Dear Student-Athlete:

On behalf of the athletic training staff, we would like to welcome you to San José State University. You will be required to report to campus for your pre-participation physical exam. You will be notified by your coach for the date and time of your exam. Please come to your physical exam appropriately dressed, in shorts and a t-shirt or tank top. Enclosed you will find physical forms, consent forms, and insurance information forms which you will need to read and fill out completely before reporting for your physical exam. The following directions are provided to allow you to fill your paperwork out in the correct and most efficient manner. Please bring a photo ID with you to your physical exam.

Assumption of Risk Form: Read, initial, sign and date the disclaimer.

University Drug Testing Consent: Read, sign and date the form.

ADD/ADHD Disclosure Form: Read, sign and date the form.

Insurance Information: Fill in all personal and insurance information, sign, and date form. Please make a photo copy of the front and back of insurance card and bring with you to your physical exam.

Disclosure of Protected Health Information: Read, sign and date the form.

Sports Medicine Health History: Complete all pages of form, sign and date.

Athlete’s Authorization for Disclosure of General Medical Information: Read, sign and date the form.

Alcohol Policy and Authorization for Release of Information: Read, sign and date the form

Consent for Medical Treatment of Minors: To be completed only if student-athlete is under the age of 18.

**IF YOU ARE UNDER THE AGE OF 18:** A parent or guardian must sign the Assumption of Risk form, University Drug Testing Consent form, Alcohol Policy and the Consent For Medical Treatment of Minors form. These forms must be signed for a physical to be completed.

Please do not hesitate to call if you have any questions or concerns regarding your pre-participation physical exam.

Sincerely,

Scott Shaw MA, ATC
Director of Sports Medicine
(408) 924-1297
scott.shaw@sjsu.edu
The Intercollegiate Athletic Program carries an excess accidental insurance policy. This means the policy will cover costs not paid by the student-athletes’ or student-athletes’ parents’ primary insurance.

• Student-athletes will be covered by the accidental insurance only if they complete a physical exam and provide a completed insurance information form.
• No individual may practice or compete without obtaining an athletic clearance from the Team Physician and completion of these forms. If this is not done, insurance coverage cannot be provided and medical care cannot be given. A PHYSICAL FROM AN OUTSIDE PHYSICIAN IS NOT ACCEPTABLE.
• Benefits are limited to injuries sustained during participation in regularly scheduled and supervised team activities. Coverage includes participation in actual games, practices, scrimmages, strength and conditioning workouts, or while in transit from the Campus to another institution with the Team.
• San José State University athletic health insurance only provides secondary coverage. This means that your own or your parent’s health insurance policy will take precedence when paying medical expenses. Any medical expenses not covered by the insurance company will be the athlete’s responsibility.
• Any student-athlete with a pre-existing or recurring (i.e. an injury that occurred prior to participation at this institution) injury will not be covered by the athletic insurance unless the particular injury has been cleared by the team physician and recorded as stable.
• The head athletic trainer administers athletic insurance claims and medical referrals.
• The insurance provided by the Athletic Department will not cover any illness or incident unrelated to athletics. Student medical insurance can be purchased through the California State University Health Insurance Program. This insurance is a supplement to the service provided through the Student Health Center. This coverage can be purchased by the semester or for an entire school year. This coverage is recommended for the college student who is without any type of medical insurance. Go to www.csuhealthlink.com to find out more information and/or purchase this insurance.
• Any injury or condition that will affect an athlete’s participation in team practice or competition must be reported to the athletic trainer before referral to the Student Health Center or Team Physician.
• No individual will be permitted to return to practice or competition after a significant injury without the consent of the Team Physician or athletic trainer.
• All injuries must be reported to the athletic trainer. Under no circumstances should an athlete seek outside care without proper referral by the Team Physician or Staff Athletic Trainer. If an athlete seeks outside medical care without an appropriate referral THEY WILL BE RESPONSIBLE FOR ALL RELATED MEDICAL EXPENSES. No liability on the part of San José State University exists or may be assumed to exist for off-campus medical or dental treatment or hospitalization of any kind of athletic injuries without prior referral.
• Primary medical insurance: This is coverage arranged by you, a parent, spouse or employer. Typically classified as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). HMO’s are affordable and convenient; however, severely limit the medical service required by a competing athlete. Delays may affect ability to complete or be ready for a season. Recommended coverage involves insuring through a plan that allows for a physician of choice to be seen when required. If coverage is through an HMO the primary care physician should be located close to campus.
• Medical bills: Please take all medical bills and corresponding Explanation of Benefits (EOB) to the head athletic trainer. The head athletic trainer will send the bill and EOB to the Athletic Department’s insurance company for payment. Please contact the Head Athletic Trainer if there are any further questions regarding medical bills or insurance coverage.
DISCLAIMER:

I. I have read the entire contents of the “Insurance Policies” and understand all of the statements outlined. Initial _____

II. I realize that there is a risk of injury or death as a result of athletic practice and competition. Any type of injury can occur. Possible serious injuries include (but are not limited to) the following:
   - Brain damage
   - Spinal cord injury
   - Quadriplegia (paralysis of all four limbs)
   - Paraplegia (paralysis of two limbs, usually legs)
   - Fractured (broken) neck
   - Fractured (broken) back
   - Heat Injury/Illness Can lead to internal organ damage or death
   - Other types of less serious injuries that can occur include strains, sprains, contusions and other fractures Initial _____

III. I accept the responsibility for reporting my injuries and illnesses to the San José State University Sports Medicine Staff, including signs and symptoms of concussions. Initial _____

III. I understand that my signature below means that I accept the “San José State University Insurance Policies”; that I understand the risk of potential injury stated in paragraph II; that I accept responsibility for reporting my injuries and illnesses; and that I consent to assume the risk involved throughout my participation as an Intercollegiate Athlete at San José State University.

_________________________________________  ____________________________
Date                                     Signature of Student-Athlete

_________________________________________  ____________________________
Date                                     Signature of Parent or Guardian if student-athlete is 17 years old or younger
DRUG TESTING CONSENT FORM
SAN JOSE STATE ATHLETICS DEPARTMENT
DRUG SCREENING AND
SUBSTANCE ABUSE PROGRAM 2016-2017

I, __________________________ hereby acknowledge that I have received a copy of the San José State University (SJSU) Department of Athletics (DIA) Drug Screening and Substance Abuse Program. I further acknowledge that I read the policy, that it has been outlined to me, and that I fully understand the provisions of the Program. I understand that I must sign this Consent Form in order to participate in intercollegiate athletics at SJSU.

I agree to allow the DIA to drug test me in accordance with the Drug Screening and Substance Abuse Program;

I understand that I am subject to the penalties outlined in the Drug Screening and Substance Abuse Program;

I was provided an opportunity to review the procedures outlined in the Drug Screening and Substance Abuse Program;

I understand that DIA drug testing results will be provided to the Director of Athletics (AD)/designee, Director of Sports Medicine, my Head Coach and parent(s) or legal guardian;

I understand that the consequences outlined below include both the DIA drug-testing program, as well as the NCAA year-round drug-testing program;

- A first positive drug test will result in a minimum of an initial evaluation and two counseling sessions at the University Counseling Services, I will be suspended for 10 percent of my team’s competitions if testing positive for street drugs, I will be suspended for 20 percent of my team’s competitions if testing positive for performance enhancement drugs and may also be disciplined further if deemed appropriate by the AD.
- A second positive drug test will result in a minimum of an initial evaluation and two counseling sessions at the University Counseling Services, I will be immediately suspended for 50 percent of my team’s competitions if testing positive for street drugs. As a result of the second positive test for performance enhancement drugs, I will not be permitted to participate in athletics at SJSU and athletics financial aid will cease permanently.
- A third positive drug test will result in not being permitted to participate in athletics at SJSU and athletics financial aid will cease permanently.

______________________________
Date Signature of Student-Athlete

______________________________
Date Signature of Parent (if student-athlete is a minor)

Name (please print)

______________________________
Sport SJSU ID #
The NCAA is requiring that all student-athletes that require the use of prescription medication for the treatment of attention deficit disorder (ADD) and attention deficit-hyperactivity disorder (ADHD) disclose such use prior to competition. This disclosure requires that the sports medicine staff have on file a copy of a diagnostic evaluation reporting that the student-athlete has been diagnosed as ADD or ADHD, history of treatment and copies of the most current prescription written for ADD/ADHD treatment. Should a student-athlete be drug tested by the NCAA and report positive for amphetamine use, this information must immediately be available for submission to the NCAA in order to appeal for a medical exception. If this information is not available, the student-athlete could be suspended for one year.

I, _____________________________________ acknowledge that (circle one) I AM / AM NOT presently taking any medications prescribed by a doctor for the treatment of ADD/ADHD. I understand that if I am, I must assist the sports medicine staff with obtaining the proper documentation prior to competition.

If not taking any medication for ADD/ADHD, I understand that doing so without having been diagnosed as ADD/ADHD and without having a prescription from a physician will cost me a year of athletic eligibility.

____________________________  ____________________________  
Sport      SJSU ID #  

________________________________________________________________________
Date   Signature of Student-Athlete
________________________________________________________________________
Date   Signature of Parent (if student-athlete is a minor)

________________________________________________________________________
Name (please print)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
# Health Insurance Information / Authorization

**Student-Athlete's Name:** ____________________________  
**SJSU ID #:** ____________________________  
**Yr. In School:** __________

**Sex:**  
- [ ] Male  
- [ ] Female  

**Date of Birth:** ____________________________  
**Sport:** ____________________________

**Permanent Address:** ____________________________

**City:** ____________________________  
**State:** ____________________________  
**Zip:** ____________________________

**Phone #:** ____________________________  
**Social Security No.:** ____________________________

**Campus Address:** ____________________________

**City:** ____________________________  
**State:** ____________________________  
**Zip:** ____________________________

**Cell Phone #:** ____________________________  
**E-Mail:** ____________________________

**Emergency Contact Names:**  
1. ____________________________  
2. ____________________________

**Relationship:**  
1. ____________________________  
2. ____________________________

**Home Phone Number:**  
1. ____________________________  
2. ____________________________

**Work/Cell Phone Number:**  
1. ____________________________  
2. ____________________________

### PRIMARY INSURANCE INFORMATION

| Insured Name: | ____________________________ |
| SS No.: | ____________________________ |
| Home Address: | ____________________________ |
| Home Phone: | ____________________________ |
| Employer: | ____________________________ |
| Employer Address: | ____________________________ |
| Work Phone: | ____________________________ |
| Insurance Company: | ____________________________ |
| Address: | ____________________________ |
| Insurance Company Phone #: | ____________________________ |
| Group #: | ____________________________ |
| Policy / ID #: | ____________________________ |

**Type of Insurance:**  
- [ ] HMO  
- [ ] PPO  
- [ ] Other  

**Primary Care Physician:** ____________________________  
**Physician’s Phone #:** ____________________________

**Is pre-authorization necessary for diagnostic medical services?**  
- [ ] Yes  
- [ ] No  

---

### SECONDARY INSURANCE INFORMATION

| Insured Name: | ____________________________ |
| SS No.: | ____________________________ |
| Home Address: | ____________________________ |
| Home Phone: | ____________________________ |
| Employer: | ____________________________ |
| Employer Address: | ____________________________ |
| Work Phone: | ____________________________ |
| Insurance Company: | ____________________________ |
| Address: | ____________________________ |
| Insurance Company Phone #: | ____________________________ |
| Group #: | ____________________________ |
| Policy / ID #: | ____________________________ |

**Type of Insurance:**  
- [ ] HMO  
- [ ] PPO  
- [ ] Other  

**Primary Care Physician:** ____________________________  
**Physician’s Phone #:** ____________________________

**Is pre-authorization necessary for diagnostic medical services?**  
- [ ] Yes  
- [ ] No  

---

* The San José State University 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 San José State University Department of Intercollegiate Athletics’ insurance carrier consider payment for any remaining balances.

* I hereby authorize the San José State University Department of Intercollegiate Athletics, affiliated hospitals & physicians, to furnish information to insurance carriers concerning any illness, injury & treatments, and I hereby assign to the party all payments for medical services rendered to the student-athlete.

* I agree to supply any and all information requested by my primary insurance, the San José State University Department of Intercollegiate Athletics and their excess insurance in a timely manner.

* A photocopy of this authorization shall be deemed as effective and valid as the original.

* I agree to notify the San José State University Athletic Training Room 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 and all charges incurred.

* I hereby certify that I have read and understand the above statements, that any and all questions have been answered to my satisfaction, and that the answers provided are true, complete and correct to the best of my knowledge.

**Student-Athlete’s Signature:** ____________________________  
**Date:** ____________________________
SAN JOSÉ STATE UNIVERSITY
STUDENT-ATHLETE AUTHORIZATION/CONSENT FOR
DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____________________________, hereby authorize San José State University and its physicians, athletic
trainers and health care personnel to disclose my protected health information and any related information
regarding any injury or illness during my training for and participation in intercollegiate athletics to the SJSU
Athletics Media Relations and Mountain West Conference (MW)/Mountain Pacific Sports Federation (MPSF).

I understand that my protected health information will be used by the SJSU Athletics Department and
MW/MPSF for whatever reasonable purposes deemed necessary.

I understand that my injury/illness information is protected by federal regulations under either the Health
Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of
1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my
consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary
and that my institution will not condition any health care treatment or payment, enrollment in a health plan or
receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this
disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for
participation in NCAA or conference athletics.

I also understand that the MW and MPSF are not covered by HIPAA and the Buckley Amendment and that
these regulations will not apply to the MW or MPSF’s use or disclosure of my injury/illness information.

This authorization expires 400 days from the date of my signature below, but I have the right to revoke it in
written notification to the Director of Sports Medicine at SJSU. I understand that a revocation is not effective to
the extent action has already been taken in reliance on this authorization/consent.

_________________________________ _________________________________ _______________
Printed Name of Student-Athlete   Signature     Date

_________________________________
SJSU ID #
SAN JOSÉ STATE UNIVERSITY
SPORTS MEDICINE HEALTH HISTORY FORM

Name ______________________________    Sport ____________________   Date ____________
SJSU ID # __________________________

Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:
____________________________________________________________________________________
____________________________________________________________________________________

Explain “Yes” answers below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>HEALTH HISTORY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, please identify below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Asthma        _____ Anemia        _____ Diabetes        _____ Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ High Blood Pressure        _____ High Cholesterol        _____ Heart Murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Heart Infection        _____ Kawasaki Disease        Other:________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, Echocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Females Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. How many periods have you had in the last 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician’s Notes**
____________________________________________________________________________________
____________________________________________________________________________________
### HEALTH HISTORY QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does anyone in your family have a heart problem, pacemaker or implanted defibrillator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has anyone in your family had unexplained fainting, unexplained seizure or near drowning?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician’s notes
_________________________________________ _______________________
_________________________________________ _______________________
_________________________________________ _______________________

### MEDICAL QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any allergies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please identify specific allergy below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines ____________________________ Pollens __________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food ________________________________ Stinging Insects __________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you cough, wheeze or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there anyone in your family who has asthma?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you born without or are you missing a kidney, eye, testicle (males), your spleen or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had infectious mononucleosis (mono) within the last month?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any rashes, pressure sores or other skin problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had herpes or MRSA skin infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a head injury or concussion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a hit or blow to the head that causes confusion, prolonged headache or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a history of seizure disorder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have headaches with exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you get frequent muscle cramps when exercising?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you or someone in your family have sickle trait or disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had any eye injuries?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wear glasses or contact lenses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you on a special diet or do you avoid certain types of foods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you recently lost more than 15 pounds in a three-month period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you believe yourself to be fat when others say you are thin?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you worry that you have lost control over how much you eat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you make yourself sick because you feel uncomfortably full?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you say food dominates your life?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
49. Have you ever been diagnosed with disordered eating?
50. I often have trouble sleeping.
51. I wish that I had more energy most days of the week.
52. I think about things over and over.
53. I feel anxious and nervous much of the time.
54. I often feel sad or depressed.
55. I struggle with being confident.
56. I don’t feel hopeful about the future.
57. I have a hard time managing my emotions (frustration, anger, impatience).
58. I have feelings of hurting myself or others.
59. Do you have any concerns that you would like to discuss with a doctor?

**Physician’s notes**

**BONE AND JOINT QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>46. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or game?</td>
<td></td>
</tr>
<tr>
<td>47. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
</tr>
<tr>
<td>48. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches?</td>
<td></td>
</tr>
<tr>
<td>49. Have you ever had a stress fracture?</td>
<td></td>
</tr>
<tr>
<td>50. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)</td>
<td></td>
</tr>
<tr>
<td>51. Do you regularly use a brace, orthotics or other assistive device?</td>
<td></td>
</tr>
<tr>
<td>52. Do you have a bone, muscle or joint injury that bothers you?</td>
<td></td>
</tr>
<tr>
<td>53. Do any of your joints become painful, swollen, feel warm or look red?</td>
<td></td>
</tr>
<tr>
<td>54. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
</tr>
</tbody>
</table>

**Physician’s Notes**

**Explain “yes” answers here**

I hereby state that, to the best of my knowledge, my answers to the above health history questions are complete and correct.

Date __________________ Signature of Student-Athlete __________________
Athlete's Authorization For Disclosure of General Medical Information

This authorization for disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq. of the California Civil Code.

**AUTHORIZATION**

I hereby authorize San José State University Student Health Center and University Counseling Services to release any medical and mental health information pertaining to referrals by athletics and any injury/illness that may affect the athlete’s playing or practice status to the Athletic Training Staff, San José State University Intercollegiate Athletics.

**THIS AUTHORIZATION MAY INCLUDE THE FOLLOWING MEDICAL INFORMATION:**
- Medical records related to my illness/injury
- Health History and Physical Examination
- X-ray report(s)
- Laboratory test(s)
- Complete medical record

**DURATION:**

This authorization shall become effective immediately and shall remain in effect for the duration of athletic eligibility during this academic year.

**RESTRICTIONS:**

I understand that the SJSU Intercollegiate Athletic Training Staff may not further use or disclose the medical information unless authorization is obtained from me, or unless such use or disclosure is specifically required or permitted by law.

Patient's Signature _____________________________ ID# __________________________
Printed Name _____________________________ Birth Date __________________________
Address _____________________________
          (street)  (City & State)  (Zip)
Date _____________________________
I hereby acknowledge that I have received a copy of the San José State University Intercollegiate Athletic Alcohol Policy and fully understand the policy. **I understand that I must sign this Consent Form in order to participate in intercollegiate athletics at SJSU.**

I understand that I am subject to the penalties outlined in the Intercollegiate Athletics Alcohol Policy;

I was provided an opportunity to review the procedures outlined in the Intercollegiate Athletics Alcohol Policy;

I further authorize you to make a confidential release to the Athletic Director, Deputy Director for Internal Operations, my head coach, parent(s), or legal guardian(s) documents in accordance with that Policy. To the extent set forth in this document, I waive any privacy or privilege I may have in connection with such information.

San Jose State University, employees, and agents are hereby released from legal responsibility or liability for the release of such information and records as authorized by this form.

__________________________
Print Full Name

__________________________
Signature

__________________________
Date

__________________________
Parent/Guardian-required if under 18

__________________________
Date

__________________________
Phone #

__________________________
SJSU ID #
ATHLETIC TRAINING ROOM
SAN JOSÉ STATE UNIVERSITY

CONSENT FOR MEDICAL TREATMENT OF MINORS

The undersigned parent or guardian of ___________________________________________ who is ________ years old, hereby authorizes the medical staff of the Athletic Training Room, as agents for the undersigned to consent to any diagnostic procedure (including x-rays), to the administration of any medical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by, and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act.

This authorization is given in advance of any specific diagnosis, treatment or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

Date ___________________     Signature ____________________________________________

(Parent or Guardian)

Student’s Full Name ____________________________

(Last)     (First)

Address ____________________________________________

Telephone Where Parent or Guardian May Be Reached:

Mother/Guardian
Home: ( ) ___________________ Business: ( ) ___________________

Father/Guardian
Home: ( ) ___________________ Business: ( ) ___________________

Student’s Birthdate: ____________  Student ID Number: ________________________

Allergies to Medication or Foods: _______________________________________________

Any Special Medications or Pertinent Information: __________________________________

Student’s Physician: ________________________ Phone: ( ) ______________
