/CellPhone: _____
Email: _____ Email: _____
Relation to Athlete: _____ Relation to Athlete: _____

Insurance Information

Primary Insurance Policy

Insurance Co.: _____
Address: _____
Policy/ID#: _____
Group#: _____
Insurance Co. Phone#: _____
Insurance Type: HMO PPO Standard Other
Primary Care Physician: _____
Physician Phone#: _____
Do you need a referral from your Primary Care (PCP) to see a specialist? Yes No

Secondary Insurance Policy

Insurance Co.: _____
Address: _____
Policy/ID#: _____
Group#: _____
Insurance Co. Phone#: _____
Insurance Type: HMO PPO Standard Other
Primary Care Physician: _____
Physician Phone#: _____
Do you need a referral from your PCP to see a specialist? Yes No

Medications, Allergies, Medical Alerts

Please list any previous history of or if currently taking any medications, allergies to any medications, foods, etc. Include any recent surgery, history of diabetes, seizure disorders, or any continuing treatable condition.

Allergies: _____

Medications and Supplements: _____

Medical Alerts: _____

******Student-Athlete Document Responsibility******

The student-athlete's documentation from the prescribing physician to the athletics departments/sports medicine staff should contain a minimum of the following information to help ensure that ADHD has been diagnosed and is being managed appropriately:

- A. Description of the evaluation process which identifies the assessment tools and procedures.**
- B. Statement of the Diagnosis, including when it was confirmed.**
- C. History of ADHD treatment (previous/outgoing).**
- D. Statement that a non-banned ADHD alternative has been considered if a stimulant is currently prescribed.**
- E. Statement regarding follow-up and monitoring visits.**

Medical Eligibility Requirements

In order to be medically eligible to participate in intercollegiate programs at UMass Boston, you must have valid proof of the following:

- 1. Physical Examination**
- 2. Immunization Records**
- 3. Insurance Coverage**

*****Under no circumstances will an athlete be allowed to participate without proof of insurance*****

- Athletes must pay the student health insurance fee on their tuition bill unless he/she is covered by private insurance.
- This form must be completed and returned to the Sports Medicine Department prior to your first practice, or you will not be allowed to participate. There are NO EXCEPTIONS.
- If any portion of this form is submitted incomplete, you will not receive medical clearance until completed fully.

ALL STATEMENTS AND ANSWERS IN THE ABOVE MEDICAL HISTORY QUESTIONNAIRE ARE TRUE AND COMPLETELY REPRESENT MY CURRENT HEALTH STATUS TO THE BEST OF MY KNOWLEDGE. I HAVE NO ABNORMALITY, LIMITATION, OR RESTRICTION NOT MENTIONED IN THIS RECORD. I UNDERSTAND THAT THIS INFORMATION IS TO HELP DETERMINE MY FITNESS TO PARTICIPATE IN ATHLETICS, AND TO AID IN THE TREATMENT AND DIAGNOSIS OF FUTURE INJURIES/ILLNESSES THAT I MAY INCUR.

PRINTED NAME OF ATHLETE _____ DATE _____

SIGNATURE OF ATHLETE _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____
(IF STUDENT IS A MINOR)

**UMASS BOSTON SPORTS MEDICINE
PERSONAL HEALTH HISTORY**

DIRECTIONS: PLEASE FILL OUT THE FOLLOWING INJURY AND ILLNESS QUESTIONNAIRE. YOU ARE REQUIRED TO ANSWER ALL QUESTIONS. WHEN ASKED TO EXPLAIN A CERTAIN ITEM, PLEASE INCLUDE THE DATE OF EPISODE WHERE APPROPRIATE. EXPLAIN "YES" ANSWERS IN THE SPACES PROVIDED.

1. Are you currently under a physician's care? Yes___ No___
2. Have you seen a physician in the past year? Yes___ No___
3. Have you been advised by a physician during the past five years to restrict athletic activity? Yes___ No___
4. Are you currently taking any medication? Yes___ No___
5. Date of last tetanus shot: _____
6. Date of last visit to the dentist: _____
7. Female athletes: Have you ever had a history of irregular menstrual periods? Yes___ No___
8. Do you currently wear contacts/glasses? Yes___ No___
9. Do you currently wear oral braces? Yes___ No___

Explain "yes" answers _____

ILLNESS HISTORY:

List all CURRENT Illness/Infections: _____

1. Have you ever had an illness/infection lasting more than 1 year? Yes___ No___
2. Have you ever had a surgical operation due to an illness/infection? Yes___ No___
3. Have you ever been hospitalized for an illness/infection? Yes___ No___
4. Do you have impaired function or loss of a paired organ? Yes___ No___
(kidney, eye, ear, etc...)
5. Have you ever experienced any of the following?

___ chest pain	___ frequent headaches
___ "black-outs"/fainting	___ illness/weakness from physical exertion
___ shortness of breath	___ heat illness

Explain "yes" answers _____

6. Do you have concerns about your eating patterns/habits? Yes___ No___ Your Weight? Yes___ No___
Would you like to speak to someone regarding these concerns? Yes___ No___

7. Do you have now or ever had?(check all that apply)

___ Abnormal bleeding tendency	___ Diabetes disorder	___ Impaired mobility/paralysis	___ Pneumothorax
___ Anemia	___ Heart murmur/click	___ Kidney disease	___ Rheumatic fever
___ Anorexia Nervosa	___ Heart disease/problems	___ Malaria	___ Sickle cell disease/trait
___ Appendectomy	___ Hepatitis	___ Migraines	___ Stomach problems
___ Arthritis	___ Hernia	___ Neuro-muscular disease	___ Thyroid disease
___ Asthma	___ High blood pressure	___ Phlebitis/deep vein clot	___ Tuberculosis
___ Bulimia			
___ Cancer/malignant disease			

Explain "yes" answers _____

FAMILY HISTORY:

1. Does anyone in your family(include grandparents), have a history of any of the following?

- Sudden death before the age of 50 from a non-traumatic cause
- Heart disease or cardiac abnormality
- Marfan's syndrome
- High blood pressure
- Sickle cell anemia
- Diabetes

Explain any "yes" answers _____

ALLERGIES:

Check all that apply and list where appropriate:

- To medications: _____
- To foods: _____
- Environmental: _____

INJURY HISTORY:

List all CURRENT injuries: _____

- 1. Have you ever been hospitalized due to an injury? Yes ___ No ___
- 2. Have you ever had a surgical operation due to an injury? Yes ___ No ___
- 3. Have you ever been "knocked unconscious" Yes ___ No ___
If "yes", number of times? _____
Were you seen by a physician? Yes ___ No ___
Were you hospitalized? Yes ___ No ___
- 4. List and explain any orthopedic bracing devices currently used: _____

5. Have you ever sustained an injury to any body part listed below?(check all that apply):

- | | | | |
|-----------------------------------|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Arm | <input type="checkbox"/> Internal organ | <input type="checkbox"/> Lower Leg |
| <input type="checkbox"/> Face | <input type="checkbox"/> Elbow | <input type="checkbox"/> Back | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hip | <input type="checkbox"/> Foot/toes |
| <input type="checkbox"/> Jaw | <input type="checkbox"/> Hand/fingers | <input type="checkbox"/> Pelvis/groin | |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Chest | <input type="checkbox"/> Upper leg | |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Ribs | <input type="checkbox"/> Knee | |

Explain any "yes" answers: _____

I the undersigned,

- 1) Certify that I have read & understand the above statements & that the answers provided are true, complete, & correct to the best of my knowledge.
- 2) Grant permission to the UMass Boston Athletic Trainers, personnel or agents to secure necessary and appropriate emergency and non-emergency medical care.
- 3) Understand that having passed a medical evaluation does not necessarily mean that I am physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify me a the time of said evaluation.
- 4) Understand that if I am removed from a practice or a game or willingly leave a practice or game due to injury or illness, that I must have appropriate medical clearance before returning to participation.

Name (Please print)

Date

Signature of Student-Athlete or Parent/Guardian (Only if athlete is under the age of 18)

Date

STUDENT ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

The undersigned herewith formally acknowledges and declares the following:

I understand that participation in sport requires a personal acceptance of risk of injury. Athletes generally expect that those who are responsible for the conduct of sport take reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict wrongful injury upon them. _____ (initial)

I understand that participation in Intercollegiate Athletics at the University of Massachusetts at Boston may result in injury/illness, permanent physical or mental impairment or even death. These injuries may be minor or may be career or life threatening. I understand that UMass Boston cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques which are made known to me by my coaching staff, athletic training staff, or by the strength and conditioning coach or are otherwise known to me from another source, including but not limited to medical personnel of the university. _____ (initial)

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for any and all such risks while participating in Varsity Athletics at UMass Boston. I also agree to the following:

1. _____ Voluntarily assume all risks associated with my participation in Varsity Athletics. _____ (initial)

2. _____ Accept that UMass Boston and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have. _____ (initial)

3. Understand that passing a pre-participation exam does not necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at UMass Boston, but only that the evaluator did not find a medical reason to disqualify me at the time of the pre-participation exam. _____ (initial)

4. Understand that I must refrain from practice while injured or ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission, based on independent exercise of professional judgment, by the Certified Athletic Trainer, Team Physician(s) or his/her designated representative after review of my condition and fitness for the rigors of my sport. This may occur during or at the conclusion of medical treatments. _____ (initial)

5. Understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Athletic Training Staff, and to adhere to the established injury management guidelines which include total rehabilitation and reevaluations before I am released to return to full participation. _____ (initial)

6. Understand that I must wear the proper equipment as dictated by the rules of the sport. I may also have to wear padding or braces as indicated by the Athletic Training Staff or medical personnel. Failure to do so may put me at risk for further injury. _____ (initial)

THIS AGREEMENT EXPIRES SIX YEARS FROM THE DAY IT IS SIGNED.
I HAVE READ, UNDERSTAND AND VOLUNTARILY AGREE TO THE ABOVE STATEMENTS.

Name (please print)

Sport(s)

Signature

Date

Parent/Guardian Signature (if under 18 years of age)

Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize the athletic trainers, team physicians, and medical staff representing the University of Massachusetts at Boston to gain/release information concerning my medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information to individuals/institutions that may include but are not limited to:

- School Administration
- Athletics Staff
- Coaches
- Parents/Guardians
- Student Health Center
- Required Medical Facilities (Hospital, Physical Therapist, Diagnostic Center, etc.)
- Insurance Companies
- Sports Medicine Students (Co-ops, Clinical Students, Work Study Students)
- Teammates

This information is in regards to injuries or illness related to my participation in athletics at UMass Boston.

The purpose of this disclosure is to advise of the nature, diagnosis, prognosis, or treatment concerning my medical condition and any injuries or illnesses I have or may have had. This information will be used to make decisions regarding my athletic ability and suitability to compete while I am a student athlete. I understand that the entities that receive the information may not be health care providers or health plans covered by federal privacy regulations and that the information may no longer be protected by those regulations.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA), or the Family Educational Rights and Privacy Act of 1974 (The Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain medical treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying the Sports Medicine Staff. Doing so will not affect actions that UMass Boston will take in reliance to this authorization prior to receiving the revocation. This authorization expires six years from the day it is signed.

Printed Name of Student-Athlete

Sport(s)

Signature of Student Athlete

Date

Signature of Parent/Guardian
(If Student-Athlete is under 18)

Date

I have reviewed the above statements and do not wish to authorize this release. _____
Initials