Student-Athlete Instructions

Dear Student-Athletes and Parents/Guardians,

On behalf of the Sports Medicine Staff, we are excited about the upcoming academic year and athletic seasons. We look forward to working with you. Our staff is committed to maintaining the health and well-being of our student athletes.

As part of our preventative efforts, we ask that you **thoroughly read and complete** the paperwork found in this Pre-participation Physical Examination (PPE) packet. All forms and medical documentations are due back to the sports medicine department by **August 1.**

Failure to do so will delay your participation in our PPE screening process which may impede your ability to practice with your team. Please note that all forms should be filled out prior to printing. Make sure that all forms are signed and dated prior to submission to your team's athletic trainer.

Please include an enlarged copy of the front and back of your primary insurance card (Rx, Dental, Vision, or secondary). If you do not have medical insurance please disregard this statement and indicate so in the insurance section of the PPE.

For Wrestling only:

Please make sure the last page of the PPE is filled out, signed and dated.

Please mail all documents back to:

HOFSTRA UNIVERSITY
Sports Medicine Department
230 HOFSTRA UNIVERSITY
Hempstead, NY 11549
Attention**: __ (name) __TEAM ATC**

HOFSTRA UNIVERSITY 2010 ATHLETIC TRAINERS SPORTS ASSIGNMENTS

Evan Malings: Cross Country, Men's Basketball

Andrew Wetstein: M & W Tennis, Wrestling

Robert Sullivan: M & W Golf, Men's Lacrosse

Robert DiMonda: Field Hockey, Women's Lacrosse

David Riviere: Volleyball, Baseball

Marie Siler: Women's Soccer, Softball

Lindsay Adams: Men's Soccer, Women's Basketball

ATHLETIC CLEARANCE FORM

____ _________________________
STUDENT - ATHLETE NAME SPORT

____
DATE

_______ CLEARED:

____

____

____

_______ NOT CLEARED – REASON: ____________________________________

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RECOMMENDATIONS: ____

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PHYSICIAN (*print*):____

PHYSICIAN SIGNATURE: ______________________________________

SPORTS MEDICINE

INSURANCE INFORMATION 2010-2011

NAME ______________________ **DATE OF BIRTH** ______________________

SS # ______________________ **HOFSTRA ID #** ______________________

☐ **Transfer/First Year Student** ☐ **Returning Student** **SPORT (S)** ______________________

HOME ADDRESS______________________ HOME PHONE #, ______________________

CITY ______________________STATE ________ ZIP ____________ CELL PHONE # ____________

POLICY HOLDERS NAME ______________________ D.O.B ______________ PHONE # ______________

PRIMARY INSURANCE COMPANY NAME ______________________

POLICY # ______________________ GROUP # ______________________

ADDRESS ______________________ CITY ____________ STATE __________ZIP ____________

PHONE # ______________ NAME OF PERSON INSURED ______________ D.O.B ______________

DO YOU HAVE A SECONDARY INSURANCE COMPANY ☐ **YES** ☐ **NO**

NAME/POLICY#/GROUP #______________________

TELEPHONE # ______________________

DOES YOUR INSURANCE REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN?
☐YES ☐NO

DOES YOUR INSURANCE REQUIRE PRE-APPROVAL FOR MEDICAL CARE? ☐YES ☐NO

☐ I AM NOT COVERED BY ANY PERSONAL HEALTH/MEDICAL INSURANCE PLAN

All of the above provided information is accurate and complete to the best of my knowledge.

This insurance information form will be provided to medical/health care providers that I am referred to by the University Medical staff. I also provided a copy of my insurance card to be attached to this form. In all cases, the Hofstra University provided insurance is secondary to my personal insurance coverage. My signature below signifies my consent to such a release.

Furthermore, I understand the following:

Hofstra University Certified Athletic Trainers, Team Physicians, and Wellness Center staff will make all health care referrals of University Student-Athletes. Non-authorized referral (s) to off-campus physicians or other health care providers is not accepted procedure at Hofstra University. A student-athlete may self refer to an off-campus medical health care provider of his/her choice. However, should a student athlete choose to use an outside (non-University) provider without proper referral from the University Medical Staff, they will be responsible for any and all costs incurred. They must use their private medical health insurance and personal financial resources for payment of their bills. University Provided insurance and financial resources are not available in these cases.

Signature ______________________________________Date ______________________

Parent/Guardian Signature (If Under 18) ______________________Date ______________________

Student-Athlete's Initials ____________

SPORTS MEDICINE

Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Sports Medicine Department of Hofstra University for the purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(Please **Type** or print clearly in ***BLUE or BLACK INK ONLY!)***

Name ______________________________ Date ____________

Seven Hundred # ____________________ Date of Birth ____________________

Race: ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other ________

Sport(s) ____________________ Position(s) ____________________

Height ________ **Weight** _______ **Peak Flow** ______ **Vision (R)** ____ / ______ **(L)** ______ / _______ ☐ **Corrected**

BP ______ / ______ **Pulse** ______ ☐ Right Handed ☐ Left Handed

PERMANENT ADDRESS:

____
STREET

____
CITY STATE ZIP CODE

____
PHONE 1 (HOME) PHONE 2 (CELLULAR)

Father's Name ______________________________ Age ____________

If Deceased, Cause of Death ______________________________ Age @ Death __________

Father's Occupation ______________________________ Father's D.O.B ______________

Address *(if different from permanent address):*

____
STREET

____
CITY STATE ZIP CODE

____
HOME PHONE WORK PHONE

Mother's Name ______________________________ Age ____________

If Deceased, Cause of Death ______________________________ Age @ Death __________

Mother's Occupation ______________________________ Mother's D.O.B ______________

Address *(if different from permanent address):*

____
STREET

____
CITY STATE ZIP CODE

____
HOME PHONE WORK PHONE

I. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ______

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ______

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? ☐ YES ☐ NO

- Please Describe ______

Do you get tired more quickly than your teammates / friends do during exercise / practice? ☐ YES ☐ NO

- Please Describe ______

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please Describe ______

Has any family member or relative died or heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please Describe ______

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please Describe ______

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / Please Describe ______

Does anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please Describe ______

Have you ever been told that you have / had high blood pressure? ☐ YES ☐ NO

- Please Describe ______

Does anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please Describe ______

Have you even been told that you have / had high blood cholesterol? ☐ YES ☐ NO

- Please Describe ______

II. Allergies:

Have You Ever Been Diagnosed With Seasonal Allergies? ☐ YES ☐ NO

- Please Describe ______

Are You Presently Taking/Have You Previously Taken Any Allergy Medications? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? ☐ YES ☐ NO

- Please Describe ______

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? ☐ YES ☐ NO

- Please Describe ______

III. Asthma:

Have You Ever Been Diagnosed With Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ____________________
- Please Describe ____________________

Are You Presently Taking / Have You Previously Taken Any Asthma Medications / Use an Inhaler? ☐ YES ☐ NO

- Date(s)? ____________________
- Please Describe ____________________

How Many Times Do You Use Your Rescue Inhaler (e.g. Albuterol, Proventil, etc.) During An Average Week? ____________

How Many Acute Asthma Attacks Have You Had In The Past 12 Months? ____________________

- Date(s)? ____________________
- Please Describe ____________________

Have You Ever Been Hospitalized As a Result of Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Asthma Or Any Related Condition? ☐ YES ☐ NO

- Please Describe ____________________

IV. Head Injuries / Concussion:

Have You Ever Suffered a Head Injury / Concussion (no matter how minor)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Have You Ever Been Evaluated By a Doctor for a Head Injury / Concussion? ☐ YES ☐ NO

- Please Describe ____________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Neuropsychological Testing ☐ Other ____________________

Have You Ever Been Hospitalized, Knocked Out, Become Unconscious, and/or Lost Your Memory Due To A Head Injury / Concussion? ☐ YES ☐ NO

- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Head Injury / Concussion? ☐ YES ☐ NO

- Please Describe ____________________

Do You Suffer From Headaches? ☐ YES ☐ NO

- When? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
- Where Are Your Headaches Located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Your Head

Do You Have A History of Migraine Headaches? ☐ YES ☐ NO

- How Often ____________________ Please Describe ____________________
- Medications Taken for Migraines? ____________________

Have You Had Headaches For More Than Three (3) Months? ☐ YES ☐ NO

- If yes, please explain ____________________

V. Eye:

When Was Your Last Eye Exam? ______________________

- Findings? ______________________

Have You Ever Suffered An Injury To Your Eye(s) and/or Been Advised That You Have An Eye Disease? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized and/or Seen an Ophthalmologist for an Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Eye Injury? ☐ YES ☐ NO

- Please Describe ______________________

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO

- Please Describe ______________________

Do you routinely wear glasses? ☐ YES ☐ NO

Do you routinely wear contact lenses? ☐ YES ☐ NO Type ______________________

Do you require any special devices / equipment? ☐ YES ☐ NO Type ______________________

VI. Ear / Nose / Throat:

Have You Ever Suffered An Injury To Your Ear(s), Nose, and/or Throat? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized For A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ear, Nose, and/or Throat Injury? ☐ YES ☐ NO

- Please Describe ______________________

VII. Dental:

When Was Your Last Dental Exam? ______________________

- Findings? ______________________

Have You Ever Suffered An Injury To Your Mouth, Jaw, and/or Teeth? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? ☐ YES ☐ NO (check all that apply)

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______________________

Have You Ever Been Hospitalized For A Mouth, Jaw, and/or Tooth Injury? ☐ YES ☐ NO

- Please Describe ______________________

VIII. Cervical Spine / Neck:

Have You Ever Suffered An Injury To Your Cervical Spine and/or Neck? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ________
- Please Describe ________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Cervical Spine / Neck Injury? ☐ YES ☐ NO

- When? ________ Where? ________
- Please Describe ________

Have You Ever Had "Burners", "Stingers", or Brachial Plexus Injuries? ☐ YES ☐ NO

- How Many? ________ Date(s)/Time Missed? ________

Have You Ever Experienced Numbness and/or Tingling in Your Arms/Fingers? ☐ YES ☐ NO

- Date(s)? ________
- Please Describe? ________

Have You Ever Had Surgery of Any Kind on Your Cervical Spine / Neck? ☐ YES ☐ NO

- When? ________ Surgeon? ________
- Please Describe ________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Cervical Spine / Neck Injury?

☐ YES ☐ NO

- Please Describe ________

Do You Presently Wear A Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? ☐ YES ☐ NO

Have You Ever Worn or Been Advised To Wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

☐ YES ☐ NO If yes, please explain ________

IX. Shoulder / Upper Arm:

Have You Ever Suffered An Injury To Your Shoulder / Upper Arm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ________
  ____
- Please Describe ________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Shoulder / Upper Arm Injury? ☐ YES ☐ NO

- When? ________ Where? ________
- Please Describe ________

Have You Ever Had Surgery of Any Kind on Your Shoulder / Upper Arm? ☐ YES ☐ NO

- When? ________ Surgeon? ________
- Please Describe ________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Shoulder / Upper Arm Injury?

☐ YES ☐ NO

- Please Describe ________

X. Elbow / Forearm:

Have You Ever Suffered An Injury To Your Elbow / Forearm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Elbow / Forearm Injury? ☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Had Surgery of Any Kind on Your Elbow / Forearm? ☐ YES ☐ NO

- When? ____________________ Surgeon? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Elbow / Forearm Injury?

☐ YES ☐ NO

- Please Describe ____________________

XI. Wrist, Hand, & Fingers:

Have You Ever Suffered An Injury To Your Wrist(s), Hand(s), and/or Finger(s)?

☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ____________________
- Please Describe ____________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Wrist, Hand, and/or Finger Injury?

☐ YES ☐ NO

- When? ____________________ Where? ____________________
- Please Describe ____________________

Have You Ever Had Surgery of Any Kind on Your Wrist, Hand, and/or Finger(s)?

☐ YES ☐ NO

- When? ____________________ Surgeon? ____________________
- Please Describe ____________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Wrist, Hand, and/or Finger Injury?

☐ YES ☐ NO

- Please Describe ____________________

XII. Spine / Low Back / Sacroiliac Joint:

Have You Ever Suffered An Injury To Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Spine / Low Back / Sacroiliac Joint Injury? ☐ YES ☐ NO

- When? ______________ Where? ______________
- Please Describe ______________________________

Have You Ever Had Surgery of Any Kind on Your Spine / Low Back / Sacroiliac Joint? ☐ YES ☐ NO

- When? ______________ Surgeon? ______________
- Please Describe ______________________________

Have You Ever Had Numbness/Tingling Down One (1) or Both Legs? ☐ YES ☐ NO

- Date(s)/Time Missed? ______________________________
- Please Describe? ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Spine, Low Back, or SI Joint Injury? ☐ YES ☐ NO

- Please Describe ______________________________

XIII. Hip / Groin:

Have You Ever Suffered An Injury To Your Hip / Groin *(including hernias and/or sports hernias)?* ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________________
- Please Describe ______________________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Hip / Groin Injury? ☐ YES ☐ NO

- When? ______________ Where? ______________
- Please Describe ______________________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Hip and/or Groin Injury? ☐ YES ☐ NO

- Please Describe ______________________________

Student-Athlete's Initials ______________

XIV. Thigh / Hamstring / Quadriceps:

Have You Ever Suffered An Injury To Your Thigh, Hamstring, and/or Quadriceps? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When? ______________ Where? ______________
- Please Describe ______________________

Have You Ever Had Surgery For A Thigh, Hamstring, and/or Quadriceps Injury? ☐ YES ☐ NO

- When? ______________ Surgeon? ______________
- Please Describe ______________________

Have You Ever Not Participated In Athletic Activities Due To A Thigh, Hamstring, or Quadriceps Injury? ☐ YES ☐ NO

- Please Describe ______________________

XV. Knee / Patella:

Have You Ever Suffered An Injury To Your Knee and/or Patella (kneecap)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______________________
- Please Describe ______________________

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When? ______________ Where? ______________
- Please Describe ______________________

Have You Ever Had Surgery For A Knee and/or Patella Injury? ☐ YES ☐ NO

- When? ______________ Surgeon? ______________
- Please Describe ______________________

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Knee / Patella Injury? ☐ YES ☐ NO

- Please Describe ______________________

Have You Ever/Do You Presently Wear A Knee Brace? ☐ YES ☐ NO

- Which Knee? ______________ Brand / Model of Brace?______________
- Reason for Wearing? ______________________

Student-Athlete's Initials ______________

XVI. Ankle / Lower Leg:

Have You Ever Suffered An Injury To Your Ankle / Lower Leg? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Been Hospitalized For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Had Surgery For An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Ankle / Lower Leg Injury? ☐ YES ☐ NO

- Please Describe ______

Do You Presently ☐ Tape Your Ankle(s) ☐ Use Ankle Brace(s) ☐ Other

- Please Describe ______

XII. Foot / Toes:

Have You Ever Suffered An Injury To Your Foot / Toe(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Foot / Toe Injury? ☐ YES ☐ NO

- When? ______ Surgeon? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Foot and/or Toe Injury? ☐ YES ☐ NO

- Please Describe ______

XIII. Ribs / Thorax / Chest:

Have You Ever Suffered An Injury To Your Rib / Thorax / Chest? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (Check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For A Rib / Thorax / Chest Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Ribs, Thorax, and/or Chest Injury? ☐ YES ☐ NO

- Please Describe ______

Student-Athlete's Initials ______

XIX. Abdomen:

Have You Ever Been Diagnosed With A Problem With Your Stomach, Abdomen, Intestines, or Rectum? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Have You Ever Suffered An Injury To Your Abdomen? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed ______
- Please Describe ______

Were Any Diagnostic Tests Performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have You Ever Had Surgery For An Abdomen Injury? ☐ YES ☐ NO

- When? ______ Where? ______
- Please Describe ______

Do You Routinely Suffer From Severe Or Recurrent Abdominal Pain? ☐ YES ☐ NO

- Please Describe ______

Do you Routinely Suffer From Chronic or Recurrent Diarrhea? ☐ YES ☐ NO

- Please Describe ______

Do You Have Only One Of Two Paired, Functioning Organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO

- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To An Abdomen Injury? ☐ YES ☐ NO

- Please Describe ______

XX. Medical Testing:

Have You Ever Been Diagnosed With A Communicable Disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? ☐ YES ☐ NO

- List Dates/Time Missed ______
- Please Describe ______

XXI. Dermatological:

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)?

☐ YES ☐ NO

- Please Describe ______

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

- Please Describe ______

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ YES ☐ NO

- Please Describe ______

Student-Athlete's Initials ______

XXII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

MEDICATION	**PURPOSE**	**DOSAGE**	**DATE(S)**

XXIII. Supplements / Ergogenic Aids:

Please List **ALL** Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

SUPPLEMENT	**PURPOSE**	**DOSAGE**	**DATE(S)**

XXIV. Heat Related Problems:

Have You Ever Suffered From A Heat Related Injury? ☐ YES ☐ NO (check all that apply):

- ☐ Heat Cramps- Date(s)? ______
- ☐ Heat Syncope (Fainting)- Date(s)? ______
- ☐ Heat Exhaustion- Date(s)? ______
- ☐ Heat Stroke- Date(s)? ______

Have You Ever Received Intravenous Fluids (IV) For A Heat Related Problem? ☐ YES ☐ NO

- Date(s)? ______

Have You Ever Been Hospitalized For a Heat-Related Problem? ☐ YES ☐ NO

- Date(s)? ______ Where? ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To A Heat Related Injury? ☐ YES ☐ NO

- Please Describe ______

XXV. Diabetic History:

Have You Ever Been Diagnosed With Diabetes? ☐ YES ☐ NO

- Date? ______

Are You Presently Taking or Have You Taken Any Diabetic Medications? ☐ YES ☐ NO

Medication	Form	Dosage	Frequency

Do You Daily Monitor Your Blood Sugar Level? ☐ YES ☐ NO

- How Many Times Per Day? ______ What Is Your Average Level? ______

Have You Had Your A1C Level Checked Within The Last Three (3) Months? ☐ YES ☐ NO Level ______

Have You Had Any Hypoglycemic Episodes (low blood sugar) Within The Last Twelve (12) Months? ☐ YES ☐ NO

- Please Describe ______

Have You Ever Been Advised Not To Participate In Athletic Activities Due To Diabetes? ☐ YES ☐ NO

- Please Describe ______

Please List Any Precautions That You Take and/or Additional Information Not Mentioned Above:

______

XXVI. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Date? ______ Result? ______

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe ______

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO

- Please Describe ______

XXVII. For Females Only:

At what age did you have your first menstrual period? ______

☐ YES ☐ NO Have you had menstrual periods within the past 12 months?

- If yes, how many? ______ When was your most recent menstrual period? ______
- How much time do you usually have from the start of one period to the start of another? ______
- What was the longest time between menstrual periods within the past year? ______

☐ YES ☐ NO Do you have painful or heavy menstrual periods?

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? ______

☐ YES ☐ NO Do you take birth control pills? If yes, what brand? ______

☐ YES ☐ NO Have you ever had any problems with your breasts?

☐ YES ☐ NO Have you had a pelvic examination within the last year?

XXVIII. Please Answer: *{All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!}*

☐ YES ☐ NO Have you ever had any injury or illness other than those already noted?
☐ YES ☐ NO Do you have any ongoing or chronic illnesses?
☐ YES ☐ NO Have you ever been hospitalized overnight?
☐ YES ☐ NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
☐ YES ☐ NO Are you currently under a physician's care for any medical conditions?
☐ YES ☐ NO Have you ever been under the care of a psychiatrist and/or psychologist?
☐ YES ☐ NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
☐ YES ☐ NO Do you take any vitamins or supplements?
☐ YES ☐ NO Have you ever had a rash or hives develop during and/or after exercise?
☐ YES ☐ NO Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
☐ YES ☐ NO Have you ever been told that you have kidney disease?
☐ YES ☐ NO Have you ever had rubella ("German Measles") and/or Rubella ("red measles")?
☐ YES ☐ NO Have you ever had a stomach and/or duodenal ulcer?
☐ YES ☐ NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ YES ☐ NO Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES ☐ NO Have you ever had gall bladder disease and/or a urinary problem?
☐ YES ☐ NO Do you have ringing in your ears or trouble hearing?
☐ YES ☐ NO Do you have frequent ear infections or nosebleeds?
☐ YES ☐ NO Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ YES ☐ NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
☐ YES ☐ NO Have you ever had the chickenpox? If yes, when? ____________________
☐ YES ☐ NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Hofstra University at this time?
☐ YES ☐ NO Have you had a tetanus booster within the past five (5) years? If yes, when? ____________________
☐ YES ☐ NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? ____________

☐ YES ☐ NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
☐ YES ☐ NO Do you use alcohol? If yes, how often? ____________________
☐ YES ☐ NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
☐ YES ☐ NO Do you have any questions regarding drugs, tobacco, or alcohol?
☐ YES ☐ NO Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
☐ YES ☐ NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
☐ YES ☐ NO Are you a vegetarian? If yes, what type? ____________________
☐ YES ☐ NO Do you regularly lose weight to participate in your sport?
☐ YES ☐ NO Do you want to weigh more or less than you presently do?
☐ YES ☐ NO Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
☐ YES ☐ NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ YES ☐ NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain: ____________________

____

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____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fourteen (14) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I fully understand that **Hofstra University,** its agents, servants, trustees, and employees disclaim liability, and will not be held liable for any injuries and/or illnesses not noted.

Student-Athlete Signature — Date

Student-Athlete Print Name

Parent/Guardian Signature *(if under 18 years of age)* — Date

Parent/Guardian Print Name

Witness — Date

Reviewed By:

Reviewer's Signature — Date

Reviewer Print Name

HOFSTRA UNIVERSITY

INFORMED CONSENT

Injuries can and do occur during athletic practice and/or competition. Such injuries can result in, but are not limited to, temporary or permanent disability, paralysis, illness or death to you or your opponent. These injuries may occur with or without intent to violate any rules of specific events.

Improper or unauthorized use or alteration of protective equipment is in violation of NCAA rules and can contribute to injuries. Hofstra University student-athletes may utilize only University-issued equipment, and are not to make any alterations to such equipment.

HELMET WARNING:
Men and Women Lacrosse, Baseball and Softball

Do not use your helmet to butt, ram or spear an opposing player, or use your helmet as a weapon. This is in violation of the rules and can result in sever head, neck or back injuries, paralysis or death to you and possible injury to your opponent. There is a risk that injuries may also occur as a result of accidental contact without intent to butt, ram or spear another player. No helmet can prevent all injuries.

> I have read the above statements and I agree to comply with all NCAA and HOFSTRA UNIVERSITY rules and policies. I understand that injuries can and do occur during athletic competition. I seek to Participate with full knowledge of these risks.

I hereby agree to release and discharge Hofstra University, its trustees, directors, officers, representatives, employees, agents, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have in connections with my participation in athletic practice and/or competition, including that which may result from travel to and/or from said athletic practices and/or competition.

I hereby acknowledge that I am eighteen year of age or older and competent to contract in my own name.

I have read the foregoing before affixing my signature below, and warrant that I fully understand the contents thereof.

Name (*print*): ______________________________

SIGNATURE: ______________________________ Date: ____________

Address: ______________________________

Address: ______________________________

Witness Name (*print*): ______________________________

SIGNATURE: ______________________________ Date: ____________

Address: ______________________________

Address: ______________________________

HOFSTRA UNIVERSITY

Student-Athlete Authorization/Consent
For
Disclosure of Protected Health Information
To the
National Collegiate Athletic Association

I, ___________________________________ hereby authorize ___________________________________
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for participation in intercollegiate athletics to Hofstra University Athletic Department, Team Physician, Athletic Training Staff, and affiliated Medical Facilities.

I understand that my protected health information will be used only by the NCAA's Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA; NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injuries/illness 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 my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization request for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

___________________________________ ___________________________ ________
Printed Name of Student-Athlete Signature Date

HOFSTRA UNIVERSITY

MEDICAL INFORMATION/RECORDS
RELEASE AUTHORIZATION

I ________________________________ , authorize the release of my medical records, and any other pertinent information to the Hofstra University Team Physicians, Wellness Center and/or Athletic Training Staff. This includes any information from my medical history, physical examination, any diagnostic test performed, any appointments or treatments that I have received, surgeries, and my present medical status.

In addition I authorize the physicians, and/or other health care professionals, involved in my diagnosis and treatment to discuss any known health and/or medical conditions with the Hofstra University team Physicians, Wellness Center and/or Athletic Training staff. Such communication may be by telephone or facsimile.

I understand that I may revoke this consent at any time, and that it remains valid until revoked by me in writing.

Name (printed) ____

Student ID # 70 _________________

Signature ____ Date _____________________

Witness (printed)____

Signature ____ Date_____________________

PRIVACY POLICY

Hofstra University takes your personal privacy very seriously. We understand its importance and safeguards are in place to protect your information. Federal law requires us to share in writing our Privacy Policy. Please take a few minutes to read our privacy policy.

Privacy Principles

- We do not sell student athlete information
- We do not provide student athlete information medical or insurance to persons or organizations that are not providing medical care/insurance coverage on our behalf
- Medical information will not be released without your prior consent

Information We Collect

We collect and use information we believe necessary to administer our business as a healthcare provider, advise you about our services, and to provide you with quality healthcare. We collect and maintain several types of information needed for these purposes, such as those below:

- From you, information we receive on Medical History From, Injury Report Form, Insurance Form, Physician's Clinic Report Form, Health and Safety Program documents, Drug Testing Report Forms
- From other healthcare providers, visit notes, test results, studies (x-ray, MRI, bone scan)
- From insurance companies, both the student athletes and the University policy, claim notices, Explanation of Benefits, or any other paperwork related to a claim

Information Disclosure

Medical information

We may disclose medical information to team physicians, media, family, coaches, University administration or other medical personnel you may be referred to in providing you with appropriate medical care.

If you prefer we do not share your medical information with certain individuals or entities, you will have the opportunity to do so at the time of your initial evaluation for each medical condition. You can change your consent for your information release at any time.

A record of any and all disclosures regarding your medical information will be maintained. This is available for your review. Please contact your team Certified Athletic Trainer for further information.

Insurance Information

We may disclose this information to any healthcare provider who requires it on your behalf to receive care. Information will also be released to Klais & Company, Inc. Hofstra University's athletic insurance company.

I have read Hofstra University's Athletic Training Privacy Policy and Understand that my medical information will not be released without my consent and information gathered from me will be used only for the intended purpose of providing medical/health care as I require.

Name (printed) ______________________________ Sport ____________________________

Signature ___________________________________ Date ____________________________

HOFSTRA UNIVERSITY

Parental Consent

As the parent or legal guardian of ________________________________, I give my consent for him/her to practice and play in athletic events/games with the ___________________ team. I grant permission for any treatment deemed necessary for a condition arising during practice/competition, including medical or emergency treatment recommended by a medical doctor. I understand the every effort will be made to contact me prior to treatment/testing.

I grant permission for Hofstra University team physicians to conduct a comprehensive physical examination prior to my son/daughter being cleared to play; and will abide by any recommendations made for further evaluation/treatment found necessary during such physicals.

I understand that Hofstra University Athletic Trainers, Physicians, coaches, and/or any other personnel involved in health care decisions of Hofstra University student-athletes to have access to medical information and I understand that such information will be kept strictly confidential.

Student ID # 70_________________

Name (printed) ____

Signature ____ Date _____________________

Witness (printed)____

Signature _______________________________________ Date______________________

WRESTLING PROGRAM

I have read and signed the HOFSTRA UNIVERSITY "Sports Medicine Medical Questionnaire," including the provision confirming that I have been informed that injuries may occur during my participation in athletic practice and competition.

I have also read and reviewed the NCAA guidelines relating to skin infections and wrestling. I acknowledge that my participation in the Wrestling Program may bring me into contact with various contagious skin conditions and infections and that as a result, I may contract such infections or conditions. I seek to participate in the Wrestling Program with full knowledge of these risks.

I hereby agree to release and discharge Hofstra University, its officers, representatives, employees, agents, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have in connection with my participation in the Wrestling Program.

I hereby warrant that I am eighteen years of age or older and competent to contract in my own name.

I have read the foregoing release before affixing my signature below, and warrant that I fully understand the contents thereof.

____________________________________ __________________
Signature Date

____
Printed Name

Address: ______________________________

____

____________________________________ __________________
Witness Signature Date

____
Printed Name

Address: ______________________________

____