

MARYLAND



SPORTS MEDICINE

May 2012,

Dear University of Maryland Incoming Student-Athlete-

Welcome to the University of Maryland Athletics family. In preparation for your pre-participation physical examination as a student-athlete at the University of Maryland, please take note of the following important information-

1. All necessary forms and pertinent information regarding physical exams and University of Maryland Sports Medicine insurance coverage can be found on the University of Maryland Sports Medicine website at <http://www.umterps.com/school-bio/md-sports-exam-info.html>.

• All completed forms should be faxed to 877-863-2802

2. Student-athletes must send an email to mdsportsmedicine@umd.edu to schedule a physical exam prior to **August 24, 2012**. Physical Exams will take place in the Gossett Football Team House on the following dates during the summer-
 - **Tuesday, May 29th @ 3:00pm – 5:30pm**
 - **Tuesday, June 12th @ 3:00pm – 5:30pm**
 - **Tuesday, June 26th @ 3:00pm – 5:30pm**
 - **Tuesday, July 10th @ 3:00pm – 5:30pm**
 - **Month of August (daily @ time TBD)-**
 - **Tuesday, August 28th @ 4:00pm @ Comcast Center**

In the body of the email, please include the following-

- *Student-athlete name*
- *Sport*
- *Desired date of the physical exam*
- *Cell phone number where you can be contacted in case of a time change and/or conflict.*

3. **The University of Maryland mandates that all students have primary health insurance.** All newly-admitted students must complete an online form to indicate whether they have health insurance and wish to waive the requirement or wish to purchase health insurance. All student-athletes entering the University after May 2009 must adhere to the University of Maryland's primary health insurance mandate.
- Students must complete an online form by July 1st of each academic year. ***The online form can be found after May 1st of each year on the University of Maryland University Health Center website at www.health.umd.edu/geninfo/insurance.html***
 - After July 1st, you will be automatically enrolled in the SHIP for the academic year and the total cost (~\$1300.00) will be billed to your student bursar account if you have not completed the required waiver process.
 - Student-athletes and/or parents with questions regarding the University of Maryland's mandatory health insurance requirement should contact the University of Maryland University Health Center Business Office-
 - **Phone- (301) 314-8165**
 - **Email- health@umd.edu**
 - **www.health.umd.edu/geninfo/insurance.html**
4. **All student-athletes must also submit a legible photocopy (front & back) of their health insurance card and their prescription benefits card on a yearly basis. Cards may be faxed to 877-863-2802, scanned and emailed to mdsportsmedicine@umd.edu, and/or brought with you when you come for your physical exam.**

If you have any questions or concerns regarding your physical exam and/or general sports medicine questions, please call or email the general University of Maryland Sports Medicine line at (301) 314-7340 or mdsportsmedicine@umd.edu.

Thank you for your time and consideration in completing these important tasks. We wish you the best of luck throughout the summer and are looking forward to seeing you in August.

Sincerely,

Darryl Conway

Darryl P. Conway, MA, ATC, EMT-T
Assistant Athletic Director- Sports Medicine
Email- dconway@umd.edu

MARYLAND



SPORTS MEDICINE

PLEASE FILL OUT AND SIGN THE FOLLOWING FORMS IN BLACK INK

WHEN COMPLETED, PLEASE FAX OR EMAIL THE COMPLETED PACKET TO-

- Fax) 1-877-863-2802
- Email) mdsportsmedicine@umd.edu

PLEASE EMAIL mdsportsmedicine@umd.edu TO SCHEDULE A DATE AND TIME FOR A PHYSICAL EXAM.

PLEASE INCLUDE THE FOLLOWING IN THE BODY OF YOUR EMAIL-

1. Student-athlete name
2. Sport
3. Phone number

UNIVERSITY OF MARYLAND SPORTS MEDICINE

Health Insurance Information / Authorization

Student-Athlete's Name _____

Sex Male Female Date of Birth _____ Sport _____

Permanent Address _____

City _____ State _____ Zip _____ Phone _____

Campus Address _____ Cell Phone _____

Medications currently taking? _____

Allergies / Asthma / Medical Conditions? _____

FATHER'S / GUARDIAN'S INFORMATION	MOTHER'S / GUARDIAN'S INFORMATION
Name _____	Name _____
DOB _____	DOB _____
Home Address _____	Home Address _____
Home Phone _____	Home Phone _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____

STUDENT-ATHLETE INSURANCE INFORMATION	
Insurance Company _____	Policy Owner _____
Address _____	DOB _____
City _____ State _____ Zip _____	Coverage-
Phone # _____	<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> VISION
Type of Insurance-	<input type="checkbox"/> Other _____
<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Military	Is preauthorization necessary for medical/diagnostic services?
<input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____
Policy / ID # _____	Primary Care Physician _____
Group # _____	Physician Phone # _____

PLEASE READ CAREFULLY!

- The University of Maryland Department of Intercollegiate Athletics' accident policy provides insurance for student-athletes with *injuries occurring only when participating in the play or practice of intercollegiate athletics*. This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will the University of Maryland's Department of Intercollegiate Athletics' insurance carrier consider payment for any remaining balances.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, the University of Maryland Department of Intercollegiate Athletics & their excess insurance company in a timely manner.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize the University of Maryland Sports Medicine Unit and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify the University of Maryland Sports Medicine Unit immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.
- I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

Policy Holder's Signature _____	Date _____
Student-Athlete's Signature _____	Date _____

UNIVERSITY OF MARYLAND SPORTS MEDICINE DEPARTMENT
Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Sports Medicine Department of the University of Maryland for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(please print clearly in **BLUE or BLACK INK ONLY!**)

Name _____ Date _____

Date of Birth _____

Race: Caucasian Afro-American Hispanic Asian/Pacific Alaskan/Indian Other _____

Sport(s) _____ Position(s) _____

Height _____ Weight _____ Right Handed Left Handed

Family History (please complete / check appropriate boxes):

	FATHER	MOTHER
Current Age		
If Deceased, Cause of Death		
Age @ Death		
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)		
History of Diabetes		
History of heart disease, high blood pressure, and/or high cholesterol		
History of stroke		
History of tuberculosis		
History of Cancer		

	SIBLING 1	SIBLING 2	SIBLING 3	SIBLING 4
Current Age				
If Deceased, Cause of Death				
Age @ Death				
History of Blood diseases (e.g. sickle cell anemia, leukemia, etc.)				
History of Diabetes				
History of heart disease, high blood pressure, and/or high cholesterol				
History of stroke				
History of tuberculosis				
History of Cancer				

I. Cardiovascular Risk Factors:

- Have you ever had chest pain and/or shortness of breath during or after exercise / practice? YES NO
- Please Describe _____
- Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? YES NO
- Please Describe _____
- Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? YES NO
- Please Describe _____
- Do you cough, wheeze, and/or have trouble breathing during or after exercise / practice? YES NO
- Please Describe _____
- Do you get tired more quickly than your teammates / friends do during exercise / practice? YES NO
- Please Describe _____
- Have you ever been told that you have a heart murmur? YES NO
- Please Describe _____
- Has any family member or relative died of heart problems and/or of sudden death before age 50? YES NO
- Please Describe _____
- Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? YES NO
- Please Describe _____
- Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? YES NO
- Dates / Please Describe _____
- Does anyone in your family have a history of high blood pressure? YES NO
- Please Describe _____
- Have you ever been told that you have / had high blood pressure? YES NO
- Please Describe _____
- Does anyone in your family have a history of high blood cholesterol? YES NO
- Please Describe _____
- Have you even been told that you have / had high blood cholesterol? YES NO
- Please Describe _____

II. Allergies:

- Have You Ever Been Diagnosed With Seasonal Allergies? YES NO
- Please Describe _____
- Are You Presently Taking/Have You Previously Taken Any Allergy Medications? YES NO
- Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? YES NO
- Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? YES NO
- Please Describe _____
- Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? YES NO
- Please Describe _____

III. Asthma:

- Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? YES NO
- Date(s)? _____
 - Please Describe _____
- Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? YES NO
- Date(s)? _____
 - Please Describe _____
- How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week? _____
- How Many Acute Asthma Attacks Have You Had In The Past 12 Months? _____
- Date(s)? _____
 - Please Describe _____
- Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? YES NO
- Date(s)? _____
 - Please Describe _____
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? YES NO
- Please Describe _____

IV. Sickle Cell Trait:

- Have you ever been tested for Sickle Cell Anemia and/or Sickle Cell Trait that you are aware of? YES NO
- Date? _____ Result? _____
- Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? YES NO
- Please Describe _____
- Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? YES NO
- Please Describe _____
- Have you ever restricted, modified, and/or been instructed to restrict or modify your participation in sports due to muscle pain and/or cramping during or after exercise? YES NO
- Please Describe _____

V. Head Injuries / Concussion:

Have You Ever Suffered A Head Injury / Concussion (*no matter how minor*)?

YES NO

If YES, please complete the following chart for each head injury / concussion

DATE					
Signs / Symptoms (please check the appropriate box)					
Headache(s) and/or "Pressure in the Head"					
Dizziness and/or Balance Problems					
Loss of Consciousness / "blacked out"					
Loss of Memory					
Ringing in the Ears / Hearing Problems					
Nausea and/or vomiting					
Vision problems (double vision; blurred vision)					
Balance problems					
Difficulty concentrating / Confusion					
Difficulty sleeping					
Lethargy / Drowsiness / Fatigue					
Irritation / Anxiety / Nervousness					
Sensitivity to Light and/or Noise					
Sadness / Depression / "Feeling in a Fog"					
Other (please describe)					
Care / Treatment (please check the appropriate box)					
Evaluation by a physician					
Emergency Room / Hospitalization					
Neuropsychological Testing (e.g. ImPACT, etc.)					
Balance and/or Vision Testing					
Diagnostic Testing (e.g. CT Scan, MRI, x-ray, etc.)					
Other (please describe)					
Time Missed					
Days					
Practices					
Games					

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion?

YES NO

• Please Describe _____

Do You Suffer From Headaches?

YES NO

- When? Every Day 1-2 Times/Week 1-2 Times/Month
- Where Are Your Headaches Located? Left Side of Head Right Side of Head
 Front of Head Back of Head All Over Your Head

Do You Have A History of Migraine Headaches?

YES NO

- How Often _____ Please Describe _____
- Medications Taken for Migraines? _____

Have You Had Headaches For More Than Three (3) Months?

YES NO

• If yes, please explain _____

VI. Eye:

When Was Your Last Eye Exam? _____

- Findings? _____

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____

- Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray MRI CT-Scan Other _____

Have You Ever Been Hospitalized and/or Seen An Ophthalmologist For An Eye Injury? YES NO

- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? YES NO

- Please Describe _____

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? YES NO

- Please Describe _____

Do you routinely wear glasses? YES NODo you routinely wear contact lenses? YES NO Type _____Do you require any special devices / equipment? YES NO Type _____**VII. Ear / Nose / Throat:**Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____

- Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray MRI CT-Scan Other _____

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? YES NO

- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? YES NO

- Please Describe _____

VIII. Dental:

When Was Your Last Dental Exam? _____

- Findings? _____

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____

- Please Describe _____

Were Any Diagnostic Tests Performed? YES NO (check all that apply)

- X-ray MRI CT-Scan Other _____

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? YES NO

- Please Describe _____

IX. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? YES NO

- How Many? _____ Date(s)/Time Missed? _____

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? YES NO

- Date(s)? _____
- Please Describe? _____

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury? YES NO

- Please Describe _____

Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? YES NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

YES NO If yes, please explain _____

X. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury? YES NO

- Please Describe _____

XI. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury? YES NO

- Please Describe _____

XII. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury? YES NO

- Please Describe _____

XIII. Spine / Low Back / Sacroiliac Joint:

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? YES NO

- Date(s)/Time Missed? _____
- Please Describe? _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Spine, Low Back, or SI Joint Injury? YES NO

- Please Describe _____

XIV. Hip / Groin:

Have You Ever Suffered An Injury To Your Hip / Groin (*including hernias and/or sports hernias*)? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? YES NO

- Please Describe _____

XV. Thigh / Hamstring / Quadriceps:

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? YES NO

- Please Describe _____

XVI. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery For A Knee and/or Patella Injury? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? YES NO

- Please Describe _____

Have You Ever/Do You Presently Wear A Knee Brace? YES NO

- Which Knee? _____ Brand / Model of Brace? _____
- Reason for Wearing ? _____

XVII. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? YES NO

- Please Describe _____

Do You Presently Tape Your Ankle(s) Use Ankle Brace(s) Other

- Please Describe _____

XVIII. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? YES NO

- When? _____ Surgeon? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? YES NO

- Please Describe _____

XIX. Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? YES NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? YES NO

- When? _____ Where? _____
- Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? YES NO

- Please Describe _____

XX. Abdomen:

- Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? YES NO
- List Date(s) / Time (e.g. practices or games) Missed _____
 - Please Describe _____
- Have You Ever Suffered An Injury To Your Abdomen? YES NO
- List Date(s) / Time (e.g. practices or games) Missed _____
 - Please Describe _____
- Were Any Diagnostic Tests Performed? (check all that apply) X-Rays MRI CT-Scan Bone Scan
- Have You Ever Had Surgery For An Abdomen Injury? YES NO
- When? _____ Where? _____
 - Please Describe _____
- Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? YES NO
- Please Describe _____
- Do you Routinely Suffer From Chronic or Recurrent Diarrhea? YES NO
- Please Describe _____
- Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? YES NO
- Please Describe _____
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? YES NO
- Please Describe _____

XXI. Medical Testing:

- Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? YES NO
- List Dates/Time Missed _____
 - Please Describe _____

XXII. Dermatological (Skin):

- Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? YES NO
- Please Describe _____
- Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? YES NO
- Please Describe _____
- Have you ever been diagnosed with ringworm, herpes, impetigo, or other type of bacterial, viral, or fungal skin infection? YES NO
- Please Describe _____
- Have you ever been under the care of a dermatologist for any condition? YES NO
- Please Describe _____
- Have you ever been advised not to participate in athletic activities due to a skin condition? YES NO
- Please Describe _____

XXIII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XXIV. Supplements / Ergogenic Aids:

Please List **ALL** Vitamins, Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

<u>SUPPLEMENT</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>DATE(S)</u>

XXV. Heat Related Problems:

- Have You Ever Suffered From A Heat Related Injury? YES NO (check all that apply):
- Heat Cramps- Date(s)? _____
 - Heat Syncope (Fainting)-Date(s)? _____
 - Heat Exhaustion- Date(s)? _____
 - Heat Stroke- Date(s)? _____
- Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? YES NO
- Date(s)? _____
- Have You Ever Been Hospitalized For a Heat-Related Problem? YES NO
- Date(s)? _____ Where? _____
- Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? YES NO
- Please Describe _____

XXVI. Diabetic History:

Have You Ever Been Diagnosed With Diabetes? YES NO

• Date? _____

Are You Presently Taking or Have You Taken Any Diabetic Medications? YES NO

<u>Medication</u>	<u>Form</u>	<u>Dosage</u>	<u>Frequency</u>

Do You Daily Monitor Your Blood Sugar Level? YES NO

• How Many Times Per Day? _____ What Is Your Average Level? _____

Have You Had Your A1C Level Checked Within The Last Three (3) Months? YES NO Level _____

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? YES NO

• Please Describe _____

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? YES NO

• Please Describe _____

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

XXVII. For Females Only:

- YES NO At what age did you have your first menstrual period? _____
- YES NO Have you had menstrual periods within the past 12 months?
 - ◆ If yes, how many? _____ When was your most recent menstrual period? _____
 - ◆ How much time do you usually have from the start of one period to the start of another? _____
 - ◆ What was the longest time between menstrual periods within the past year? _____
- YES NO Do you have painful or heavy menstrual periods?
- YES NO Do your menstrual periods change with changes in your training regimen? If yes, please explain? _____
- YES NO Do you take any medications during your menstrual periods? If yes, what? _____
- YES NO Do you take birth control pills? If yes, what brand? _____
- YES NO Have you ever had any problems with your breasts?
- YES NO Have you had a pelvic examination within the last year?
- YES NO Do you take a calcium or iron supplement? If yes, what brand / strength? _____

XXVIII. Please Answer: {All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!}

- YES NO Have you ever had any injury or illness other than those already noted?
- YES NO Do you have any ongoing or chronic illnesses?
- YES NO Have you ever been hospitalized overnight?
- YES NO Have you ever been told by a physician to restrict your sports activity and/or not to participate in a sport?
- YES NO Are you currently under a physician's care for any medical conditions?
- YES NO Have you ever been under the care of a psychiatrist and/or psychologist?
- YES NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
- YES NO Have you ever had a rash or hives develop during and/or after exercise?
- YES NO Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants?
- YES NO Have you ever been told that you have kidney disease?
- YES NO Have you ever been told that you cannot donate blood?
- YES NO Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
- YES NO Have you ever had a stomach and/or duodenal ulcer?
- YES NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past twelve (12) months?
- YES NO Have you ever had seizures, convulsions, and/or epilepsy?
- YES NO Have you ever had gall bladder disease and/or a urinary problem?
- YES NO Do you have ringing in your ears or trouble hearing?
- YES NO Do you have frequent ear infections or nosebleeds?
- YES NO Have you ever had an abnormal chest x-ray and/or pneumonia?
- YES NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
- YES NO Have you ever had the chickenpox? If yes, when? _____

- YES NO Are you aware of any reasons why you should not participate in intercollegiate athletics at the University of Maryland at this time?
- YES NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
- YES NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
- YES NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
- YES NO Do you use alcohol? If yes, how often? _____
- YES NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
- YES NO Do you have any questions regarding drugs, tobacco, or alcohol?
- YES NO Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
- YES NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
- YES NO Are you a vegetarian? If yes, what type? _____
- YES NO Do you regularly lose weight to participate in your sport?
- YES NO Do you want to weigh more or less than you presently do?
- YES NO Do you experience cramps or upset stomach when drinking milk or eating dairy products (e.g. yogurt, cheese, ice cream)
- YES NO Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
- YES NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
- YES NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain: _____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fifteen (15) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature

Date

Student-Athlete Print Name

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

Date

Parent/Guardian Print Name

Witness

Date

Reviewed By:

Reviewer's Signature

Date

Reviewer Print Name



STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

I, _____, acknowledge that I am currently taking and/or have
 Student-Athlete Print Name

(within the past 6 months) taken the following vitamins, ergogenic aids, creatine powder, amino acids, protein supplements, or other similar substances, hereinafter referred to as "Supplements." (Use the back of this form if necessary.)

NAME	DOSAGE	MAIN INGREDIENTS	COMMENTS

I understand and agree:

- The University of Maryland Department of Intercollegiate Athletics neither approves of nor condones the use of Supplements;
- I have been informed of the University of Maryland Department of Intercollegiate Athletics, Atlantic Coast Conference, National Collegiate Athletic Association (NCAA), and United States Olympic Committee (USOC) policies with regards to the use of Supplements, and have had any questions about these policies answered;
- The use of Supplements may result in serious harm to me, possible permanent injury to my health, and even death.**
- I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance;
- I must list all Supplements on the Chain of Custody Forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at anytime in the future any form of Supplements.

I further understand and agree the University of Maryland, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, and/or future use of Supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release the State of Maryland, the University of Maryland, and their officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of Supplements.

I understand the statements in this form, and have had all questions about the information in this from answered to my satisfaction.

 Student-Athlete's Signature

 Date

 Parent / Guardian's Signature (if under 18 years old)

 Date

MARYLAND

SPORTS MEDICINE

Medical Examination & Authorization Waiver

I, the undersigned, hereby acknowledge, affirm, and represent the following:

A. PRESENT PHYSICAL CONDITION:

I have previously warranted and represented to **University of Maryland Athletic Department** that I am in excellent physical condition. Upon reporting to the University of Maryland, I completed a "Health History Questionnaire" form and was examined by a University of Maryland Team and/or consulting physician and/or his/her designee. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history; that my Health History Questionnaire Form was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with an University of Maryland Team and/or consulting physician and/or his/her designee; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition.

B. FUTURE COMPLAINTS:

I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to the University's Team Physician, the Assistant Athletic Director- Sports Medicine, and/or his/her designee, no matter how minor or insignificant I may deem them to be. **I understand that my responsibility to report injuries and illnesses includes, but is not limited to, signs and symptoms of concussions. I acknowledge that I have received educational materials about concussions from University of Maryland Sports Medicine personnel, and that I understand the signs and symptoms of concussions.**

C. MEDICAL TREATMENT:

I hereby authorize the University of Maryland team physicians, athletic trainers, and designated medical staff to examine and treat any injuries, which may occur, while participating in intercollegiate athletics for the University of Maryland. I authorize the team physicians, athletic trainers, and designated medical staff to communicate with athletic department officials and coaching staff regarding their findings and recommendations. I further understand that the team physician and/or his/her designee have the authority to eliminate me from participation as a student-athlete due to an injury/illness, and/or due to undue liability risk of the University of Maryland.

I understand that I will have **ninety (90) days** from the date of the expiration of my eligibility and/or voluntary or involuntary separation from the University of Maryland to have any medical conditions and/or injuries incurred evaluated and/or treated by University of Maryland Sports Medicine personnel and/or University of Maryland Team Physicians. All medical services must be provided by University of Maryland Sports Medicine personnel and/or University of Maryland Team Physicians unless otherwise approved in writing by the Assistant Athletic Director- Sports Medicine and/or his/her designee. After the **ninety (90) day** period, the University of Maryland Department of Intercollegiate Athletics will not be obligated to provide, or pay for, any treatment and/or medical services for any medical condition or injury.

D. STATEMENT OF MEDICAL INSURANCE:

I understand that as a student-athlete at the University of Maryland, I should be covered by some type of individual health insurance before participating in any strength and conditioning session, practice, game, and/or competition. This insurance shall be considered the **PRIMARY** insurance coverage for all athletic related injuries. I understand that the University of Maryland Department of Intercollegiate Athletics and the National Collegiate Athletic Association (NCAA) will provide a medical and catastrophic insurance program for student-athletes injured in practices, games or competitions, and/or related travel that was supervised by approved University coaching staff and approved by the Director of Athletics according to NCAA regulations. **THIS POLICY, HOWEVER, IS SECONDARY TO, OR IN EXCESS OF, THE STUDENT-ATHLETE'S INDIVIDUAL HEALTH INSURANCE AND WILL COVER RELATED EXPENSES FOR 102 WEEKS AFTER THE INITIAL DATE OF INJURY.** In addition, I further understand and agree that the insurance of the University of Maryland Department of Intercollegiate Athletics is not effective for an aggravation or re-injury to a preexisting injury, and therefore, the State of Maryland, University of Maryland, and their officers, employees, and agents will not be liable for any expenses resulting from such injury, regardless of its disclosure to the team physician(s) and/or members of the Sports Medicine Department.

I understand that it is my responsibility to understand the conditions that apply to my personal health insurance policy and comply with any requests for information, etc. from my health insurance company. I understand that any delinquent bills resulting in bad credit due to non-compliance with insurance company requests may be my responsibility.

I understand that in the event that I and/or my parent(s) / guardian(s) receives payment / reimbursement directly from my insurance company for an injury / illness that occurred as a direct result of participation in intercollegiate athletics at the University of Maryland, **the full account balance becomes my responsibility until payment is turned over to the provider or the University of Maryland.**

I understand that the University of Maryland Sports Medicine Department must receive any changes to my health insurance policy as soon as they occur. If proper notification is not received, the University of Maryland Department of Intercollegiate Athletics may not be responsible for any delays in payment, collections notices, credit reports, etc. that occur and/or the full account balance.

I understand that I must submit all correspondence from an insurance company (i.e. statement, invoice, bill, explanation of benefits {EOB}, insurance documentation, etc.) for any injury and/or illness that occurred as a direct result of my participation in intercollegiate athletics at the University of Maryland in a timely manner. Documents not received by the University of Maryland Sports Medicine Department in a timely manner may be my responsibility. **The University of Maryland Department of Intercollegiate Athletics WILL NOT be responsible for any delays in payment, collections notices, credit reports, etc. that occur due to documents not being submitted in a timely manner.**

E. AGREEMENT TO PARTICIPATE:

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Because of the aforementioned dangers of participating in any athletic activity, I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Sports Medicine Department. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

In consideration of the University of Maryland permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release the State of Maryland, University of Maryland, and their officers, agents, and employees from any and all liability, any medical expenses not covered by the University of Maryland Department of Intercollegiate Athletics' medical insurance coverage, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics.

The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

F. AUTHORIZATION:

I fully understand that this authorization shall be effective and valid for one year (52 weeks) after the termination of my playing and/or academic career at the University of Maryland.

MARYLAND



SPORTS MEDICINE

I hereby attest that I have read and fully understand the University of Maryland Sports Medicine Department's Medical Examination and Authorization Waiver. Further, I agree to abide by all the requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

Student-Athlete Signature

Date

Student-Athlete Print Name

Sport

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

Date

Parent/Guardian Print Name

Witness

Date

QUESTIONS & ANSWERS REGARDING THE USE OF BANNED STIMULANTS FOR TREATMENT OF ADHD, ADD, AND/OR LIKE CONDITIONS

Background-

The NCAA bans classes of drugs that can be harmful to student-athletes and that can create unfair advantages during competition (NCAA Bylaw 31.2.3). Some medications that student-athletes are prescribed for legitimate medical reasons contain NCAA banned substances. The NCAA, through the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) has a **Medical Exceptions Procedure** procedure to review and approve the use of medications that contain NCAA banned substances. Effective **August 1, 2009**, with respect to the use of banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and/or like conditions, (e.g. Ritalin, Stattera, Adderall, Concerta, etc.), the NCAA now requires documentation of a comprehensive clinical evaluation to support treatment with NCAA banned stimulants and a current prescription.

What should student-athletes who are prescribed stimulant medications for ADHD, ADD, and/or like conditions do?

Student-athletes who have been prescribed stimulant medications for the treatment of ADHD, ADD, and/or like conditions should immediately notify a member of the Sports Medicine Department to ensure that they have the necessary documentation on file.

What documentation must the student-athlete obtain from his/her prescribing physician?

At a minimum, student-athletes prescribed NCAA banned stimulants for the treatment of ADHD, ADD, and/or like conditions must have their prescribing physician complete the **University of Maryland ADHD / ADD Medical Exceptions packet**. The prescribing physician must provide the following documentation-

1. Evidence of comprehensive clinical evaluation (recording observations and results from standardized rating scales and/or neuropsychological testing), a physical exam and any lab work (attaching all documentation);
 - **A simple statement from a prescribing physician that he/she is treating the student-athlete for ADHD, ADD, and/or like conditions with the prescribed stimulant IS NOT adequate documentation**
2. Statement of diagnosis, including when diagnosis was confirmed;
3. History of ADHD, ADD, and/or like conditions treatment (previous and ongoing);
4. Recommended treatment (attaching current prescription);
5. Statement that a non-banned ADHD alternative has been considered and why banned stimulant was prescribed; and
6. Annual follow-up with prescribing physician and updated letter or copy of medical record is required in each year of eligibility.

When and where should documentation be sent?

- **The aforementioned documentation must be on file with the University of Maryland Sports Medicine Department in order for the student-athlete to participate in intercollegiate athletics at the University of Maryland.**
- All documentation should be sent to the following address-

University of Maryland Sports Medicine
Attn: Darryl Conway
Gossett Football Team House
379 Field House Drive
College Park, MD 20742
Fax- 877-863-2802 {secure fax}
Email- dconway@umd.edu

Who can student-athletes, parents, coaches, etc. contact with questions regarding issues surrounding ADHD medications and the NCAA Medical Exceptions Policy?

Student-athletes and/or parents with questions regarding the use of prescribed stimulants to treat ADHD, ADD, and/or like conditions should start by directing questions to the physician who initially conducted the evaluation and diagnosis.

Individuals with specific questions regarding the NCAA Bylaws related to banned substances, drug testing, and/or medical exceptions can view the NCAA website (www.ncaa.org/health-safety) and/or contact Darryl Conway (301-314-2663; dconway@umd.edu) or Dr. Yvette Rooks, MD (yrooksm@yahoo.com).



ADHD MEDICAL EXCEPTIONS NOTIFICATION FORM

I, _____ affirm that I have been informed by University of
Student-Athlete Print Name

Maryland Sports Medicine personnel on _____ about the NCAA Banned Substances List
Date
and NCAA Medical Exceptions Policy as it specifically pertains to the use of banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. I attest that:

Initial _____	<u>I AM NOT</u> presently taking and/or have taken within the last 12 months any banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions.
Initial _____	<u>I AM</u> presently taking and/or have taken within the last 12 months banned stimulant medications (e.g. Ritalin, Stattera, Adderall, Concerta, etc.) that are used to treat Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), or like conditions. Medication _____

I, the undersigned, do hereby affirm that I understand that I am to immediately notify a member of the University of Maryland Sports Medicine Department should I ever be prescribed the aforementioned stimulant medications and that I must obtain and submit appropriate documentation from the prescribing physician.

I further attest that I have had any and all questions regarding the NCAA ADHD Medical Exceptions Policy answered to my satisfaction.

Student-Athlete Signature

Date

Athletic Trainer Signature

Date

Athletic Trainer Print Name