Southern Illinois University Edwardsville
Department of Intercollegiate Athletics

www.siuecougars.com

Campus Box 1129 • Edwardsville, Illinois 62026 • (618) 650-2871 • (618) 650-3369 (Fax)

June 22, 2011

Dear SIUE Student-Athlete and Parents,

Welcome to SIUE! We are grateful to the parents for all the support and encouragement you have given your child to be able to compete in intercollegiate athletics. We are excited he or she has chosen to be a part of the SIUE athletics family. I am sure that it is a busy time in your lives as you prepare for him or her to come to school at SIUE.

In this packet are several forms we use for the pre-participation physical exam (PPE). The PPE policy has been formulated in conjunction with our Health Services office and our team physicians to provide protection for the student-athlete from a potentially catastrophic injury.

Enclosed you will find a Student-Athlete Health History Questionnaire Form, a Pre-participation Physical Exam Form, a Parent Insurance Information Form, and a copy of our updated Sports Medicine Medical Policies/Insurance Coverage Information procedures for your reference.

All new student-athletes need a PPE prior to the start of each team's official practice. Check with your coach as to the exact time and place of your first practice. SIUE Student Health Services will be offering PPEs throughout the summer. The cost of the PPE is $25.00, to be paid at the time of the examination. All student-athletes <u>must</u> bring the completed Student-Athlete Health History Form to the PPE appointment. If you would like to have Student Health Services perform the PPE, please contact an athletic trainer at (618) 650-2883 or (618) 650-2160 to arrange a time for your exam.

As a result of new NCAA legislation, effective August 1, 2010, all new student-athletes will have to submit to the sports medicine staff a copy of the lab results of a previous sickle cell trait solubility blood test done to check for the sickle cell trait, or take a sickle cell trait solubility blood test for the sickle cell trait and present copies of the results to the sports medicine staff. The cost for this blood test at Student Health Services is $10.00 and will be the responsibility of the student-athlete. If you choose to have the test performed at Student Health Services, the total cost for the PPE and the test for sickle cell trait test will be $35.00.

A student-athlete can also visit his or her personal physician for his or her PPE as long as the physician uses the enclosed forms for the exam and reviews the health history questionnaire with the student-athlete. The sickle cell test, like the PPE, can be performed by the athlete's primary care physician. All forms submitted will be reviewed by the sports medicine staff and/or the SIUE team physicians. We reserve the right to require additional testing that may be considered necessary to ensure the safety of the student-athlete. Costs for such additional tests will be the responsibility of the student-athlete, their parents or guardians, and their primary insurance company.

The forms need to be answered as completely and carefully as possible and will remain on file to ensure vital information is available to health care providers in the event of a serious or life-threatening injury. Please do not forget to include a copy of your current insurance card (front and back) that covers the student-athlete. The SIUE sports medicine staff will follow the federal privacy laws known as HIPAA that regulate all protected medical information.

The completed forms, along with a copy (front and back) of all insurance cards that cover the student-athlete, and the sickle cell trait blood test result must be turned in to the Athletic Training Room (VC 2201) by August 1, 2011. If you prefer, you may mail forms to:

Southern Illinois University Edwardsville
Attn: Athletic Training
Campus Box 1129
Edwardsville, Illinois 62026

All documentation **must** be on file and complete before the student-athlete will be allowed to practice with his or her team.

If you have any questions or concerns, please feel free to contact me or the other athletic trainers at (618) 650-2883 or (618) 650-2160. Thank you for your help and cooperation regarding this important matter. Remember, it's a great day to be a Cougar!

Sincerely,

Gerald "Gerry" Schlemer, M.Ed., ATC, LAT
Athletic Trainer

Enclosures

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Department of Intercollegiate Athletics
Sports Medicine

Mission Statement
The primary focus of the Department of Intercollegiate Athletics Sports Medicine Office is to care for the student-athlete in all situations where an injury occurs. Our goal is to provide the best possible care to allow the prompt return to the student-athlete's sport safely and expeditiously. A staff of four certified athletic trainers coordinates and staffs the operations of the sports medicine facilities on campus which include preventive care, emergency care, medical referrals, and rehabilitative care. We also have a network of team physicians and providers with whom we work to ensure all injuries are addressed effectively and quickly.

Pre-Participation Physical Exam Policy
All student-athletes are required to complete a pre-participation physical exam (PPE) by a physician before their first season of competition. The evaluation will include a Student-Athlete Health History Questionnaire and a physical exam. The sports medicine unit and Student Health Services will conduct physical exams for student-athletes before their first practice. The cost of the PPE will be determined by Student Health Services and must be paid for at the time of service. If a student-athlete does not pass the PPE based on the evidence presented, he or she will not be allowed to participate in athletics until further tests are performed (at the student-athlete's expense) to clear them for competition. If additional testing still does not warrant passing due to a life-threatening condition, then the student-athlete will not be allowed to participate in athletics at SIUE. If the additional testing reveals a preexisting injury or structural abnormality that is not considered life-threatening but could result in aggravation of the condition if the student-athlete participates in athletics, then the student-athlete may be allowed to participate provided he or she and his or her parents sign a preexisting condition waiver. The waiver would state that the parents and the student-athlete hold the University, its team physicians, and Student Health Services harmless from any liability and costs associated with aggravation of this injury or condition. The final decision on the physical qualifications ore rejection of a student-athlete rests with the team physicians. Returning student-athletes do not need to have a PPE unless notified in writing by the sports medicine staff based on information noted in the previous year's health history or because of a season-ending injury.

Personal Physician Statement
If a student-athlete wishes to visit his or her personal physician, the PPE must be documented on the SIUE forms. If, after review of the submitted documentation, the sports medicine staff and team physicians determine that a condition may exist that poses a risk for the student-athlete and the University, the student-athlete must be willing to submit to any additional assessments required (at the student-athlete's expense).

Sickle Cell Trait Testing (new student-athletes only)
As a result of new NCAA legislation, effective August 1, 2010, all new student-athletes will have to either present a copy of official lab results from a sickle cell trait solubility blood test to the sports medicine staff or have a sickle cell trait solubility blood test. The cost for this blood test will be the responsibility of the student-athlete. If you choose, this can also be performed at Student Health Services. The cost of the test is $10.00.

Forms
All new student-athletes are required to have all forms completed and on file by **August 1, 2011,** before being allowed to practice or participate in any intercollegiate athletic activity. The forms that need to be completed and returned are:

Student-Athlete Health History Questionnaire
Pre-participation Physical Exam Form
Parent Insurance Information Form
Copies of student-athlete's medical insurance card(s) (front and back)
Acknowledgement of having received Medical Policies and Insurance Coverage Information
Sickle Cell trait test lab results

All returning student-athletes are required to have all forms completed and on file by **August 1, 2011,** before being allowed to practice or participate in any intercollegiate athletic activity. The forms that will need to be completed and returned are:

Returning Student-Athlete Medical Update
Parent Insurance Information Form
Copies of student-athlete's medical insurance card(s) (front and back)
Acknowledgement of having received Medical Policies and Insurance Coverage Information

Injury/Illness Reporting
It is the responsibility of the student-athlete to understand the importance of reporting all signs and symptoms of potential injuries and illnesses immediately to the SIUE sports medicine staff, including the athletic trainers, team physicians, and/or to the sports coaching staff. This would also include any potential signs and symptoms of concussions. Failure to report these signs and symptoms may result in additional injury/complication including death. Student-athletes who are injured or become ill during a practice or contest must inform the sports medicine staff **immediately**. However, if a student-athlete wakes up with an injury or illness, he or she must report that injury or illness to the sports medicine staff before 11:00 a.m. Costs pertaining to an injury or illness not reported in a timely manner may be the responsibility of the student-athlete and/or his or her parent(s)/guardian(s). The athletic trainer on duty will evaluate the severity of the injury and work with the student-athlete and a full-time athletic trainer to make the necessary referrals to a qualified physician.

Medical Referrals

The SIUE Department of Intercollegiate Athletics has worked to foster positive relationships with many medical providers in the area who have consistently provided high-quality service to SIUE student-athletes. Members of the SIUE sports medicine staff will refer student-athletes to these providers, unless extenuating circumstances necessitate a different provider. Student-athletes with HMO policies are strongly encouraged to have a local primary care physician so that referrals can be made to ensure timely care is given. All student-athletes must be seen and evaluated by a full-time staff member of SIUE before referral to a physician will be made. A full-time member of the SIUE sports medicine staff must authorize and properly refer all student-athletes to see a physician or medical consultant and/or for diagnostic tests. **If a student-athlete decides to see a physician/medical consultant and/or undergo a diagnostic test without prior authorization or referral from a full-time member of the SIUE sports medicine staff, then the student-athlete and/or the student-athlete's parent(s)/guardian(s) will be financially responsible for any and all medical expenses incurred.**

Medical Second Opinions

Athletes are free to use any physician they wish; however, the relationships we have established with our team physicians may allow for an immediate evaluation and diagnosis. If a student-athlete and/or his or her parent(s)/guardian(s) desire another physician's opinion, a full-time SIUE sports medicine staff member will make a written referral for the second opinion.

Referral Form Protocols

An Injury Referral Form must be filled out in its entirety and signed by the student-athlete and a member of the SIUE sports medicine staff whenever a student-athlete is sent to a physician's office; to Student Health Services; or referred for a diagnostic test, physical therapy, surgery, prescription, etc.

SIUE Department of Intercollegiate Athletics Injury Referral (Authorized Expense)

- This form is used when the student-athlete is being referred for an injury that is the direct result of participation in the intercollegiate athletics program during the dates of primary competitive season and designated off-seasons as approved by the Director of Athletics according to NCAA regulations.
- The referral form will be sent with the student-athlete with the student-athlete's insurance information and physician's prescription (if applicable) attached.
- The student-athlete will return with form indicating the physician's diagnosis and treatment orders.

SIUE Department of Intercollegiate Athletics Illness Referral (Non-Authorized Expense)

- This form is used when the student-athlete is being referred for an injury and/or illness that **will not** be paid by the SIUE Department of Intercollegiate Athletics including illness, preexisting conditions, or resulting injuries from non-sanctioned athletic activity.
- If the condition is for an injury that occurred from a non-supervised athletic activity, then the Illness Referral Form will be used and marked at the top that this is a "**Non-SIUE Department of Intercollegiate Athletics Authorized Expense**."
- The referral form will be sent with the student-athlete with the student-athlete's insurance information and physician's prescription (if applicable) attached.
- The student-athlete will return with form indicating the physician's diagnosis and treatment orders.

The physician's rehabilitation orders, in most cases, can be carried out by the certified athletic trainers at SIUE. Following an injury, it is the responsibility of the team or personal physician to clear the student-athlete before the athlete will be allowed to return to official practice or competition.

Rehabilitation Procedures

In most cases, the student-athlete's rehabilitation orders can be carried out by the certified athletic trainers at SIUE. However, there are times when it may be necessary for a student-athlete to utilize an outside or out-of-town rehabilitation facility. Such cases include winter or summer breaks or the need for specialized rehab (i.e., hand rehab after hand surgery). In such situations, permission must be granted in advance from a full-time SIUE sports medicine staff member. **If a student-athlete decides to utilize rehabilitation services without the prior written authorization from the full-time member of the SIUE sports medicine staff, the student-athlete and/or the student-athlete's parent(s)/guardian(s) will be financially responsible for any and all medical expenses incurred**.

Missed Doctor's Appointment Policy

Student-athletes who are late and/or fail to show up for a scheduled appointment with the team physician, medical consultants, and/or diagnostic tests/procedures will be financially responsible for any and all charges resulting from the missed appointment. In addition, the student-athlete may be responsible for rescheduling the appointment and providing his or her own transportation.

Privacy Policy

Southern Illinois University Edwardsville follows the guidelines established by the 1996 Health Insurance Portability and Accountability Act (HIPAA) and the 1974 Family Educational Rights and Privacy Act (FERPA). Any medical information that needs to be shared with health care providers, coaches, and insurance companies is released only after the athlete (or parents if athlete is a minor) has signed a written authorization allowing the release. The student-athlete has a right to limit what information is shared and with whom this information is shared and has the right to revoke at any time any authorizations—provided the revocation is in writing. The sports medicine staff will not release any information to the media or general public as to the condition, availability, or extent of any injury.

Injury Protocols

The protocol for a serious injury to a student-athlete occurring on campus is as follows: The SIUE athletic trainer on duty will assess any injuries that occur at the contest or practice. The care of the student-athlete is our first priority. If the injury is assessed to be serious enough to warrant immediate treatment at an emergency room, the injured athlete will be transported by ambulance. In situations where transportation by ambulance is not warranted, a member of the athletic trainer staff will accompany the student-athlete to the hospital/urgent care facility and assist with dispensation of information to the medical staff. After care has been secured for the student-athlete, the athletic trainer or a coach will obtain consent from the student-athlete to inform the parents as to the nature and extent of the injury and location of the athlete. An athletics department staff member will remain with the student-athlete until his or her condition warrants release or other arrangements have been made.

The protocol for a serious injury to a student-athlete occurring off campus is as follows: An SIUE athletic trainer traveling with the team will assess the severity of the injury. If the team is traveling without an SIUE athletic trainer, the host athletic trainer will make the assessment and make a recommendation to the coaching staff. In the case of a severe injury needing medical care at a hospital, the student-athlete will be transported to the hospital by ambulance. In situations where transportation by ambulance is not warranted, a member of the athletic training staff or coaching staff will accompany the student-athlete to the hospital with insurance information to provide a communication link. After care has been secured for the student-athlete, the athletic department staff member will obtain consent from the student-athlete to inform the parents as to the nature and extent of an injury and location of the athlete. The staff member will remain with the student-athlete until his or her condition warrants release or other arrangements are made. Upon the student-athlete's return to campus, a member of the SIUE Sports Medicine Staff should be notified and will make arrangements to follow up with the student-athlete and make any necessary referrals. Should the student-athlete's condition warrant remaining in the hospital, a member of the athletic department's full-time staff will make the necessary arrangements to allow for the return of the student-athlete and the staff member remaining behind with the injured student-athlete.

Insurance Coverage

The insurance coverage the SIUE Department of Intercollegiate Athletics carries on student-athletes should pay most of the out-of-pocket expenses incurred at the usual and customary rate—provided the primary insurance carrier's rules are followed. However, this coverage is limited to **athletic injuries only**. Our coverage is a **secondary accident policy** and does not cover:

- Preexisting conditions of a chronic nature that occurred prior to participation in intercollegiate athletics at SIUE
- Injuries that occurred as a result of activities other than supervised intercollegiate athletics (i.e., auto accident, intramural, etc.)
- Routing illness (i.e., flu, colds, appendicitis)

The insurance coverage will cover at the usual and customary rate and will utilize discounts provided by the student-athlete's primary insurance.

All student-athletes should consider coverage under some type of individual health insurance before beginning school. Any insurance that covers the student-athlete's insurance should cover athletic-related injuries and/or illnesses and shall be considered the primary insurance coverage for all athletic-related injuries. The student-athlete and the parents must complete the Parent Insurance Information Form and supply on a yearly basis a photocopy (front and back) of any health insurance cards that cover the student-athlete.

The SIUE insurance program will pay for the excess of the necessary medical treatment up to the usual and customary limits for such expenses incurred within 104 weeks (2 years) from the initial date of the injury or accident. The first documented visit to a medical provider must occurred within 30 calendar days of the initial date of the injury/accident.

It is the responsibility of the student-athlete and his or her parent(s)/guardian(s) to understand the conditions that apply to their policy and comply with any requests for information from the primary insurance company. Any delinquent bills resulting in bad credit due to noncompliance with insurance company requests may be the responsibility of the student-athlete and/or his or her parent(s)/guardian(s). In the event that a student-athlete and/or his or her parent(s)/guardian(s) receive payment/reimbursement directly from their insurance company for athletic-related injury or illness claims, the full account balance becomes the responsibility of the student-athlete and/or his or her parent(s)/guardian(s) until payment is turned over to the provider.

********* IMPORTANT NOTE *********

If your primary family coverage is through an **HMO** (health maintenance organization) or a **PPO** (preferred provider organization), you must follow the procedures required by the plan in order for the SIUE insurance to satisfactorily complete its portion of the claim. This is especially important if the plan requires preauthorization to have your athlete treated out of the service area. We suggest that you and your student-athlete become very familiar with the type of plan under which he or she is covered and the rules that need to be followed when seeking medical attention. The athlete will need all necessary phone numbers and policy numbers should medical attention be required while away from home.

Any changes to a health insurance policy or status of a student-athlete must be reported to the SIUE athletic training staff as soon as they occur. If proper notification is not received, the SIUE Department of Intercollegiate Athletics is not responsible for any delays in payment, collection notices, or negative reflection on credit reports that may occur.

Insurance Claims Procedure

All medical bills for injuries incurred by a student-athlete as a result of an accident in the intercollegiate athletic program should be sent directly to your address or to your medical insurance company. In some cases, SIUE will get a copy of the bill. In no instance should SIUE or the athletic department be the primary place for the bill to be sent by the medical provider. Bills not received in a timely manner may be the responsibility of the student-athlete and/or the student-athlete's parent(s)/guardian(s). The SIUE Department of Intercollegiate Athletics will not be responsible for any delays in payment, collection notices, or negative reflections on credit reports that may occur when bills are not submitted in a timely manner.

When the primary or family insurance company receives a claim, the company will:

1. Honor the claim and pay all or a portion of the bill, or
2. Not honor the claim and send a letter of denial (i.e., student-athlete is no longer covered due to an age restriction).

Any balance remaining after payment has been made by your primary, family, or employer group insurance should be submitted to the Head Athletic Trainer. The insurance company should send you an Explanation of Benefits (EOB) indicating amounts paid toward the claim. Please forward the EOB and the itemized bill (the Health Care Financing Administration form (HCFA 1500) from individual providers or the Uniform Bill form (UB 92) from the hospital) directly to the Athletic Trainer.

If the claim has been rejected, you should receive a letter of denial from your insurance company. Forward the letter of denial and the itemized bill to the Athletic Trainer. If coverage is not available for your son or daughter, a letter from you may be necessary.

Once your EOB form and itemized statement are received, your claim will be submitted promptly to the department's secondary insurance carrier for consideration. Should additional information be needed, please respond promptly.

Correspondence may be mailed to:

Gerry Schlemer
Athletic Trainer
SIUE Intercollegiate Athletics
Campus Box 1129
Edwardsville, IL 62026

The fax number is (618) 650-3369

Exclusions and Limitations

The secondary medical insurance policy will not apply to situations indicated below. This list is not all inclusive.

1. Injuries/illnesses which are not a direct result of intercollegiate athletics participation during the dates of the primary competitive season and designated off-seasons as approved by the Director of Athletics according to NCAA regulations.
2. Experimental procedures.
3. Cosmetic surgery or procedures unless directly related to an athletics-related injury.
4. Injuries/illnesses which are a result of intramural, club sport, or recreational activities (non-intercollegiate activities) as well as training/conditioning activities that occur outside of the primary competitive season and designated off-season periods.
5. Injuries/illnesses which are recurrences of old injuries/illnesses sustained before participation in the intercollegiate sports program.
6. Expenses for athletic injuries incurred after completion of the student-athlete's intercollegiate athletic eligibility.
7. Medical expenses beyond the limitations and exclusions of, or not covered by, the SIUE Department of Intercollegiate Athletics insurance policy.

The importance of having some form of personal health insurance coverage cannot be overemphasized. Medical bills resulting from the aforementioned activities will be submitted to the student-athlete's primary medical insurance. **Any unpaid balances are the responsibility of the student-athlete and/or the student-athlete's parent(s)/guardian(s)**.

International Student-Athletes

In order to enroll in classes at any United States college or university, international students must prove they have insurance that complies with standards set by the federal government. Insurance requirements will vary depending under what status the student qualifies. International Student Services and Student Health Services can assist the student-athlete with all insurance inquiries.

Questions

If you have additional questions or concerns, please feel free to contact Gerry Schlemer at (618) 650-2883 or by e-mail at gschlem@siue.edu.

Please keep this as your source of reference information for policies regarding insurance coverage.

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Department of Intercollegiate Athletics
Sports Medicine

Acknowledgement of Medical Policies and Insurance Coverage Information

I have received and read a copy of the Department of Intercollegiate Athletics Medical Policies and Insurance Coverage Information. I understand that these policies and procedures will be followed.

I agree to notify and provide the new insurance information to the sports medicine office of the Department of Intercollegiate Athletics should my primary insurance coverage change during the course of the year.

______________________________ ______________
Student-Athlete's Signature Date

______________________________ ______________
Parent/Guardian Signature Date

This form must be signed and returned to the Athletic Training Room (VC 2201) before the student-athlete will be allowed to practice.

Please sign and return this form to:

SIUE Sports Medicine
Department of Intercollegiate Athletics
Campus Box 1129
Edwardsville, IL 62026

Office Use Only	
HMO (In Area)	HMO (Out of Area)
PPO Coverage	No Insurance
Date _______	Reviewed ________

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Department of Intercollegiate Athletics
Sports Medicine

Parent Insurance Information Form (2011-2012)

IMPORTANT: This form **must** be returned with a copy (front and back) of all insurance cards to the athletic training staff before any student-athlete can participate or practice in his or her sport. Complete all blanks with the required information or place an N/A if not applicable.
*Please print clearly in **BLUE INK** or **BLACK INK** only. Pencil is **NOT** acceptable. Initial any changes.*
Failure to complete every line could result in the loss of your athletic insurance coverage.

NAME OF STUDENT-ATHLETE Last First MI	YEAR IN SCHOOL F So Jr Sr	SPORT(S)	DATE OF BIRTH

LOCAL OR COLLEGE ADDRESS	CITY	STATE	ZIP CODE	LOCAL OR CELLULAR PHONE (include area code)

PERMANENT HOME ADDRESS	HOME PHONE (include area code)

CITY	STATE	ZIP CODE	STUDENT–ATHLETE'S SOCIAL SECURITY NUMBER	STUDENT-ATHLETE'S UNIVERSITY ID NUMBER

FATHER or GUARDIAN NAME	MOTHER or GUARDIAN NAME
HOME ADDRESS	HOME ADDRESS

CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

DAY TELEPHONE (include area code)	NIGHT TELEPHONE (include area code)	DAY TELEPHONE (include area code)	NIGHT TELEPHONE (include area code)
EMPLOYER'S NAME	ADDRESS	EMPLOYER'S NAME	ADDRESS

ALTERNATE EMERGENCY CONTACT NAME	RELATIONSHIP	DAY TELEPHONE (Include area code)	NIGHT TELEPHONE (include area code)

Is student-athlete covered under a medical/health insurance plan? ❑YES ❑NO
If the student-athlete is NOT covered by any insurance plan, please skip this section. If the student-athlete is covered by more than one policy, put the primary insurance below and list the secondary on the back of this sheet.

Is the insurance provided through the parent(s) or guardian(s) workplace? ❑YES ❑NO

MEDICAL INSURANCE COMPANY NAME OR PLAN NAME	Is the medical plan that covers the athlete considered one of these managed care plans? □ HMO (Health Maintenance Organization) □ PPO (Preferred Provider Organization)

MEDICAL INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

POLICY OR IDENTIFICATION NUMBER	GROUP NUMBER	INSURANCE COMPANY PHONE NUMBER (include area code)

NAME OF POLICY HOLDER (i.e., PARENT'S NAME)	LAST 4 DIGITS OF POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S BIRTHDATE

Does your insurance or plan require a second opinion before surgery? ❑YES ❑NO
Is the student-athlete covered by dental insurance? ❑YES ❑NO

DENTAL INSURANCE COMPANY	ADDRESS	POLICY NUMBER

I hereby give authorization to the SIUE athletic training staff, the accident insurance carrier, and the risk management staff of Southern Illinois University Edwardsville to inspect and/or secure copies of case history records, laboratory reports, diagnoses, x-rays, itemized bills, explanations of insurance benefits, and other coverage data related to athletic injuries sustained while at Southern Illinois University Edwardsville. A photocopy of this authorization shall be deemed effective and valid as the original. I authorize the University or its insurance agents to pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by the University for athletic participation.

I further give authorization to the SIUE athletic training staff to share the information contained on this form with the student health center, the University's medical providers and consultants, as well as the coaching staff for emergency information and billing purposes. I understand that any or all of this authorization may be revoked by me at any time by doing so in writing.

STUDENT–ATHLETE'S SIGNATURE	PARENT SIGNATURE

NOTE: A parent must sign this form if the insurance that covers the student-athlete is provided through a parent or parents.
If you have secondary insurance for the student-athlete please write it on the back of the form.
Please include a copy of that insurance card (front and back) as well.

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Department of Intercollegiate Athletics
Sports Medicine

Intercollegiate Athletics Pre-participation Physical Form

Name ______________________________ Date ___/___/___ Sport _____________________

FR SO JR SR 5th Date of Birth ___/___/___ Student ID #_________________ Sex M / F

Allied Health Professional Section

Height ___________________ (Stated) Weight ____________ lbs.

Vision R Eye 20/_______ L Eye 20/_______ Both Eyes 20/_______ Corrected Y N

Resting BP_______/_______ Resting Pulse _______ Post 2 Min Exercise Pulse _______ PO2 ________

	WNL R	WNL L	ABNORMAL R	ABNORMAL L	NEEDS PHYS. REVIEW	COMMENTS
FOOT & ANKLE						
Heel Cord Flex	□	□	□	□	□	
Strength (all ranges)	□	□	□	□	□	
Drawer Test	□	□	□	□	□	
AROM	□	□	□	□	□	
KNEE						
Ligament Stability	□	□	□	□	□	
Muscular Strength	□	□	□	□	□	
Muscular Flexibility	□	□	□	□	□	
Reflex Test	□	□	□	□	□	
MacMurry Test	□	□	□	□	□	
Apley's Compression	□	□	□	□	□	
Lachman's Test	□	□	□	□	□	
HIP, BACK AND NECK						
Back AROM All Ranges	□	□	□	□	□	
Neck AROM All Ranges	□	□	□	□	□	
SLR	□	□	□	□	□	
Hamstring Flexibility	□	□	□	□	□	
Hip Strength All Ranges	□	□	□	□	□	
UPPER EXTREMITY						
Shoulder AROM All Ranges	□	□	□	□	□	
Shoulder Subluxation	□	□	□	□	□	
Elbow AROM	□	□	□	□	□	
Grip Strength	□	□	□	□	□	
Wrist Hand Finger	□	□	□	□	□	

Examiner's Signature __________________________ Title ___________________ Date __________

Physician Section

	NORMAL	ABNORMAL	COMMENTS
Eyes			
Ears			
Mouth			
Heart			
Lungs			
Abdominal			
Genitalia/Hernia			
Skin			

I certify that I have reviewed the health history and examined the student-athlete and I recommend:

		COMMENTS
_____	Clearance with no limitations	
_____	Clearance pending further evaluation or testing	________________________________
_____	Referral to other health care professional prior to clearance	________________________________
_____	Clearance with limitations	________________________________
_____	Disqualified from competition	________________________________

Physician's Name (print): ________________________________ Phone: ________________________________

Address: ____
(Street) (City) (State) (ZIP)

Physician's Signature: ________________________ MD or DO Date: ________________________

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Department of Intercollegiate Athletics
Sports Medicine

Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the SIUE sports medicine unit for purposes of determining if you pose a health threat/risk to yourself on the athletic field. Bring this form (completed) to the physician's office when obtaining your Pre-Participation Physical Exam. This information will remain **confidential** at all times.

Please print clearly in BLUE or BLACK ink only! Pencil is not acceptable. Initial any changes.

A. General Information

Name ______________________________ Sport(s) ________________ Date ____________
LAST NAME FIRST NAME MIDDLE INITIAL

Social Security # ________________ Student ID________________ Date of Birth: ____________

PERMANENT ADDRESS: ____
STREET
____
CITY STATE ZIP CODE

Home Phone: (________)__________________ Cellular Phone: (_________)________________

B. Family Health History

Father's health conditions:______________________ Age:______ If deceased, cause of death ________________Age at the time of death:_______

Mother's health conditions:______________________ Age:______ If deceased, cause of death ________________Age at the time of death:_______

Sibling's health conditions:______________________ Age:______ If deceased, cause of death ________________Age at the time of death:_______

Sibling's health conditions:______________________ Age:______ If deceased, cause of death ________________Age at the time of death:_______

Sibling's health conditions:______________________ Age:______ If deceased, cause of death ________________Age at the time of death:_______

C. Medical Questions

If you answer **YES** to any of the following questions, please provide an explanation at the end of this section or on a separate sheet of paper.
Please remember, all answers to the questions will remain confidential.

1. Have you ever had chest pain and/or shortness of breath, dizziness, lightheadedness, or passed out during or after exercise/practice? ☐ YES ☐ NO
   If yes, what was the cause? ________________________________
2. Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice? ☐ YES ☐ NO
3. Do you get tired more quickly than your teammates/friends do during exercise/practice? ☐ YES ☐ NO
4. Have you ever been told that you have a heart murmur? ☐ YES ☐ NO
5. Has any family member or close relative had heart problems and/or died of sudden death before the age of 50? ☐ YES ☐ NO
6. Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems? ☐ YES ☐ NO
7. Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO
   If yes, what was the reason and the result? ________________________________
8. Does anyone in your family have a history of high blood pressure or high cholesterol? ☐ YES ☐ NO
9. Have you ever been diagnosed with seasonal allergies? ☐ YES ☐ NO
10. Are you presently taking or have you previously taken any allergy medications? ☐ YES ☐ NO
11. Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications, food, insect bites, or bee stings? ☐ YES ☐ NO
12. Have you ever been diagnosed with asthma and/or exercised-induced asthma? ☐ YES ☐ NO
13. Are you presently taking or have you previously taken any asthma medications or used an inhaler? ☐ YES ☐ NO
    Date(s) ________________________________
    Please describe ________________________________
14. If yes, then how many times do you use your rescue inhaler (e.g., Albuterol, Proventil, etc.) during an average week? ____________
15. If yes, then how many acute asthma attacks have you had in the past 12 months? ____________
16. Have you ever suffered a head injury/concussion (no matter how minor)?? ☐ YES ☐ NO
17. List date(s)/time(s) (e.g., practices or games) missed ________________________________
18. When you had the concussion(s), did you have amnesia/memory loss associated with it? ☐ YES ☐ NO
19. Have you ever been knocked unconscious? ☐ YES ☐ NO
20. List date(s) ________________________________

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21. Do you suffer from headaches? ☐ YES ☐ NO
    a. How often? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
    b. Where are your headaches located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Head
22. Do you have a history of migraine headaches? ☐ YES ☐ NO
    a. How often? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
    b. Where are your headaches located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Head
23. When was your last eye exam? ______________________
24. Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ YES ☐ NO
25. Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO
26. Do you routinely wear glasses? ☐ YES ☐ NO
27. Do you routinely wear contact lenses? Type ______________________ ☐ YES ☐ NO
28. Do you require any special hearing devices/equipment? Type ______________________ ☐ YES ☐ NO
29. Have you ever suffered an injury to your ear(s), nose, and/or throat? ☐ YES ☐ NO
30. Have you ever suffered an injury to your mouth, jaw, and/or teeth? ☐ YES ☐ NO
31. Have you ever suffered an injury to your cervical spine and/or neck? ☐ YES ☐ NO
32. Have you ever had "burners," "stingers," or brachial plexus injuries? ☐ YES ☐ NO
33. Have you ever experienced numbness and/or tingling in your arms/fingers? ☐ YES ☐ NO
34. Have you ever suffered an injury to your shoulder/upper arm? ☐ YES ☐ NO
35. Have you ever suffered an injury to your elbow/forearm? ☐ YES ☐ NO
36. Have you ever suffered an injury to your wrist(s), hand(s), and/or finger(s)? ☐ YES ☐ NO
37. Have you ever suffered an injury to your spine/low back/sacroiliac joint? ☐ YES ☐ NO
38. Have you ever had numbness/tingling down one or both legs? ☐ YES ☐ NO
39. Have you ever suffered an injury to your hip/groin (including hernias and/or sports hernias)? ☐ YES ☐ NO
40. Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? ☐ YES ☐ NO
41. Have you ever suffered an injury to your knee and/or patella (kneecap)? ☐ YES ☐ NO
42. Have you ever or do you presently wear a knee brace? ☐ YES ☐ NO
    Which knee? ______________________ Brand/Model of brace? ______________________
    Reason(s) for wearing? ______________________
43. Have you ever suffered an injury to your ankle/lower leg/feet/toes? ☐ YES ☐ NO
44. Do you presently ☐ tape your ankle(s) ☐ use ankle brace(s) ☐ Other. Please describe ______________________
45. Have you ever suffered an injury to your rib/thorax/chest? ☐ YES ☐ NO
46. Have you ever been diagnosed with a problem with your stomach, abdomen, intestines, or rectum? ☐ YES ☐ NO
47. Do you routinely suffer from severe or recurrent abdominal pain? ☐ YES ☐ NO
48. Do you routinely suffer from chronic or recurrent diarrhea? ☐ YES ☐ NO
49. Do you have only one of two paired, functioning organs (e.g., kidney, testicles, ovary)? ☐ YES ☐ NO
50. Have you ever been diagnosed with a communicable disease (STD; HIV; Hepatitis A, B, or C; Herpes Simplex; Syphilis; Tuberculosis)? ☐ YES ☐ NO
51. Do you have any skin problems that we should be aware of (e.g., itching, rashes, acne, warts, eczema, fungus)? ☐ YES ☐ NO
52. Have you ever suffered from a heat-related illness? ☐ YES ☐ NO
    (Check all that apply): ☐ heat cramps/heat syncope (fainting) ☐ heat exhaustion ☐ heat stroke
53. Have you ever received intravenous fluids (IV) or been hospitalized for a heat-related problem? ☐ YES ☐ NO
54. Have you ever been diagnosed with Diabetes? ☐ YES ☐ NO
55. If yes, do you daily monitor your blood sugar level? ☐ YES ☐ NO
    a. How many times per day? ______________________ What is your average level? __________
    b. Have you had your A1C level checked within the last three (3) months ☐ YES ☐ NO
    c. Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months? ☐ YES ☐ NO
56. Have you ever, to the best of your knowledge, been tested for Sickle Cell Anemia? ☐ YES ☐ NO
57. Does any member of your family, to the best of your knowledge, carry the Sickle Cell Trait/have Sickle Cell Anemia? ☐ YES ☐ NO
58. Have you ever been advised that you carry the Sickle Cell Trait/have Sickle Cell Anemia? ☐ YES ☐ NO
59. Have you ever had any injury or illness other than those already noted? ☐ YES ☐ NO
60. Do you have any ongoing or chronic illnesses? ☐ YES ☐ NO
61. Have you ever been told by a physician to restrict your sports activity or not to participate in a sport? ☐ YES ☐ NO
62. Have you ever been under the care of a psychiatrist and/or psychologist? ☐ YES ☐ NO

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63 Have you ever had a rash or hives develop during and/or after exercise? ☐ YES ☐ NO

64. Have you ever been told that you have kidney disease? ☐ YES ☐ NO

65. Have you ever had Rubella (German Measles) and/or Rubeola (Red Measles) or Chicken Pox? ☐ YES ☐ NO

66. Have you ever had a stomach and/or duodenal ulcer? ☐ YES ☐ NO

67. Have you had a viral infection (i.e., mononucleosis, myocarditis) within the past six (6) months? ☐ YES ☐ NO

68. Have you ever had seizures, convulsions, and/or epilepsy? ☐ YES ☐ NO

69. Have you ever had gallbladder disease and/or a urinary problem? ☐ YES ☐ NO

70. Do you have frequent ear infections or nosebleeds? ☐ YES ☐ NO

71 Have you had a tetanus booster within the past five (5) years? If yes, when? ________________________ ☐ YES ☐ NO

72. Have you ever received the Hepatitis B (HBV) vaccination series (all 3 shots)? If yes, when?________________________________ ☐ YES ☐ NO

73. Have you had a weight change (loss or gain) of greater than 10 pounds in the past year? ☐ YES ☐ NO

74. What is your ideal weight? _________________ lbs.

75. Are you a vegetarian? If yes, what type? _____________________________ ☐ YES ☐ NO

76. Do you regularly lose weight to participate in your sport? ☐ YES ☐ NO

77. Do you want to weigh more or less than you presently do? ☐ YES ☐ NO

78. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders? ☐ YES ☐ NO

For Females Only

79. At what age did you have your first menstrual period? ____

80. Have you had menstrual periods within the past 12 months? ☐ YES ☐ NO

a. If yes, how many? __________________________ When was your most recent menstrual period? ______________________________________

b. How much time do you usually have from the start of one period to the start of another? ____

c. What was the longest time between menstrual periods within the past year? ____

81. Do you have painful or heavy menstrual periods? ☐ YES ☐ NO

82. Do you take any medications during your menstrual periods? If yes, what? ____ ☐ YES ☐ NO

83. Do you take birth control pills? If yes, what brand? ____ ☐ YES ☐ NO

84. Have you ever had any problems with your breasts? ☐ YES ☐ NO

85. Have you had a pelvic examination within the last year? ☐ YES ☐ NO

For Males Only

86. Have you ever had a testicular examination? Date ___________ ☐ YES ☐ NO

87. Have you ever been diagnosed with testicular cancer? ☐ YES ☐ NO

Answers

If you have answered <u>YES</u> to any of the above, please explain: ____

____

____

____

____

____

Prescription Medications:

Please list <u>all</u> prescription and over-the-counter medications you are <u>currently</u> taking or have taken in the past two (2) years and for what purpose.

MEDICATION	PURPOSE	DOSAGE	DATE(S)

Student-Athlete's Initials ______

Supplements/Ergogenic Aids:

Please list all supplements/ergogenic aids that you are currently taking or have taken in the past two (2) years and for what purpose.

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

Catastrophic Injury Statement

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I understand that by participating in intercollegiate athletics at Southern Illinois University Edwardsville, the potential for a catastrophic injury does exist. With this fact in mind, I understand the importance of the rules and the procedures as well as the necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though I follow all instruction as to proper technique. I understand that the team physicians will have the final authority to eliminate me from further participation due to an injury, illness, or medical condition which could represent a risk to my safety and an undue liability risk to Southern Illinois University Edwardsville.

Student-Athlete's Signature:____ Date: ___________________________

Medical History Statement

I have completed this medical history questionnaire and answered it truthfully and to the best of my knowledge. I am prepared to answer questions from the Southern Illinois University Edwardsville medical staff (including team physicians, athletic trainers, nurses, and consultants) concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have **not disclosed** on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to the Southern Illinois University Edwardsville medical staff and its consultants as it may be a matter of life or death.

Student-Athlete's Signature:____ Date: ___________________________

Authorization to Treat/Authorization to Release Information

I give authorization to the athletic training staff, team physicians, health services, and the medical consultants of Southern Illinois University Edwardsville to evaluate and treat any injuries that may occur during my participation in intercollegiate athletics. I also give authorization to the athletic training staff to make referrals for treatment to the team physicians and/or other medical consultants of Southern Illinois University Edwardsville. I give authorization to the athletic training staff to communicate with the physicians, health services, and medical consultants of Southern Illinois University Edwardsville about any injuries and inform the coaching staff of my particular sport(s) and my parents as to the nature of my injury(ies), limitations, and estimated time of return. Finally, I give authorization to the athletic training staff to share with the coaching staff emergency information as to my medical history (i.e., allergies, conditions, etc.) and insurance information which would be considered important for health care staff to have if I were in an accident and unable to give this information. I understand that this authorization is valid for one calendar year and that any or all of it may be revoked by me at any time by doing so in writing.

Student-Athlete's Signature:____ Date: ___________________________

Reporting of Signs and Symptoms of Potential Injuries/Illnesses Statement

I accept the responsibility and understand the importance to report all of my signs and symptoms of potential injuries and illnesses immediately to Southern Illinois University Edwardsville Sports Medicine Staff (including the athletic trainers and team physicians) and/or my sport's coaching staff. This includes the signs and symptoms of a potential concussion. I further understand that failure to report these signs and symptoms may results in additional injury/complications, including death.

Student-Athlete's Signature:____ Date: ___________________________

If the student-athlete is under 18 years of age, please have a parent sign.

Physician Review

I have reviewed this health history at the time of this student-athlete's Pre-participation Physical Exam.

______________________________	______________________________	________________
Physician's Name (print)	Signature	Date

SIUE Sports Medicine Review

______________________________ ATC/LAT	______________________________	________________
Reviewer's Name (print)	Signature	Date

Student-Athlete's Initials ______