Dear Incoming Student Athlete and Parents,

Welcome on behalf of the Athletic Training Staff at Delaware State University. We have some pertinent information regarding our medical policies and forms for you for the upcoming school year. The following is a list of forms your child will need prior to coming to campus:

- Student Health Forms
- First Year Student Athlete Health Packet from Athletic Training
- Proof of Sickle Cell Testing/results (signed by a doctor)
- Current Insurance Card (or photo copy)

*Student athletes will not be allowed to receive a pre-participation exam or participate in any athletic related activities until all of the above forms are completed.*

Once the above requirements have been met, all new incoming student athletes (freshman, transfers) will be required to see the DSU team physician for their pre-participation physical exam. Students who have sustained any recent fractures, dislocations, severe sprains or other injury to the head, neck, back, shoulder, knee, internal organs, or any other body part are required to report these injuries to their team athletic trainer and team physician at this time. The failure to report such injuries will relieve the University of all Responsibility and liability to the student in the event the student re-injures the affected part and, provided the team physician determines the original injury contributed to the re-injury. If your child has sustained an injury prior to arriving at DSU he/she may need additional diagnostic testing before he/she will be cleared to participate in their sport. The athlete and/or parent will be financially responsible for any pre-existing injury that requires further testing to be cleared for their sport (i.e. x-rays, blood tests, etc.).

Per NCAA guidelines, the loss of any paired organ (eye, kidney, testicle, etc.) may disqualify anyone from participating on any intercollegiate team sponsored by the Department of Athletics. In the event that a student athlete experiences a loss of a paired organ, the following factors will be considered by the DSU team physicians to determine an athlete’s participation status:

- The quality and function of the remaining organ
- The probability of injury to the remaining organ
- The availability of current protective equipment and the likely effectiveness of such equipment to prevent injury to the remaining organ.

**The decision to deny clearance for athletic participation based on the above factors is at the sole discretion of the DSU team physicians.**
FIRST YEAR ATHLETICS PRE-PARTICIPATION PHYSICAL EXAMINATION (2017-2018)

Background

1. Name: __________________________________________

   E-mail address: __________________________________

2. Date of Birth _____/_____/_______  3. Gender: Male  Female

4. Academic Class (for the upcoming year)

   Freshman  Sophomore  Junior  Senior

   Co-term (concurrently completing a bachelor’s and master’s degree)  Graduate

5. Are you on an athletic scholarship?  Yes  No

6. Varsity sport(s) (Circle all that apply & number of years played)

   Baseball  _______  Softball  _______
   Basketball  _______  Tennis  _______
   Bowling  _______  Track & Field  _______
   Cross Country  _______  Volleyball  _______
   Football  _______  Women’s Lacrosse  _______
   Soccer  _______  Women’s Golf  _______
   Cheerleading  _______

MEDICAL HISTORY

7. How many years has it been since your last complete health examination, other than an examination that was required for you to participate in sports?

   1 year  2 years  3 years  more than 3 years

   Never had a complete health exam other than for sports

8. Are you presently taking any prescribed or over the counter medication? (This including birth control pills, insulin, allergy shots, or pills, asthma inhalers, vitamin or mineral supplements including iron, anti-inflammatory including aspirin).

   Yes  (if so, please fill out the table below)  NO

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Frequency of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

9. Do you have an allergy to any?  
   | Drug or medicine (over the counter or prescribed) | Yes | No | Specify Allergy: |
   | Insects or animals |     |    |                |
   | Plants, grasses, pollen, dust or other environmental factors |     |    |                |
   | Other |     |    |                |

10. Has a doctor ever told you that you have had any of the following medical problems? (if you don’t know, mark ‘NO’)
   | Mononucleosis | Jaundice | Yes | No |
   | Rubella (German measles) | Stomach or intestinal ulcer | Yes | No |
   | Chicken pox | Hernia | Yes | No |
   | Repeated sinus infections | Eczema | Yes | No |
   | Nose fracture | Psoriasis | Yes | No |
   | Hearing defect or loss | Diabetes | Yes | No |
   | Recurrent ear infection | Sickle cell anemia/carryer | Yes | No |
   | Epilepsy | Other anemia | Yes | No |
   | Tumor, growth, cyst, cancer | Abnormal bleeding or clotting disorder | Yes | No |
   | Over-active thyroid | Blood clot or embolism | Yes | No |
   | Under-active thyroid | Leukemia or other blood disorder | Yes | No |
   | Arthritis | Kidney injury | Yes | No |
   | Marfan’s syndrome | Other kidney disease | Yes | No |
   | Oral herpes (cold sores) | Frequent urinary infections | Yes | No |
   | Genital herpes | Depression or other mood disorders | Yes | No |
   | Injury to liver or spleen | Anxiety Disorders or other mental health disorders | Yes | No |
   | Hepatitis | Birth defect | Yes | No |

11. Have you ever had surgery to the following?
   | Eyes | Yes | No | Month | Year | If yes, give reason for surgery |
   | Ears/nose/throat |     |    |       |      |                                  |
   | Heart |     |    |       |      |                                  |
   | Lungs |     |    |       |      |                                  |
   | Stomach/bowels/appendix |     |    |       |      |                                  |
   | Kidneys |     |    |       |      |                                  |
   | Liver/spleen |     |    |       |      |                                  |
   | Bone |     |    |       |      |                                  |
   | Muscle/ligament/tendon |     |    |       |      |                                  |
Joint
Other (please specify)

<table>
<thead>
<tr>
<th>12. Were you born with two normal:</th>
<th>Eyes</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ears</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Kidneys</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Do you presently have the following skin problems:</th>
<th>Rash</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fungal Infection</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Cold Sore (s)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

| 14. Have you ever had heat exhaustion/heatstroke/sun stroke? | Yes | No |

<table>
<thead>
<tr>
<th>15. During or after exercise, have you ever:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been dizzy or light-headed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passed out (fainted)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had chest pain, discomfort or tightness?</td>
<td></td>
<td></td>
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<tr>
<td>Found it more difficult to breath than usual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had problems with coughing?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 16. Have you ever been told that you have a heart murmur? | Yes | No |

| 17. Have you ever had racing of your heart, irregular or skipped beats? | Yes | No |

<table>
<thead>
<tr>
<th>18. Have you ever been told by a doctor that you have had:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pericarditis, myocarditis, endocarditis (infections of the heart)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other heart or vascular problems? (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19. Have you ever had any medical test for your heart (i.e. EKG, echocardiogram)?
   Yes (if so specify test and reason below) No

<table>
<thead>
<tr>
<th>Test</th>
<th>Reason</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

20. Have you ever had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchitis?</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis?</td>
<td></td>
<td></td>
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<tr>
<td>Asthma?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing that starts during or just after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumothorax (collapsed lung)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Have you ever had a concussion (injury to the head) with or without loss of consciousness?
   Yes (if so, please complete the table below) No

<table>
<thead>
<tr>
<th>How many times?</th>
<th>1X</th>
<th>2X</th>
<th>3X</th>
<th>4X</th>
<th>5X</th>
<th>More than 5 times</th>
</tr>
</thead>
</table>

22. Have you ever been knocked unconscious?
   Yes (if so, please complete the table below) No

<table>
<thead>
<tr>
<th>How many times?</th>
<th>1X</th>
<th>2X</th>
<th>3X</th>
<th>4X</th>
<th>5X</th>
<th>More than 5 times</th>
</tr>
</thead>
</table>

   What is the longest time that you have been unconscious due to a head injury?
   
   A few seconds  up to 5 minutes  6-15 minutes  longer than 15

23. Have you ever had any long term problems due to a head injury (e.g. memory loss headaches)
   Yes  No

24. Have you ever had numbness, tingling, or weakness in your:
   Yes  No

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulders/arms hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buttocks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legs/feet?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. Have you ever had a “burner” or “stinger” (an injury causing a sudden burning pain and numbness down the arm and/or hand)?  Yes  No
26. Have you ever had a seizure?  
   Yes  No

27. Do you experience migraine headaches?  
   Yes  No

28. Have you ever had a serious eye injury?  
   Yes (if so, please specify below)  No

29. Do you wear glasses or contact lenses?  
   Yes (if so, please complete the questions below)  No
   
   Do you wear glasses or contacts when you train or compete?  
   Yes  No
   
   Have you had your eyes checked in the past 12 months?  
   Yes  No

30. Are you legally blind in either of your eyes?  
   Yes  No

31. During the past month, have you often been bothered by feeling down, depressed, or hopeless?  
   Yes  No

32. During the past month, have you often been bothered by little interest or pleasure in doing things?  
   Yes  No

WOMEN ONLY, MEN SKIP TO QUESTION # 36

31. At what age did your menstrual periods start?  ________ Years of age.

32. When was your most recent menstrual period?  
   1 month ago  1-3 months ago  4-6 months ago  6 months ago

33. In the past 12 months:  

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had trouble with menstrual bleeding?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had bleeding between periods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had menstrual cramps or pain which affected your school or athletic performance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had any unusual discharge from your vagina?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   How many periods have you had?  
   0  1-3  4-6  7-12  >12

   What was the longest time between periods?  
   <1 month  1-3 mo  4-6 mo  >6 mo

   On the average how long has each period lasted?  
   1-5 days  6-10d  11-15 d  >15d
34. Are you presently taking any female hormones (estrogen, progesterone, birth control pills) for the purpose of regulating your periods?  
   Yes  No

35. Have you ever had a pelvic exam/pap smear?  
   Yes (if so, please complete the table below)  No

   When were your last pelvic exam/ Pap smear?  1 year  1-3 years  3 years

   Has your pelvic exam/Pap smear ever been abnormal?  Yes  No

36. Were you born with two normal testes?  Yes  No

37. Have you ever had surgery to remove or repair a testicle(s)?  Yes  No

--- ORTHOPAEDIC HISTORY ---

38. In the past 12 months have you seen a physician, athletic trainer or other health care professional for a new or ongoing injury?  
   Yes (if so, please complete the table below)  No

   Specify injury (is):  has the injury healed completely  Yes  No

39. Do you presently use for practice or competition:  
   A brace, splint, or sleeve?  Yes  No

   Orthotics (shoe inserts)?  Yes  No

   Have you ever had or do you currently have an injury or problem of the following:

40. Neck:  Place an X if the condition exits at present.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disc disease</td>
<td>Facet disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic fracture</td>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whiplash</td>
<td>specify</td>
<td></td>
<td></td>
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</tbody>
</table>
41. **Spine/Back:** Place an X if the condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital deformity or birth defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back stiffness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spondylosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spondylolisthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disc disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facet disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sacroiliac disorder</td>
<td></td>
<td></td>
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<tr>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
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</tr>
</tbody>
</table>

42. **Shoulder/Clavicle:** Place an X if condition exists at present.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acromioclavicular (AC) joint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotator cuff tendonitis/impingement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subluxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>Specify</td>
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</tbody>
</table>

43. **Upper arm/forearm:** Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendon injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
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</tbody>
</table>

44. **Elbow:** Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ligament injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennis (golfer’s) elbow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>Specify</td>
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</tbody>
</table>

45. **Hand/Wrist/Fingers:** Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ligament injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendon injury or tendonitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
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<tr>
<td>Specify</td>
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</tbody>
</table>
46. **Pelvis/Hip**  
Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td></td>
<td></td>
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<tr>
<td>Contusion/hip pointers</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Groin strain</td>
<td></td>
<td></td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
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<td></td>
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<tr>
<td>Specify</td>
<td></td>
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</table>

47. **Thigh:**  
Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quadriceps strain/injury</td>
<td></td>
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</tr>
<tr>
<td>Stress fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe contusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendonitis</td>
<td></td>
<td></td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
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<td></td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

48. **Knee:**  
Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meniscal injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCL tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACL tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iliotibial band syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collateral ligament injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendonitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meniscal surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation of knee or patella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swelling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meniscal surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACL surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain around knee cap, (patella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensation of catching, instability,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>giving away</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49. **Lower Leg:**  
Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shin splints</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle strain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compartment syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
50. Ankle: Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stress fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sprain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tendonitis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bursitis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Instability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bone chip in joint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

51. Foot / Toes: Place an X if condition exists at present:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic Fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Flat arches of feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprain</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendonitis / tendon injury</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone spur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specifying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plantar fasciitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

52. In the past 10 years, have you been treated for a serious injury(s) not mentioned in the above?  
Yes (if so, please specify below) No

<table>
<thead>
<tr>
<th>Specify injury(s)</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53. In the past 12 months, what is the total number of days of training and competition that you have been unable to participate in due to any injury?  
(Pick the most appropriate category for each injury you have had. List each injury only once).

<table>
<thead>
<tr>
<th>Injury</th>
<th>Never had</th>
<th>1-7 days</th>
<th>8-14 days</th>
<th>&gt; 14 days</th>
<th>Specify injury site or type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shin splints</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic fracture(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress fracture(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tendonitis/ tendon injury(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulled muscle(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back problem(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ligament injury or tear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint injury(s) or pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
54. Have you ever had a cortisone injection into a tendon, bursa, or joint for an injury or pain?  
Yes (if so, please specify below)  
No  
Specify injury (s):  

<table>
<thead>
<tr>
<th>Date</th>
<th>Month</th>
<th>Year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FAMILY HISTORY

55. For each full-blood relative listed, please indicate if they have a history of the following (do not include adoptive, step, or foster relatives). (Place an X in all boxes that apply; mark no history in family if appropriate or if family history unknown):

<table>
<thead>
<tr>
<th>High blood pressure</th>
<th>Mother/Father</th>
<th>Brother/Sister</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Heart attack</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other heart abnormalities</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>High blood cholesterol</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marfan syndrome</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sickle cell anemia</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

56. Have any of your full-blood relatives (father/mother, brother/sister, grandparent) died suddenly before the age of fifty, other than due to trauma?  
Yes (if known, please specify reason below)  
No

57. Please indicate your ethnic origin (place an X in all that apply).

<table>
<thead>
<tr>
<th>Native American/Alaska Native</th>
<th>Hispanic/Latino/Chicano</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>White (non-Hispanic)</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>Other, specify:</td>
</tr>
<tr>
<td>Black./African American</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>
THE UNDERSIGNED ATHLETE:

1. Understand that after seeking medical advice or treatment for injury or illness from personal or family physicians clearance from a Delaware State University Team Physician is required to restart participation.
2. certifies that the answers to the above questions are correct and true to my knowledge.

ATHLETE’S
SIGNATURE__________________________________________DATE__________________

PARENT’S
SIGNATURE__________________________________________DATE_______________

(If under the age of 18)
Athlete Emergency Information (2017-2018)

(If you are not 18 years of age, all forms must be co signed by a parent/guardian)

Date: __________________________  Sport: __________________________

Name: _____________________________________ Student ID #:D________________

Social Security # __________________

Date of Birth: ________________ Campus Phone: _________________________

Home Phone: ________________ Cell Phone: ____________________________

College Address: ____________________________________________

                      CITY                     STATE                     ZIP CODE

                      CITY                     STATE                     ZIP CODE

Emergency Contact:
Name:_________________________ Relationship: ___________ Phone: ___________
Cell: ___________

Do you give permission to speak to family members or the above emergency contact person about your medical conditions?  YES_________ NO __________

Allergies: Food, Drug, Other:____________________________________________________
____________________________________________________________________________

Current medications (prescriptions/over the counter)
____________________________________________________________________________

Date of Last Tetanus Booster (If you know it): ______________________________

Significant Medical Conditions:
____________________________________________________________________________

Past Surgeries:__________________________________________________________

Primary Care Physician: ___________________________________ Phone:____________
Address: ________________________________________________________________

Other Physicians Consulted: ___________________________ Phone:_________________
Primary Insurance Information (2017-2018)

Name of Policy Holder: _______________________________ Relationship: ________________
Policy Holder DOB: ______________
Name of Insurance Company: _______________________________________________________
Phone: ______________________ Policy/ID#: __________________________________________
Group #: __________________________

Please Read Carefully!

• Delaware State University (DSU) accident policy provides insurance for student-athletes with **injuries occurring only when participating in the play or practice of intercollegiate athletics.** DSU’s 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 DSU’s insurance carrier consider payment for any remaining balances.
• I hereby authorize DSU, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, treatment and I hereby assign to the part all payments for medical services rendered to the student-athlete.
• I agree to supply all information requested by my primary insurance, DSU & their excess insurance company in a timely manner.
• I hereby authorize DSU and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
• I hereby authorize DSU Sports Medicine Department, DSU Student Health and/or my coach to hospitalize & secure treatment for me for any athletically related injury/illness. **(Must be cosigned by parent/guardian if student-athlete is under 18 years of age)**
• A photo copy of this authorization shall be deemed as effective & valid as the original.
• I agree to notify DSU Sports Medicine Department immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I will be responsible for any & all changes incurred.
• I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

Student-Athletes Signature____________________________________________ Date______________

Signature of Parent/Guardian (if under 18) ____________________________ Date__________

Re-disclosure: This consent allows for release of personally identifiable information from a student-athlete’s education record, which is protected by the Family Educational Rights and Privacy Act (20 USC 8 1232g). This information may not be re-released without consent of the student-athlete. This information is also protected under federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization and I may revoke my authorization at any time. This form under HIPAA allows access for no more than one (1) year from date of signature.
Sickle Cell Trait Testing Instructions for Parents/Guardians

The NCAA has passed legislation that requires all incoming freshman and transfer student-athletes to obtain the result of sickle cell trait (SCT) testing prior to the athlete being cleared to participate in any type of workout, including but not limited to: physical testing, cardio workouts, strength training, practices and tryouts.

All students must provide Delaware State University Sports Medicine with written proof of sickle cell trait testing alone the results. In the United States, All children are tested at birth for SCT. Results of the test may be on file at the birth hospital or perhaps with a pediatrician. Sickle cell trait testing is not part of normal immunization record which your normally provide to schools and camps.

Tracking down the results of the SCT testing at birth can be very difficult, so if these results cannot be located, the Student-athlete must undergo a simple blood test to obtain these results. You must specifically ask your doctor to for this test as it is NOT part of the normal blood work required of all students entering Delaware State University.

IT SOULD BE NOTED THAT THE RESULTS OF THE TESTING DO NOT CHANGE THE STUDENT –ATHLTE’S PLAYING STATUS. The information from the test assists the sports medicine and coaches in ensuring the safety of the student-athletes.

The results of the sickle cell testing may be recorded and provided to Delaware State University Sports Medicine on any of the following: a hospital forma, a lab test results form or document from a physician’s office. These testing results must be returned to Delaware State University alone with the other forms that we have provided for completion.

Sincerely,

Delaware State University
Sports Medicine Staff
(P) 302-857-7552
(F) 302-857-7312
Insurance Billing Policy

The University’s mandatory and Athletic secondary health insurance is a secondary (basic) plan. Your primary insurance plan may be billed first. If you do not have a primary health insurance and/or your primary health insurance plan does not provide out of state coverage, you will be responsible for any expenses not paid for by the DSU secondary insurance plan.

**Delaware State University** will not provide payment for any medical costs not covered by an athlete’s primary and/or DSU secondary insurance companies. With my signature below, I acknowledge that I am responsible for the payment of any medical costs not covered by these insurance companies.

____________________________________________
Student-Athlete signature

____________________________________________
Signature of Parent/Guardian (if under 18)
I GIVE PERMISSION/AUTHORIZATION: (please initial)

_____ To the athletic trainer, team physician, or team orthopedic physician and other sports medicine consultants to evaluate and treat any injuries that occur during my athletic participation at Delaware State University.

_____ For sports medicine staff, or other emergency care physicians, to evaluate and treat any injuries that may occur during intercollegiate play while traveling with Delaware State University. This includes, but is not limited to, immediate first aid, emergency care and treatment, x-ray, physical examination, follow-up and rehabilitation in the training room as well as at the Student Health Service.

_____ For my medical records to be released from the Delaware State University Sports Medicine Department to the Delaware State University Student Health Service.

_____ For my medical records to be released from the Delaware State University Student Health Service to the including Delaware State University team doctors notes, to the Delaware State University Sports Medicine Department

_____ For release of records from my Primary Care Physician and/or other medical consultants (i.e. Urgent Care, E.R., etc.) to Delaware State University Sports Medicine and from the Sports Medicine Department to my Primary Care Physician and/or other medical consultants.

_____ For sports medicine staff to inform coaches of my medical conditions and injuries as deemed necessary. This includes media reports and daily injury reports to coaches.

I understand that the team physician, team orthopedic physician, and or the athletic trainers have the authority to prohibit me from further participation because of an injury or medical condition and/or because of an undue liability risk to Delaware State University

Signature:_________________________________  Date:____________________

Signature of Parent/Guardian (if under18) ____________________________________

__________________________
Date

Re-disclosure: This consent allows for release of personally identifiable information from a student-athlete’s education record, which is protected by the Family Educational Rights and Privacy Act (20 USC 8 1232g). This information may not be re-released without consent of the student-athlete.

This information is also protected under federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization and I may revoke my authorization at any time. This form under HIPAA allows access for no more than one (1) year from date of signature.
STUDENT-ATHLETE AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby, authorize the physicians, certified athletic trainers, sports medicine staff and other health care personnel representing Delaware State University to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, emergency room physicians and personnel, athletic directors, athletics coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, academic counselors, athletic and/or college administrators, clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I understand that my authorization/consent for the disclosures of my protected health information is a condition for participation as a student-athlete for Delaware State University. I understand that my personal health 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 once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying, in writing, the Head Athletic Trainer, but if I do, it will not have any effect on actions that Delaware State University took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires one year from the date of my signature below.

_______________________________ ________________
Social Security Number Date of Birth

_______________________________
Print Name of Student-Athlete ____________ Signature ____________ Date

_______________________________
Print Name of Parent/Guardian (if under 18)

_______________________________
Signature of Parent/Guardian (if under 18) Date
Student-Athlete Authorization/Consent for Printing and Copying of Medical Documents

I hereby, authorize the certified athletic trainers, sports medicine staff and other health care personnel representing Delaware State University to print and copy medical documents paper or digital form for internal use of the Delaware State University Sports Medicine Department. This includes but is not limited to pre-participation physical exam forms, injury reports, emergency travel forms, and acknowledgement/consent forms.

Signature ________________________________________________   Date______________

Signature of Parent/Guardian (if under 18):________________________    Date:___________
DELAKE STATE UNIVERSITY
Sports Medicine Department
1200 North DuPont Highway, Memorial Hall Gym, Dover, DE 19901 302-857-7552 Fax: 302-857-7312

Sports Medicine Services (2017-2018)

NOTICE OF PRIVACY POLICIES FOR DELAWARE STATE UNIVERSITY SPORTS MEDICINE SERVICES.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
At Delaware State University, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 09/11/13, and applies to all protected health information as defined by federal regulations.

Understanding your health record/Information
Each time you visit the Sport Medical Services; a record of your visit is made. You will also receive treatments and consultation in the public Athletic Training Room where other student athletes may be present to witness evaluations, diagnosis, treatments and rehabilitation. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you receive.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source for data planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights
Although your health record is the physical property of Delaware State University’s Sports Medicine Center, the information belongs to you. You have a right to:

- Obtain a paper copy of this notice of information practices on request.
- Inspect and receive a copy of your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

Our Responsibilities
Delaware State University’s Sports Medicine Services is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. In case of policy changes you may need to sign a new form. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If you have questions and would like additional information you may contact the practice’s Privacy Officer at 302-857-7551.
If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for civil Rights. The Address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201.
Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your health care provider will document in your record his or her expectations. The members of your health care team will then record the actions they took and their observations. In that way, the healthcare provider will know how you are responding to treatment. We will also provide your healthcare provider with copies of various reports that should assist him or her in your treatment. This will include all health care providers in our practice and those assisting in coverage of our practice.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the case and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we’ve asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may leave a message on your answering machine or voice mail as a means of communication.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that Person’s involvement in your care or payment related to your care.

Food and Drug administration (FDA): We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight, agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

I have read Delaware State University Private Policy for the Sports Medicine Services.

Signature: __________________________________________________ Date: ______________

Signature of Parent/Guardian (if under 18) __________________________ Date: ___________
ASSUMPTION OF RISK

As a participant in the sport of ________________________________, I am aware that there is an acceptable risk of injury. Delaware State University has taken all precautions to reduce the risk of injury by providing competent coaching and instruction, well-maintained equipment and facilities, and proper conditioning programs.

Catastrophic injuries, although extremely uncommon, can occur to any participant in athletics. Participation in sports could result in serious head, neck, and/or spinal injuries that may result in paralysis, brain damage, or even death. Participation in sports may also cause serious injury to bones, joints, ligaments, muscles, tendons, and/or other vital organs necessary for your general health and well being.

By signing this Assumption of Risk, you hereby assume the risk of injury while participating in your sport at Delaware State University.

______________________________________________                                              _________
Student-Athlete Signature                                                                                                          Date

_______________________________________                                              _________
Signature of Parent/Guardian (if under 18):                                                                                      Date
**Heat-Related Illness Policy**

Heat-related illnesses may occur in hot or humid weather, indoors or outdoors. Athletes in all sports are vulnerable. De-conditioned athletes and athletes who have not trained in warm environments are particularly susceptible to heat-related illnesses.

Examples of heat-related illnesses include:

- **Heat Cramps**: painful cramps involving abdominal muscles and extremities caused by intense, prolonged exercise in the heat and depletion of salt and water due to profuse sweating.
- **Heat Syncope**: weakness, fatigue and fainting due to loss of salt and water in sweat and exercise in the heat. Heat syncope can predispose to heat stroke.
- **Heat Exhaustion (Water Depletion)**: excessive weight loss, reduced sweating, elevated skin and core body temperature, excessive thirst, weakness, headache and sometimes unconsciousness.
- **Heat Exhaustion (Salt Depletion)**: exhaustion, nausea, vomiting, muscle cramps, and dizziness due to profuse sweating and inadequate replacement of body salts.
- **Heat Stroke**: an acute medical emergency related to thermoregulatory failure associated with nausea, seizures, disorientation, possible unconsciousness, coma, and death. It may occur suddenly without being preceded by any of the other clinical signs. The individual is usually disoriented with a high core body temperature and hot, dry skin (some patients may still sweat profusely).

Axillary (armpit), oral, and tympanic (ear) temperatures are not valid measures in individuals exercising in hot environments. The most reliable and accurate means of assessing an athlete’s core body temperature is by rectal temperature. It is essential for medical personnel (team physicians, athletic trainers, EMT’s, etc.) to obtain an accurate core body temperature of an athlete that is believed to be experiencing heat exhaustion or heat stroke. Delays in obtaining an accurate temperature and providing rapid treatment, even waiting until arriving at a hospital, can result in chronic disability or even death. By signing below you consent to allow Delaware State University medical personnel to perform a rectal thermometer reading when it is deemed medically necessary in a heat-related emergency.

_______________________  __________/________/_________
Athlete Signature        Date

_______________________  __________/________/_________
Signature of Parent/Guardian (if under 18):    Date
I __________________________ hereby acknowledge that I have reviewed the Delaware State Athletic Department’s Drug Screening and Substance Abuse Program. I further acknowledge that I may obtain a complete copy of the policy at any time by contacting the Director of Sports Medicine and that I fully understand the provisions of the Policy. **It is understood that you must sign this form in order to participate in Intercollegiate Athletic practices and competition at Delaware State University.**

I agree to allow the Delaware State University Athletic Department to drug test in accordance with the procedures including any random and team testing as outlined to me;

I also agree that with **reasonable suspicion** due to the objective characteristics of changes in behavior, grades, and/or physical attributes observed by any of the following including the head coach, athletic trainer, or athletic administrator, I may be drug tested;

I understand that I may voluntarily enter the Safe Harbor Program at any time before being notified of a drug test;

I agree to be bound by the penalties outlined in the Athletic Department’s Drug Screening and Substance Abuse Program Policy;

I understand that a test will be considered positive if the sample provided tests positive for a banned substance, failing to show on time, or at all, and or if I leave prior to the collection of an adequate sample.

**1st Violation:** Will result in two (2) mandatory counseling sessions and suspension from 10% of the team’s competition season. The **University and suspension from competition includes pre and post season to begin immediately; (EXCLUDES PRACTICE);** and that if a minor, my parents or legal guardian will be notified;

**2nd Violation:** Will include four (4) Mandatory Counseling sessions at DSU and Suspension from 20% of the team’s season completion schedule.

**3rd Violation:** Will include Mandatory Counseling and Suspension from Athletics at Delaware State University for 1 year (365 days from the date of being notified of a 3rd failed drug test).

**4th Violation:** Will include Permanent Suspension from Athletics at Delaware State University and the Loss of Athletic-Related Aid at Delaware State University.

I agree that I was provided an opportunity to review these procedures as outlined in the Delaware State University’s Drug Screening and Substance Abuse Policy.

I agree to have the drug testing results released to everyone listed in this policy (to include the Athletic Director, Compliance Director, Sr. Associate Athletic Director, Director of Sports Medicine, Team Physician, Team’s Athletic Trainer, Designated Coach (es), and Parents/Guardians).

I understand that I am subject to the sanctions outlined in the Drug Screening and Substance Abuse Policy at Delaware State University.

I understand that if I sign this statement falsely or erroneously, I will violate NCAA legislation on ethical conduct and my eligibility will be jeopardized.

Name (print) ____________________________ Sport ____________________________

Date ____________________________ Signature of Student Athlete ____________________________

Date ____________________________ Signature of Parent/Guardian (if under 18): ____________________________
Exit Physical for Non-Returning Athletes

It is the responsibility of the student-athlete, whose eligibility has expired, to check out and receive an exit physical from the DSU Sports Medicine Department at the conclusion of his or her final season of eligibility. If the student-athlete fails to appear, it may adversely affect DSU’s insurance policy for payment of further claims.

Signature ______________________________________________  Date ____________

Signature of Parent/Guardian (if under 18): ___________________________ Date:_______
Injury Notification

It is the responsibility of the student-athlete to inform the Sports Medicine staff of any injury sustained while competing for DSU Athletics within 7 days of the incident. If this deadline is not met, it could adversely affect DSU’s insurance company’s ability to process and pay any bills or claims.

Signature ____________________________ Date________________

Signature of Parent/Guardian (if under 18):____________________ Date:___________
Authorization for Release of Medical Information to the Media and Other National Outlets

Last Name:_______________________  First Name:___________________  MI:____
Birthdate:_______________    Social Security Number:_____ - _____ - _________
Phone Number: (     ) _______ - _______     Email:_____________________________

I give my consent for the team physician, certified athletic trainers, or other medical personnel of Delaware State University to release such information regarding my medical history, record of serious illness, and rehabilitation results as may be requested by a representative of the National Football League, any National Football League team’s medical staff, National Football Scouting, Inc., Blesto, Inc., National Invitational Camp, Inc., or any of Delaware State University’s medical staff, medical consultants and the media.

I understand that such representative has made representations to the team physician, certified athletic trainers, or other medical personnel of Delaware State University that the purpose of this request for my medical information is to assist that organization represented in making a determination as to offering me employment.

This information is normally confidential and except as provided in this Release, will not be otherwise released by any of the parties in charge of the information. This Release remains valid until revoked by me in writing.

Student-Athlete Signature  ________________________________        Date:_______

Signature of Parent/Guardian (if under 18):________________________  Date:_______

Notice to Receiving Entities: Protected Health Information Disclosure Statement
The information on the above patient will be disclosed from records protected by the Family Educational Rights and Privacy Act (20 USC 8 1232g). This information may not be re-released without consent of the student-athlete. If Delaware State University determines that the third party has improperly re-disclosed this information, the University may be prohibited from permitting the third party access to information contained within its education records for a period of not less than five (5) years.

This information is also protected under federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization and I may revoke my authorization at any time. This form under HIPAA allows access for no more than one (1) year from date of signature.
CONCUSSION
A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?
A concussion is a brain injury that:
- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

HOW CAN I PREVENT A CONCUSSION?
Basic steps you can take to protect yourself from concussion:
- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department’s rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?
You can’t see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:
- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?
Don’t hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

IT’S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.
Student-Athlete Concussion Statement

☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

☐ I have read and understand the NCAA Concussion Fact Sheet.

After reading the NCAA Concussion fact sheet, I am aware of the following information:

_______ A concussion is a brain injury, which I am responsible for reporting to my athletic trainer.
Initial

_______ A concussion can affect my ability to perform everyday activities, reaction time, balance, sleep, and classroom performance.
Initial

_______ I cannot see a concussion, but I might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
Initial

_______ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.
Initial

_______ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
Initial

_______ Following concussion the brain needs time to heal. I am much more likely to have a repeat concussion if I return to play before my symptoms resolve. In rare cases, repeat concussions can cause permanent brain damage, and even death.
Initial

__________________________________________
Signature of Student-Athlete                                      Date

__________________________________________
Print name

__________________________________________
Signature of Parent/Guardian (if under 18):                           Date:
Name: ___________________________________ Date of Birth: ____________________

Cell Phone: ______________________________ Social Security # __________________

Do you give permission to speak to family members or your emergency contact person in case of emergency? YES_______ NO _______

Emergency Contact:

Name: ___________________________ Relationship: __________________

Phone: ___________________________ Cell: _____________________________

Allergies (Food, Drug, Other):
____________________________________________________________________________

Current medications (prescriptions/over the counter):
____________________________________________________________________________

Significant Medical Conditions:
____________________________________________________________________________

Primary Insurance Information (2017-2018)

Name of Policy Holder: ___________________________ Relationship: ________________

Policy Holder DOB: ________________

Name of Insurance Company: ____________________________

Phone: ___________________________ Policy/ID#: ____________________________

Group #: ____________________________

Re-disclosure: This consent allows for release of personally identifiable information from a student-athlete’s education record, which is protected by the Family Educational Rights and Privacy Act (20 USC 8 1232g). This information may not be re-released without consent of the student-athlete.

This information is also protected under federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization and I may revoke my authorization at any time. This form under HIPAA allows access for no more than one (1) year from date of signature.

I hereby, authorize the physicians, certified athletic trainers, sports medicine staff and other health care personnel representing Delaware State University to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics.

Athlete Signature_______________________________ Date______/_____/_______

________________________________

Signature of Parent/Guardian (if under 18): __________________________

Date __________________________