



RETURNING ATHLETE FORM

THIS FORM IS TO BE COMPLETED BY ALL ATHLETES. PLEASE PROVIDE ANY CHANGE OF PERSONAL INFORMATION, INSURANCE INFORMATION, OR HEALTH PROBLEMS OVER THE LAST YEAR.

PERSONAL INFORMATION

NAME: _____ SPORT(S): _____
ADDRESS: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)
HOME PHONE #: (____) _____ LOCAL PHONE #: (____) _____
CELL PHONE #: (____) _____ EMAIL ADDRESS: _____
YEAR IN SCHOOL: _____ TODAY'S DATE: _____
SS#: _____ DOB: _____ SEX: M F

EMERGENCY CONTACT INFORMATION

HAS THERE BEEN ANY **CHANGE** IN YOUR **EMERGENCY CONTACTS** IN THE PAST YEAR?
YES ____ NO ____ IF NO, PLEASE SKIP TO HEALTH INSURANCE SECTION

EMERGENCY CONTACT # 1 **EMERGENCY CONTACT # 2**
NAME _____ NAME _____
HOME ADDRESS _____ HOME ADDRESS _____
HOME PHONE _____ HOME PHONE _____
WORK PHONE _____ WORK PHONE _____
CELL PHONE _____ CELL PHONE _____
RELATION TO ATHLETE _____ RELATION TO ATHLETE _____

INSURANCE INFORMATION

HAS THERE BEEN ANY **CHANGE** IN YOUR **HEALTH INSURANCE COVERAGE** IN THE PAST YEAR?
YES ____ NO ____ IF NO, PLEASE SKIP TO MEDICAL HISTORY SECTION

DO YOU HAVE SCHOOL INSURANCE? YES ____ NO ____
➤ **IF YOU DO NOT HAVE SCHOOL INSURANCE YOU MUST COMPLETE THE FOLLOWING:**

INSURANCE CO.: _____ INS. CO. PHONE #: _____
INS. CO. ADDRESS: _____ GROUP #: _____
_____ POLICY #: _____
INSURANCE TYPE: HMO PPO STANDARD OTHER: _____
PRIMARY CARE PHYSICIAN: _____ PHYSICIAN PHONE #: _____

IS PREAUTHORIZATION NECESSARY FOR MEDICAL/DIAGNOSTIC SERVICES?
YES ____ NO ____ (IF YES) PHONE #: _____

MEDICAL HISTORY

1. HAVE YOU SUFFERED ANY ATHLETIC INJURY IN THE LAST YEAR?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

2. DO YOU HAVE INCOMPLETELY HEALED INJURIES?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

3. HAVE YOU SUFFERED ANY MEDICAL ILLNESS OR HAD SURGERY IN THE LAST YEAR?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

4. ARE YOU CURRENTLY UNDER CARE OF A PHYSICIAN?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

5. HAVE YOU BEEN PRESCRIBED ANY NEW MEDICATIONS WITHIN THE LAST YEAR?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

******You must provide documentation for any medication that has been prescribed including: diagnosis, verification of how the diagnosis was made, medical history, and dosage.(see physician letter criteria below)******

6. HAVE YOU HAD A CONCUSSION OR BEEN KNOCKED UNCONSCIOUS IN THE LAST YEAR

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

7. DO YOU FEEL THERE ARE ANY LIMITATIONS PLACED ON YOUR FULL PARTICIPATION?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

8. HAVE YOU DEVELOPED ANY ALLERGIES?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

9. HAVE YOU HAD ANY VISION CHANGES IN THE PAST YEAR?

YES ____ NO ____ IF YES, PLEASE EXPLAIN _____

TO THE BEST OF MY KNOWLEDGE, THE AFOREMENTIONED INFORMATION IS CORRECT. THE CHANGES IN MY HEALTH HISTORY OVER THE PAST YEAR ARE COMPLETE AND CORRECT.

Signature of Athlete

(DATE)

******THE DEPARTMENT OF SPORTS MEDICINE RESERVES THE RIGHT TO REQUEST AN ATHLETE BE REEVALUATED BY A PHYSICIAN BASED ON THE INFORMATION INCLUDED IN THE FOLLOW-UP HEALTH HISTORY FORM******

******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/ongoing).
- 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.