Dear New Student-Athlete,

Congratulations on becoming an NCAA Division I student-athlete at The University of Southern Mississippi. As a Sports Medicine Staff we are looking forward to the upcoming year in Southern Miss athletics! We are very excited about meeting you and are eager to begin the medical process for you to participate. This begins with medical paperwork. Below is a checklist to ensure that you have all the necessary items when you arrive for your pre-participation physical examination. For your convenience all paperwork has been combined in this one document.

What to bring with you when you come for your physical:

- **Completed** Paperwork (Pages 2-14 of this document)
  - Parent Insurance Information
  - Local Emergency Contact
  - Insurance Acknowledgement
  - Student Authorization
  - Medical History
  - Female Questionnaire (Females only)
  - Concussion Statement
  - Warning Statement
  - Policies & Procedures Acknowledgement

- Copy of ALL Medical Insurance Cards (Front & Back)
  (NOTE: Medicaid and Medicare are not sufficient to fulfill this requirement.)
  - Health Insurance
  - Vision Insurance
  - Dental Insurance
  - Prescription Insurance

- Copy of **Sickle Cell** and CBC Blood Work Results
  (Mandated by Conference USA every student athlete must show proof of Sickle Cell testing.)

- **My Physical Date/Time:** _______________________________ ____

If you have further questions regarding Pre-Participation Physicals, Physical Paperwork, or Physical times for specific sports please feel free to contact: Melissa Chastang at Melissa.Chastang@usm.edu or Katie Barker at Kathleen.barker@usm.edu.

**Southern Miss To The Top!**
The University of Southern Mississippi  
Sports Medicine  
Parent Insurance Information Form

<table>
<thead>
<tr>
<th>Student Athlete’s Name</th>
<th>Sport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

Dear Parent,

Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports, is “EXCESS” or “SECONDARY” to any other collectible insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse’s employer. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

**WE AS THE SCHOOL DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR INSURANCE.**

PLEASE NOTE:
1. Most Employers’ group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. Claims against your group insurance DOES NOT increase your individual insurance premiums.

### Parent/Guardian Demographic Information

<table>
<thead>
<tr>
<th>Father/Guardian</th>
<th>Mother/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>State</td>
</tr>
<tr>
<td>Zip</td>
<td>Zip</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Social Security #</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Employer</td>
<td>Employer</td>
</tr>
<tr>
<td>Work Phone #</td>
<td>Work Phone #</td>
</tr>
</tbody>
</table>

### Primary Insurance

<table>
<thead>
<tr>
<th>Subscriber’s Name</th>
<th>Effective Date of Plan</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance COMPANY</td>
<td>Policy Limit</td>
<td></td>
</tr>
<tr>
<td>GROUP Number</td>
<td>IDENTIFICATION Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician (PCP) Name</td>
<td></td>
</tr>
<tr>
<td>Insurance Company Mailing Address</td>
<td>PCP Address</td>
<td></td>
</tr>
<tr>
<td>Insurance Company City, State, Zip</td>
<td>PCP City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>

I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by __________________________.

Student Athlete

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. A Photo static copy of this authorization shall be considered as effective and valid as the original.

Student Athlete Signature __________________________ Date

Parent/Guardian Signature __________________________ Date

***Please also include front and back copies of ALL insurance cards.***
Name: ____________________________________________

Last                                      First                                      Middle

Social Security Number: _____-____-______   St ID #_________________________   DOB: ___/___/___

Sport: ___________________          Year in School: ______________

**LOCAL INFORMATION:**

Local Address: ____________________________________________

________________________________________________________________________

Local Phone #:___________________________

Cell Phone #:___________________________

School E-mail: ____________________________

**EMERGENCY MEDICAL INFORMATION:**

Drug Allergies: ____________________________________________

Food Allergies: ____________________________________________

Other Allergies: ____________________________________________

Permanent Home Address: ____________________________________________

________________________________________________________________________

Permanent Home Phone #:___________________________

**Emergency Contact Person:**

Name & Relationship: ____________________________________________

Address: ____________________________________________

________________________________________________________________________

Phone #:___________________________   Cell Phone #:___________________________   Work #:___________________________
Please Initial ONE of the following statements:

_____ I attest that I have insurance coverage under a current insurance policy for medical issues that may occur during my participation in intercollegiate athletics at The University of Southern Mississippi.

_____ I attest that I DO NOT have any insurance coverage under a current insurance policy for medical issues that may occur during my participation in intercollegiate athletics at The University of Southern Mississippi. I understand that the USM Department of Athletics strongly recommends that all student-athletes purchase the “USM Student Plan of Hospital, Medical, Surgical, and Major Medical Expense Protection” Insurance Program (if parents do not own medical/accident insurance, this USM student group policy could provide welcome relief to the student in the event of illness or injury NOT related to competition or practice in programs administered by the Department of Athletics.

Please Initial the following statements:

_____ I agree to notify The University of Southern Mississippi Department of Athletics if there is a change in, or expiration of, insurance coverage. I agree to update the insurance information that I have on file with the Sports Medicine Department as soon as this occurs.

_____ I understand and agree that The University of Southern Mississippi Sports Medicine Department reserves the right to deny payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics.

_____ I understand and agree the Department of Athletics cannot be held responsible for any medical and dental bills as a result of injury unless:
   A) The Participant is a recruited/scholarship student-athlete, or
   B) The Non-Recruited/Non-Scholarship Participant has been selected as a official member of the team and is taking part in practice or competition.
   C) Injuries related to supervised sports’ participation.

Authorization for Treatment

_____ I/We give authorization to the Athletic Trainers and/or Team Physicians to evaluate and treat any injuries that may occur during my intercollegiate athletic participation at The University of Southern Mississippi. This includes immediate first aid and treatment, x-rays, physical exams, follow-up care, and rehabilitation. I/We understand that the Team Physicians have the authority to eliminate me from further participation because of an injury and/or because of an undue risk to The University of Southern Mississippi.

Parent/Guardian Permission

I hereby give my consent for, ____________________________ to engage in NCAA approved athletic activities at The University of Southern Mississippi. By signing this document I acknowledge that The University of Southern Mississippi provides secondary insurance coverage for athletic related injuries/illness and agree that any medical/accident insurance I carry is the primary coverage. I/We understand that my private insurance will be billed FIRST on incurred athletically related medical expense charges and that the university’s secondary insurance policy will be utilized for the remaining expenses.

____________________________________________________  ______________________
Student Athlete Signature                           Date

____________________________________________________  ______________________
Parent/Guardian Signature                           Date
The University of Southern Mississippi
Sports Medicine
Student-Athlete Authorization

Purpose: This form is used to authorize The University of Southern Mississippi Sports Medicine Department to use or disclose your Protected Health Information (PHI) to the individual(s) of class(es) of persons (organizations) you designate and for the USM Sports Medicine Department to disclose your PHI for the purpose stated on the completed form.

Last Name: ________________________ First Name: ____________________ Sport: ____________________

Section A: Individual Authorizing Use and/or Disclosure

Complete information. This Authorization will be good for the duration of the five-year eligibility status.

Section B: The Use and/or Disclosure Being Authorized

PHI to be Used and/or Disclosed:
The PHI to be disclosed will be injury and/or illness information that directly affect your participation in intercollegiate athletics. It is important for the student athlete to understand that this authorization is all or none. If you give permission to disclose PHI, you give permission to disclose any PHI to any of the parties indicated below within the discretion of the Head Athletic Trainer.

I hereby authorize The University of Southern Mississippi’s Sports Medicine staff and its Team Physicians to disclose personal health information about me to the following persons or entities: Initial next to each as they apply:

_____ USM Head/Assistant Coaches  _____ Parents/Legal Guardians
_____ Medical Providers  _____ Professional Organizations
_____ Insurance Companies  _____ USM Strength & Conditioning Staff
_____ The University of Southern Mississippi Media Relations Staff

I understand that it is necessary for head coaches, assistant coaches, strength and conditioning staff, medical care providers, and insurance companies to have access to my PHI if I am to participate in intercollegiate athletics. Accordingly, I acknowledge that if I do not give permission for my PHI to be shared with these persons or entities, I will not be allowed to participate in intercollegiate athletics at The University of Southern Mississippi.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice to the Head Athletic Trainer. I also understand that by revocation of this authorization it may affect my ability to continue to participate in intercollegiate athletics at The University of Southern Mississippi.

Section C: Media Disclosure:

PHI disclosed to the media will be limited to the injury/illness and status of participation. You are not required to permit disclosure of your PHI to the media as a condition of participating in intercollegiate athletics. This disclosure may be revoked at any time upon written notice to the Head Athletic Trainer. Please check one:

_____ I hereby authorize The University of Southern Mississippi Intercollegiate Athletics to disclose my PHI to the media as it pertains to my status of participation within my respective sport.
_____ I do not authorize The University of Southern Mississippi Intercollegiate Athletics to disclose my PHI to the media as it pertains to my status of participation within my respective sport.

Section D: Individual’s Signature

I, ________________________________, have had full opportunity to read and consider the (Please Print Name) contents of this authorization, and I understand that, by signing this form, I am conforming my authorization of the use and/or disclosure of my protected health information, as described on this form.

___________________________________________________________
Student Athlete Signature

Date

If student-athlete is under legal age please have legal representative sign below:

___________________________________________________________
Parent/Guardian Signature

Date
In accordance with NCAA recommendations and to provide the most comprehensive medical care possible to all the student athletes at The University of Southern Mississippi, please complete the following questionnaire prior to the beginning of the school year. When answering the following questions, please think carefully about any problems you may have encountered.

**DEMOGRAPHIC INFORMATION**

Full Name: ____________________________________________________________
Social Security #: _______ - _______ - _______
Date of Birth: ___________________________
Sport: ___________________________
Year in School: _______________________
Home Phone #: _______________________
Cell Phone #: _______________________
Parent/Guardian Name(s): _______________________________________________
Permanent Address: _____________________________________________________
City: ___________________________ State: __________ Zip: _______

**FAMILY HISTORY**

Has anyone in your immediate family ever been diagnosed with any of the following? Circle Yes or No

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden Death (before age 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan’s Syndrome</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diabetes Cancer Tuberculosis Asthma Gout Mental Illness Sickle Cell Anemia Drug/Alcohol Abuse

Please explain all “Yes” answers: _____________________________________________________________________

________________________________________________________________

________________________________________________________________

***PERSONAL HISTORY***

**Allergies**

List any other allergies that you may have: ________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Medications**

Do you currently take any prescription medications? Yes No
If yes, please indicate which medication(s) you take and for what reason: ______________________________________
_____________________________________________________________________
_____________________________________________________________________

Do you currently take any over-the-counter medications? Yes No
If yes, please indicate which medication(s) you take and for what reason: ______________________________________
_____________________________________________________________________
_____________________________________________________________________

Do you take any supplements (i.e., vitamins, creatine, protein, weight gainer)? Yes No
If yes, please indicate which supplements or vitamins: __________________________
_____________________________________________________________________
_____________________________________________________________________

The University of Southern Mississippi Sports Medicine
New Athlete Medical Paperwork 2016-17
## General Medical

Have you ever been diagnosed with any of the following medical conditions?  
(Circle Yes or No)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marfan’s Syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhematic Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Palpitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers ____________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Please list any other medical illness or condition that you may have had that is not listed in this questionnaire:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Has anyone in your family suffered a premature (50 years or younger) death or significant disability from a heart condition?  
Yes  No

Do you know of any close relatives with heart conditions?  
Yes  No

Have you ever been told that you have a heart condition?  
Yes  No

Have you ever passed out during or after any exercise session?  
Yes  No

Have you ever been dizzy during or after any exercise session?  
Yes  No

Have you ever had chest pain or discomfort during or after any exercise session?  
Yes  No

Have you ever been diagnosed with high blood pressure?  
Yes  No

Have you ever been diagnosed with racing of your heart or skipping heartbeats?  
Yes  No

Have you ever had chest pain while exercising?  
Yes  No

Have you ever been told you have a heart murmur?  
Yes  No

Have you ever had high cholesterol?  
Yes  No

Have you ever missed any practices or games due to any of the above conditions?  
Yes  No

Have you ever undergone any testing on your heart?  
Yes  No

Have you ever seen a Doctor for any of the above conditions?  
Yes  No

Please explain all “Yes” answers, including when it occurred: __________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Do you have a history of Asthma?  
Yes  No

If yes, do you currently use an inhaler?  
Yes  No

Please list the medication used and how often: ______________________________________________

If yes, please provide dates: ______________________________________________

Describe Injuries: ___________________________________________________________________

Are you missing or have impaired function of any paired organ (i.e., kidney)?  
Yes  No

Have you ever had any unusual or internal bleeding?  
Yes  No

If yes, please explain: ____________________________________________________________

Have you ever been hospitalized for any reason?  
Yes  No

If yes, please explain: ____________________________________________________________

____________________________________________________________________________
Have you ever had surgery on any body part? Yes  No
If yes, please explain: ____________________________________________

Are you currently under a Doctor’s care for any reason? Yes  No
If yes, please explain: ____________________________________________

Please list the following information, if applicable:

Do you have a family doctor? Yes  No
Name of Family Doctor: ______________________ Phone #: ______________________
Address: __________________________ City: __________ State: _____ Zip: _______

**Vision History**

Do you wear glasses or contacts? Yes  No
Which? ____________________________
Do you wear them during competition? Yes  No
What is the date of your last eye exam? __________________________

**Dental History**

Do you currently suffer from any dental problems? Yes  No
Do you wear a mouthpiece or other dental protective device other than equipment required by your sport? Yes  No

**Orthopedic/Injury History**

Do you have a family orthopedic doctor? Yes  No
Name of Orthopedic Doctor: ______________________ Phone #: ______________________
Address: __________________________ City: __________ State: _____ Zip: _______

Have you ever had surgery on any body part for an injury suffered during sports participation? Yes  No
If yes, please explain, including dates: _______________________________________

Have you ever had an x-ray, CT Scan, or MRI Scan taken on any body part, including your head, neck, and spine? Yes  No
If yes, please explain, including dates: _______________________________________

Do you require any special taping or protective devices, such as a brace, for sports participation? Yes  No
If yes, please explain: _______________________________________

Please indicate any injuries to the following:

**Head:**

- Skull Fracture Yes  No
- Concussion Yes  No
- Other: __________________________

Please explain all “Yes” answers, including when they occurred: _______________________________________

Were you treated by a doctor following these head injuries? Yes  No
What doctor were you treated by? __________________________
How many games and/or practices did you miss due any head injuries? __________________________

**Neck:**

- Fracture Yes  No
- Pinched Nerve Yes  No
- Other: __________________________

Please explain all “Yes” answers: _______________________________________

The University of Southern Mississippi Sports Medicine
New Athlete Medical Paperwork 2016-17
### Back:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disc Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:

### Shoulder:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLAP Lesion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:

### Elbow/Wrist:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:

### Hip:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degenerative Joint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:

### Knee:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osgood’s Schlatter Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cartilage Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subluxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscular (Hamstring, Quad)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:

### Foot/Ankle:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sprain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shin Splints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flat Feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please explain all “Yes” answers:
Please List any other injuries not listed above: ____________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
I hereby state that, to the best of my knowledge, all of the information in this questionnaire is complete, correct, and accurate.

Print Student Athlete Name

Student Athlete Signature Date

Parent/Guardian Signature Date
The University of Southern Mississippi
Sports Medicine
Female Athlete Questionnaire
(If you are a MALE athlete DISREGARD this page.)

Name: ___________________________ Age: _____ Date: ________ Sport: ____________

Please answer each question to the best of your ability. All answers will be kept confidential between the athlete and certified athletic trainer.

1. How old were you when you had your first menstrual period? ______________________

2. How often do you have a menstrual cycle? _________________________________

3. How long do your periods last? _________________________________

4. How many menstrual cycles have you had in the past 12 months? ____________

5. Do you ever have trouble with heavy bleeding or abnormal spotting? ____________

6. Do you ever experience excessive cramping with your period? ____________

7. Have you experienced any unusual vaginal discharge? ____________

8. Do you currently take birth control or hormone therapy pills? Yes _____ No _____
   If yes, please list name of pill __________________________

9. When was your last pelvic exam? _________________________________

10. Have you ever had an abnormal PAP smear? __________________________

11. Do you have any impaired female organs (ovaries, uterus, etc.)? Yes _____ No _____
    If yes, please explain: __________________________________________

12. Have you ever been treated for anemia (low blood iron)? Yes _____ No _____ When? ____________

13. How many meals do you eat a day? ____________ How many snacks? ____________

14. What have you had to eat and drink in the last 24 hours? __________________
    __________________________________________

15. Are there certain foods or food groups that you do not eat? ____________
    Please explain: __________________________________________

16. Have you ever been on a diet? Yes _____ No _____
    How long? ____________ Why? __________________________________________

17. What is your present weight? ____________

18. Are you satisfied with this weight? Yes _____ No _____
    If not, what would you like your weight to be? __________________

19. Are you currently or have you ever used dietary supplements to control your weight? (Please List Below)
    __________________________________________

20. Have you ever been diagnosed and/or treated for an eating disorder? Yes _____ No _____
    If yes, are you currently under the supervision of a doctor? Yes _____ No _____

21. Do you have any questions or concerns about maintaining a healthy weight and body image?
    __________________________________________

22. Have/Do you suffer from stress fractures? Yes _____ No _____

23. Have you ever had a Bone Density study done? Yes _____ No _____ If yes, when? ____________________
I confirm that I have been informed by The University of Southern Mississippi’s Department of Athletics that by participating in intercollegiate athletics, I may experience any of the following symptoms when suffering from a concussion:

- Headaches
- Dizziness
- Nausea
- Blurred Vision
- Amnesia
- Possible Loss of Consciousness
- Ringing in the ears (Tinnitus)
- Confusion
- Disorientation
- Slurred or Incoherent Speech
- Delayed Verbal or Motor Response
- Light Sensitivity

I, the undersigned, do hereby affirm that it is my responsibility to notify the USM Sports Medicine Staff should I experience any of these symptoms at any time. I further attest should I suffer a concussion that I agree to abide by the USM Concussion Policy before being allowed to return to play in my sport.

__________________________________________  _____________________
Student Athletes Signature                     Date

If student-athlete is under legal age please have legal representative sign below:

__________________________________________  _____________________
Legal Representative Signature                 Date
My continuing participation in the sport of ______________________________________________ requires an acceptance of risk of injury/illness. The University of Southern Mississippi has taken reasonable precautions to minimize the risk of significant injury/illness by providing competent coaching and instructions, well-maintained equipment and facilities, proper conditioning and quality medical care.

The chances of an athlete sustaining a catastrophic sport’s injury are extremely remote, yet I understand that serious injuries/illnesses can happen to anyone. Participation in my sport could result in death, exposure to serious and even fatal infectious diseases, serious neck and spinal injury, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury/illness or impairment to other aspects of the body, general health and well-being.

I know that I risk incurring a tragic injury/illness. I understand, acknowledge and assume the risk of participating in my sport.

_______________________________________________________  
Student Athlete Printed Name

_______________________________________________________  
Student Athlete Signature  Date

_______________________________________________________  
Parent/Guardian Signature  Date
Acknowledgement of Athletic Training Policies and Procedures


These policies are located online for viewing or for a hard copy on the Sports Medicine Page under the Policy Tab.

____________________________________________
Student Athletes Signature

____________________________________________
Legal Representative Signature

____________________________________________
Date

____________________________________________
Date