Delaware State University
Preparticipation Physical Evaluation - Returning Athletes
(2017-2018)

Name: _____ Date: _____

DOB: _____ Year in School: _____ Sport: _____

Explain "Yes" answers in the space at the end of the section.

GENERAL MEDICAL

1 Has a doctor denied or stopped you from playing a sport for any reason since last year?	**YES**	**NO**
2. Do you have any ongoing medical conditions such as diabetes or asthma?	**YES**	**NO**
3 Are you taking any prescription or over the counter medicines or pills?	**YES**	**NO**
4 Do you have allergies to medications, pollen, foods or stinging insects like bees?	**YES**	**NO**
5. Have you passed out or nearly passed out DURING exercise this past year?	**YES**	**NO**
6. Have you passed out or nearly passed out AFTER exercise this past year?	**YES**	**NO**
7. Have you ever had discomfort, pain or pressure in your chest during exercise this past year?	**YES**	**NO**
8. Has a doctor ever told you that you have: (circle all that apply)		
a. High blood pressure		
b. High cholesterol		
c. A heart murmur		
d. A heart infection		
9. Does your heart race or skip beats during exercise?	**YES**	**NO**
10. Has a doctor ordered a test for your heart such as an EKG or echo this past year?	**YES**	**NO**
11. Have you spent the night in a hospital this past year?	**YES**	**NO**
12. Have you had surgery this past year?	**YES**	**NO**
13. Were you born without, or are you missing a kidney, eye, testicle, or any other organ?	**YES**	**NO**
14. Have you had mononucleosis (mono) within the last month?	**YES**	**NO**
15. Do you have any rashes, pressure sores, or other skin problems?	**YES**	**NO**
16. Have you had a herpes skin infection?	**YES**	**NO**
17. Has a doctor told you that you or someone in your family has sickle cell trait or disease?	**YES**	**NO**
18. When exercising in the heat, do you have severe muscle cramps or become ill?	**YES**	**NO**
19. Have you been diagnosed or treated for depression, anxiety, or any other mental illness this past year?	**YES**	**NO**
20. Are you happy with your weight?	**NO**	**YES**
21. Are you trying to gain or lose weight?	**NO**	**YES**
22. Has anyone recommended you change your weight or eating habits?	**NO**	**YES**
23. Do you limit or carefully control what you eat?	**NO**	**YES**

Women Only

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

2. How many periods have you had in the last 12 months?_____

Explain any "YES" answers here:

_____

_____

_____

_____

FAMILY HISTORY

1. Has anyone in your family died for no apparent reason this past year?	**YES**	**NO**
2. Does anyone in your family have a heart problem?	**YES**	**NO**
3. Has any family member or relative died of heart problems or of sudden death before the age of 50?	**YES**	**NO**
4. Does anyone in your family have Marfan's syndrome?	**YES**	**NO**
5. Is there anyone in your family who has asthma?	**YES**	**NO**
6. Has anyone in your family been diagnosed with depression, anxiety or any other mental illness	**YES**	**NO**

Explain any "YES" answers here:

ORTHOPEDIC

1. Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game this year?	**YES**	**NO**
2. Have you had any broken or fractured bones or dislocated joints this past year	**YES**	**NO**
3. Have you had a bone or joint injury that required x-rays, MRI, surgery, injections, physical therapy, brace, cast or crutches or other treatments this past year?	**YES**	**NO**
4. Have you had a stress fracture this past year?	**YES**	**NO**
5. Do you regularly use a brace or assistive device?	**YES**	**NO**

Explain any "YES" answers here:

NEUROLOGICAL

1. Have you had a head injury or concussion this past year?	**YES**	**NO**
2. Have you been hit in the head and been confused or lost your memory this past year?	**YES**	**NO**
3. Have you had a seizure this past year?	**YES**	**NO**
4. Do you have headaches with exercise?	**YES**	**NO**
5. Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling in the past year?	**YES**	**NO**
6. Have you been unable to move your arms or legs after being hit or falling this past year?	**YES**	**NO**

Explain any "YES" answers here:

RESPIRATORY

1. Has a doctor ever told you that you have asthma or allergies?	**YES**	**NO**
2. Do you cough, wheeze, or have difficulty breathing during or after exercise?	**YES**	**NO**
3. Have you ever used an inhaler or taken asthma medicine?	**YES**	**NO**

Explain any "YES" answers here:

VISION

1. Do you have any problems with your eyes or vision? **YES NO**
2. Do you wear glasses or contact lenses? **YES NO**
3. Do you wear protective eyewear, such as goggles or a face shield? **YES NO**

Explain any "YES" answers here:

During the past month, have you often been bothered by feeling down, depressed, or hopeless? **YES NO**

During the past month, have you often been bothered by little interest or pleasure in doing things? **YES NO**

Do you have any concerns that you would like to discuss? **YES NO**

Explain any "YES" answers here:

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)

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 (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

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 (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.

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.

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Insurance Billing Policy

The University's Athletic Secondary health insurance is a secondary (basic) plan. Your primary insurance plan will 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: (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, 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 daily injury reports to coaches.

I understand that the team 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 team 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, 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

Sports Medicine Department

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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, injury reports, emergency travel forms, and acknowledgement/consent forms.

Signature _____ Date_____

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

DELAWARE STATE UNIVERSITY
Sports Medicine Department

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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 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

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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

DELAWARE STATE UNIVERSITY
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Heat-Related Illness

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 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

DELAWARE STATE UNIVERSITY
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DRUG TESTING CONSENT FORM
DRUG SCREENING AND SUBSTANCE ABUSE PROGRAM 2017-2018

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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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: _____

Birth date: _____ 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.

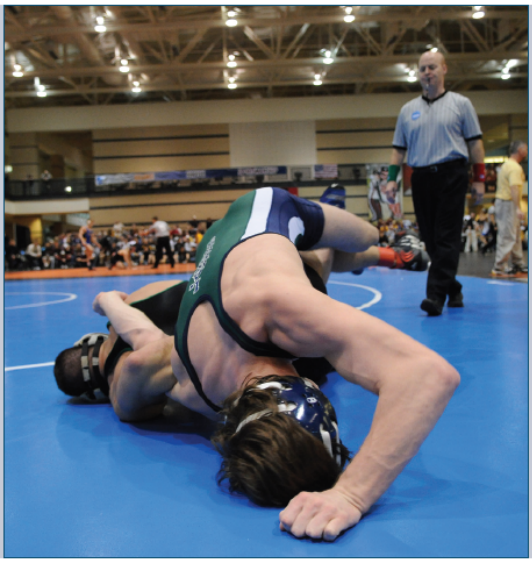
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

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

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: _____ 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