FIRST YEAR ATHLETICS PRE-PARTICIPATION PHYSICAL EXAMINATION (2015-2016)

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)

Sport	Years	Sport	Years
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? (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**

Name of Medication	Dose	Frequency of Use

9. Do you have an allergy to any?

	Yes	No	Specify Allergy:
Drug or medicine (over the counter or prescribed)			
Foods			
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'**)

	Yes	No		Yes	No
Mononucleosis			Jaundice		
Rubella (german measles)			Stomach or intestinal ulcer		
Chicken pox			Hernia		
Repeated sinus infections			Eczema		
Nose fracture			Psoriasis		
Hearing defect or loss			Diabetes		
Recurrent ear infection			Sickle cell anemia/carrier		
Epilepsy			Other anemia		
Tumor, growth, cyst, cancer			Abnormal bleeding or clotting disorder		
Over-active thyroid			Blood clot or embolism		
Under-active thyroid			Leukemia or other blood disorder		
Arthritis			Kidney injury		
Marfan syndrome			Other kidney disease		
Oral herpes (cold sores)			Frequent urinary infections		
Genital herpes			Depression or other mood disorders		
Injury to liver or spleen			Anxiety Disorders or other mental health disorders		
Hepatitis			Birth defect		

11. Have you ever had surgery to the following?

	Yes	No	Month	Year	If yes, give reason for surgery
Eyes					
Ears/nose/throat					
Heart					
Lungs					
Stomach/bowels/appendix					
Kidneys					
Liver/spleen					
Bone					
Muscle/ligament/tendon					
Joint					

Other (please specify)					

12. Were you born with two normal: Eyes **Yes** **No**

Ears **Yes** **No**

Kidneys **Yes** **No**

13. Do you presently have the following skin problems: Rash **Yes** **No**

Fungal Infection **Yes** **No**

Cold Sore (s) **Yes** **No**

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

15. During or after exercise, have you ever:

	Yes	**No**
Been dizzy or light-headed?		
Passed out (fainted)?		
Had chest pain, discomfort or tightness?		
Found it more difficult to breath than usual?		
Had problems with coughing?		

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**

18. Have you ever been told by a doctor that you have had:

	Yes	**No**
High blood pressure?		
Pericarditis, myocarditis, endocarditis (infections of the heart)?		
Rheumatic fever?		
Other heart or vascular problems? (please specify		

19. Have you ever had any medical test for your heart (i.e. EKG, echocardiogram)?
Yes (if so specify test and reason below) **No**

Test	**Reason**

20. Have you ever had:

	Yes	**No**
Bronchitis?		
Tuberculosis?		
Asthma?		
Wheezing that starts during or just after exercise?		
Pneumothorax (collapsed lung)?		

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**

How many times? 1X 2X 3X 4X 5X More than 5 times

22. Have you ever been knocked unconscious?

Yes (if so, please complete the table below) **No**

How many times? **1X 2X 3X 4X 5X More than 5 times**

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**
Shoulders/arms hands		
Buttocks?		
Legs/feet?		

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:

	Yes	No
Have you had trouble with menstrual bleeding?		
Have you had bleeding between periods?		
Have you had menstrual cramps or pain which affected your school or athletic performance?		
Have you had any unusual discharge from your vagina?		

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**

MEN ONLY, WOMEN SKIP TO QUESTION# 38

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**

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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.

	Yes	**No**		**Yes**	**No**
Disc disease			Facet disorder		
Traumatic fracture			Surgery		
Stress fracture			Other		
Whiplash			specify		

41. Spine/Back: Place an **X** if the condition exists at present:

	Yes	No		Yes	No
Congenital deformity or birth defect			Disc disease		
Traumatic fracture			Facet disorder		
Stress fracture			Sacroiliac disorder		
Back pain			Scoliosis		
Back stiffness			Surgery		
Spondyloysis			Other		
Spondylolisthesis			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Subluxation		
Bursitis			Dislocation		
Acromioclavicular (AC) joint			Surgery		
Rotator cuff tendonitis/impingement			Other		
Instability			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Surgery		
Muscle injury			Other		
Tendon injury			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Dislocation		
Ligament injury			Surgery		
Tennis (golfer's) elbow			Other		
Bursitis			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Dislocation		
Stress fracture			Surgery		
Ligament injury			Other		
Tendon injury or tendonitis			Specify		

46. Pelvis/Hip Place an **X** if condition exists at present:

	Yes	No		Yes	No
Traumatic fracture			Tendonitis		
Stress fracture			Contusion/hip pointers		
Groin strain			Surgery		
Dislocation			Other		
Bursitis			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Quadriceps strain/injury		
Stress fracture			Severe contusion		
Tendonitis			Surgery		
Bursitis			Other		
Hamstring strain/injury			Specify		

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

	Yes	No		Yes	No
Meniscal injury			Locking		
PCL tear			Dislocation of knee or patella (knee cap)		
ACL tear			Swelling		
Iliotibial band syndrome			Unexplained pain		
Collateral ligament injury			Meniscal surgery		
Tendonitis			ACL surgery		
Bursitis			Other injury		
Pain around knee cap, (patello femoral pain			Other surgery		
Sensation of catching, instability, giving away			Specify		

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

	Yes	No		Yes	No
Traumatic fracture			Shin splints		
Stress fracture			Surgery		
Muscle strain			Other		
Compartment syndrome			Specify		

50. Ankle: Place an **X** <u>if condition exists at present</u>:

	Yes	No		Yes	No
Traumatic fracture			Bone chip in joint		
Stress fracture			Dislocation		
Sprain			Surgery		
Tendonitis			Other		
Bursitis			Specify		
Instability					

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

	Yes	No		Yes	No
Traumatic Fracture			Flat arches of feet		
Stress fracture			Dislocation		
Sprain			Surgery		
Tendonitis / tendon injury			Other		
Bone spur			Specify		
Plantar fascitis					

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**

Specify injury(s)	Month	Year

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).

	Never had	1-7 days	8-14 days	> 14 days	Specify injury site or type
Shin splints					
Traumatic fracture(s)					
Stress fracture(s)					
Tendonitis/ tendon injury(s)					
Bursitis					
Sprain					
Pulled muscle(s)					
Back problem(s)					
Ligament injury or tear					
Joint injury(s) or pain					
Other injury					

Other injury					
Other injury					

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):	Date Month	Year

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):**

	No family history	**Mother/Father**	**Brother/Sister**	**Grandparent**
High blood pressure				
Heart attack				
Other heart abnormalities				
High blood cholesterol				
Diabetes				
Arthritis				
Bleeding disorder				
Marfan syndrome				
Kidney disease				
Mental illness				
Mood Disorder				
Anxiety Disorder				
Sickle cell anemia				
Epilepsy				
Cancer				

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 orgin (place an **X** in all that apply).

Native American/Alaska Native		Hispanic/Latino/Chicano	
Asian		White (non-Hispanic	
Pacific Islander		Other, specify:	
Black,/African American		Don’t know	

DELAWARE STATE UNIVERSITY
Sports Medicine Department

1200 North DuPont Highway, Memorial Hall Gym, Dover, DE 19901 302-857-7552 Fax: 302-857-7312

Athlete Emergency Information (2015-2016)

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

Date: ___________________________ **Sport**: ___________________________

Name: ______________________________________ **Student ID #:D**____________________

Date of Birth: _________________________ **Campus Phone**:____________________________

Home Phone: _________________________ Cell **Phone:** _______________________________

College Address: ____
CITY STATE ZIP CODE

Home Address: ____
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 (2015-2016)

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.

Policy Holder's Signature_________________________________ Date___________________

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.

DELAWARE STATE UNIVERSITY
Sports Medicine Department
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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 **Date**

_______________________________________ _______________
Signature of Parent/Guardian (if under 18) Date

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I GIVE PERMISSION/AUTHORIZATION: <u>(please initial)</u>

_____ 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 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 athletic trainer 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.

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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

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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, emergency travel forms, and acknowledgement/consent forms.

Signature ____ Date_____________

Signature of Parent/Guardian (if under 18):_______________________ Date:__________

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Sports Medicine Services (2015-2016)

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 CFR164.524.
- 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 care 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: ___________

DELAWARE STATE UNIVERSITY
Sports Medicine Department

1200 North DuPont Highway, Memorial Hall Gym, Dover, DE 19901 302-857-7552 Fax: 302-857-7312

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

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Heat-Related Illness Policy

Heat-related illnesses may occur in hot or humid weather, indoors or outdoors. Athletes in all sports are vulnerable. Deconditioned 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 disorientated 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

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DRUG TESTING CONSENT FORM
DRUG SCREENING AND SUBSTANCE ABUSE PROGRAM 2015-2016

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; (EXLUDES 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):

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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:_________

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Sports Medicine Department
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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:__________

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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.

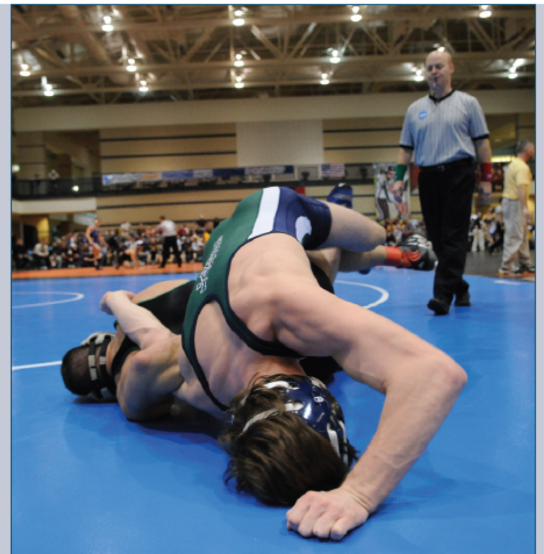
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

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.

DELAWARE STATE UNIVERSITY

Sports Medicine Department

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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:

________ Initial — 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.

____________________________________ ______________

Signature of Student-Athlete Date

____

Print name

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

DELAWARE STATE UNIVERSITY
Emergency Information Travel Form

1200 North DuPont Highway, Memorial Hall Gym, Dover, DE 19901 302-857-7552 Fax: 302-857-7312

Name: ____________________________________ **Date of Birth:** ____________________

Cell Phone: ________________________________

Do you give permission to speak to family members or your emergency contact person in case of emergency? **YES**________ **NO** ________

<u>Emergency Contact</u> :

Name: __________________________ **Relationship:** __________________

Phone: _________________________ **Cell:** _________________________

Allergies (Food, Drug, Other):

____

Current medications (prescriptions/over the counter):

____

Significant Medical Conditions:

____

Primary Insurance Information (2015-2016)

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