Dear Returning Student-Athlete,

The Southern Miss Sports Medicine Staff welcomes you back for another season of Division I athletics at The University of Southern Mississippi. As a Sports Medicine staff we are very excited about the upcoming year in Southern Miss athletics! As you know every season 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 2-10 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

- **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

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>
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<tbody>
<tr>
<td>Name</td>
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<td>City</td>
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<td>Home Phone</td>
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<tr>
<td>Social Security #</td>
<td>Date of Birth</td>
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<tr>
<td>Employer</td>
<td>Work Phone #</td>
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<tr>
<td>Employer</td>
<td>Work Phone #</td>
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</tbody>
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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>Insurance Company Mailing Address</td>
<td>PCP Name</td>
<td></td>
</tr>
<tr>
<td>Insurance Company City, State, Zip</td>
<td>PCP Address</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.***
The University of Southern Mississippi
Sports Medicine
Student-Athlete Local & Emergency Contact Information

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:

1. Name & Relationship: ______________________________________________________

   Address:_________________________________________________________________

   Phone #:_________________________  Cell Phone #:_________________________  Work #:_________________________

2. Name & Relationship: ______________________________________________________

   Address:_________________________________________________________________

   Phone #:_________________________  Cell Phone #:_________________________  Work #:_________________________
The University of Southern Mississippi
Sports Medicine Department
Insurance Acknowledgment and Participation Form

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 an 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 here by 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

_______________________________________________________
Parent/Guardian Signature

_______________________________________________________
Date

_______________________________________________________
Date

The University of Southern Mississippi Sports Medicine
Returning Athlete Medical Paperwork 2016-17
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 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 Athletes Signature  Date

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

__________________________________________  ______________________
Legal Representative 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 over the summer.

Name: ________________________________  Sport: ___________________________  Date: ____________________

(Circle One)

1. Have you been hospitalized or had major illness since the end of the school year?  Yes  No

2. Are you currently ill in any way?  Yes  No

3. Have you had a major injury (Including Cerebral Concussion) since the end of the school year?  Yes  No

4. Do you have any incompletely healed injuries?  Yes  No

5. Are you currently taking any medication?  Yes  No

6. Have you seen a doctor for any illness over the summer?  Yes  No

7. Have you seen a doctor for any injury over the summer?  Yes  No

8. Have you been diagnosed with any new allergies?  Yes  No

9. Do you want to see the Team General Practitioner for any reason?  Yes  No

10. Do you have any injuries or problems you would like checked or re-checked by the Team Orthopedic Physician?  Yes  No

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

The undersigned, herewith, certifies the answers to the questions above to be correct and true.

_________________________________  _______________________

Student Athlete 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? ______________

The University of Southern Mississippi Sports Medicine
Returning Athlete Medical Paperwork 2016-17
The University of Southern Mississippi
Department of Athletics
Concussion Policy Acknowledgement

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 Athlete’s Signature                                    Date

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

__________________________________________________________  ______________________
Legal Representative Signature                                 Date
The University of Southern Mississippi
Sports Medicine Department

Warning Statement

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

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

______________________________________________
Student Athletes Signature

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

______________________________________________
Legal Representative Signature

Date

Date