Instructions Check List

Please print this page to assure that all necessary steps and documents are completed.

Step 1) Make sure that you are completing the correct document packet, if you are **entering** your **1st year** at HOFSTRA, or if you are a **New** student **[transfer, or first year]** you **MUST complete** the ***HUSportsMED*** LONG FORM packet. All others need to complete the short form, please see reference chart below:

Type of Form	Transfer	1st Year	2nd Year/4th Year	3rd/5th Year
HU SportsMED Long	X	X		
HU SportsMED Short			X	X

Step 2) Returning Students, please fill out the ***HUSportsMED*** SHORT FORM Packet, & log on to **Hofstra2.atsusers.com** to update your insurance information and emergency contact.

Step 2a) Provide an **updated copy of your primary insurance** card. **Faxed copies will NOT! Be accepted** please mail the front and back copies with your packet. Failure to do so will delay your PPE process.

The information below applies to NEW HOFSTRA Students only…

Step 3) DO NOT FAX OR SCAN Documents as we require all original signatures in ink!

Step 4) Please make sure that you have included an **enlarged copy** of the **front** and **back** of your primary insurance card (this will be necessary to have on file as certain providers require a copy of your card to submit claims) the numbers and info you've provided are not sufficient.

Step 5) Make sure that you have completed **the sickle cell** testing paper work regardless of ethnicity as this is an NCAA requirement.

Step 6) Make sure that you have completed the information sent to you by the Hofstra Wellness Center (i.e. medical form, updated vaccination profile etc). Failure to do so will generate a HOLD on your account and prevent you from taking classes making you ineligible to play/practice.

Step 7) Make sure that you have signed up on [**Hofstra2.atsusers.com**] this is important for keeping your records, safe and accurate.

Step 8) Verify that you have completed, ***signed*** & dated all the forms included in HU SportsMED Long packet.

If you need further instructions or have any questions PLEASE direct all inquiries with regards to medical documentation and paperwork to David Riviere, email david.riviere@hofstra.edu.
We appreciate your cooperation and look forward to seeing you play.

HOFSTRA UNIVERSITY

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

SPORTS MEDICINE

Student-Athlete, 2nd & 4th yr Physical Examination

Name _____ Year in School _____

Date of Birth _____ Sport(s) _____

Since your last physical examination on _____, have you?

DATE

☐ Yes ☐ No	1. Had a serious injury / been hospitalized, or had surgery of any kind?	☐ Yes ☐ No	21. Had an unfavorable / allergic reaction to a drug, antibiotic, and/or medicine?
☐ Yes ☐ No	2. Had a sprain / strain and/or fracture?	☐ Yes ☐ No	22. Had a dental injury?
☐ Yes ☐ No	3. Had a concussion and/or head injury?	☐ Yes ☐ No	23. Do you have any allergies?
☐ Yes ☐ No	4. Been unconscious for any other reason other than anesthesia?	☐ Yes ☐ No	24. Do you require daily medications?
☐ Yes ☐ No	5. Had a neck injury?	☐ Yes ☐ No	25. Been diagnosed with asthma?
☐ Yes ☐ No	6. Had a back injury or suffered from back pain?	☐ Yes ☐ No	26. Been diagnosed with diabetes?
☐ Yes ☐ No	7. Had any of burners, stingers, numbness in neck, shoulder, and/or hand?	☐ Yes ☐ No	27. Experienced coughing, wheezing, shortness of breath, or breathing difficulties during or after exercise?
☐ Yes ☐ No	8. Had a shoulder, elbow, and/or hand / wrist injury?	☐ Yes ☐ No	28. Been diagnosed with kidney disease?
☐ Yes ☐ No	9. Had a hip and/or knee injury?	☐ Yes ☐ No	29. Been diagnosed with a hernia?
☐ Yes ☐ No	10. Had a lower leg, ankle, and/or foot injury?	☐ Yes ☐ No	30. Experienced seizures or convulsions and/or been diagnosed with epilepsy or a seizure disorder?
☐ Yes ☐ No	**11.** Have you had any skin infection in the past (Herpes, Ringworm, Staph, etc)?	☐ Yes ☐ No	31. Been diagnosed with high blood pressure and/or high blood cholesterol?
☐ Yes ☐ No	12. Are you currently undergoing physical therapy or rehabilitation for an injury?	☐ Yes ☐ No	32. Do you require any special equipment to participate in athletics?
☐ Yes ☐ No	13. Do you have any medical problems about which we should be aware?	☐ Yes ☐ No	33. Have you been told by a physician to restrict your activity or not to participate in sport?
☐ Yes ☐ No	14. Do you wear contact lenses, glasses, and/or safety glasses?	☐ Yes ☐ No	34. Are you currently taking any medications (prescription and/or over-the-counter) for any injury and/or illnesses?
☐ Yes ☐ No	15. Had frequent headaches?	☐ Yes ☐ No	35. Do you have any ongoing or chronic illnesses?
☐ Yes ☐ No	16. Been evaluated by a Hofstra University Team Physician, Hofstra University Wellness Center Health Care Professional, and/or other physician?	☐ Yes ☐ No	36. Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorder?
☐ Yes ☐ No	17. While exercising, has your heart ever "skipped" a beat, have you suffered from a "racing heart", severe chest pain, lightheadedness, or fainted?	☐ Yes ☐ No	37. Do you take vitamins, amino acids, creatine, and/or any other dietary supplement on a daily basis and/or as needed?
☐ Yes ☐ No	18. Had a heat related illness (heat cramps, heat exhaustion, and/or heat stroke) and/or missed time / received special attention (IV fluids, etc.) for a heat related problem?	☐ Yes ☐ No	38. Do you know of, or do you believe there is any health reason why you should not participate in intercollegiate athletics at Hofstra University?
☐ Yes ☐ No	19. Missed a practice and/or game due to an injury and/or illness?	☐ Yes ☐ No	39. Been diagnosed with any **NEW** injuries and/or medical problems?
☐ Yes ☐ No	20. Been recently diagnosed with infectious mononucleosis ("mono"), hepatitis B or C, HIV/AIDS, and/or any other severe infectious disease / viral infection?	☐ Yes ☐ No	40. Have you ever felt dizzy, passed out, or "blacked out" during or after exercise

FEMALES ONLY!

How long do your menstrual periods usually last? _____

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

Have you gone more than three (3) consecutive months without a menstrual period? Yes ☐ No ☐

Do you take birth control pills? If so, which one(s)? _____

Do you take pain medication for menstrual symptoms? If so, which one(s)? _____

If you answered "YES" to any of the above questions and/or have any further information, which is knowledgeable to you and not required on this form, please explain in detail *(use additional sheet(s) if necessary)*-

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements 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 understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

_____ _____

Student-Athlete Signature Date

Vital Information:

Height _____ **Weight** _____ **Peak Flow** _____ **Vision (R)** _____ / _____ **(L)** _____ / _____ ☐ **Corrected**

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

Physical Exam *(to be completed by the physician)-*	**NORMAL**	**ABNORMAL FINDINGS**
Heart / Cardiovascular	☐	
Pulmonary / Lungs	☐	
Abdomen / Gastrointestinal	☐	
Musculoskeletal Review	☐	
Re-evaluation of Medical Problems since the last exam	☐	
Other	☐	

Recommendations / Comments: _____

_____

_____

Status:

☐ Pass without restrictions

☐ Pass with restrictions _____

☐ Further Evaluation Needed- _____

_____ _____

Examiner's Signature Date

_____

Examiner Print Name

HOFSTRA UNIVERSITY

Sickle Cell Trait Status

Dear Physician:

The NCAA requires that all member institutions document the Sickle Cell Trait Status of all of their Student Athletes. Since all states require Sickle Cell Testing at birth, Hofstra University is requesting that you review the medical records of your patient listed below, who is also a Student Athlete at our University. Please answer the questions below, sign and date this document, and return to the Student Athlete for compliance with the NCAA requirement. We thank you for your time.

Student Athlete Name: _____ Date of Birth:_____

Address:_____

Phone Number:_____

Please Circle your answer for the three questions listed below:

1. **Are you or have you been a health care provider for the Student Athlete Listed Above?** **Yes** ☐ **No** ☐
2. **If Yes to Question #1, do you have a record of their Sickle Cell Trait Status?** **Yes** ☐ **No** ☐
3. **If Yes to Question #2, what is their Sickle Cell Trait Status?** **Positive** ☐ **Negative** ☐

Health Care Provider Name: _____ **Title:** _____

Address: _____

Office Phone: _____ **Office Fax:** _____

Health Care Provider Signature: _____ **Date:** _____

HOFSTRA UNIVERSITY

Responsibility for Reporting Injuries and Illnesses

As a Student Athlete at Hofstra University there are many athletic, academic, and community responsibilities of which I must comply. The most important responsibility that I have is my health.

It is my responsibility as a Student Athlete at Hofstra University to notify my designated Athletic Trainer if I have any injuries or illnesses. In the event that my Athletic Trainer is not available, it is my responsibility to notify another member of the Sports Medicine Staff (Athletic Trainer, physician) if I have any injuries or illnesses. It is also my responsibility to follow all treatment and rehabilitation instructions, and if unable to comply with these instructions I must notify a member of the Sports Medicine Staff in a timely manner in order to appropriately adjust my treatment or rehabilitation plan to improve my compliance.

During practice or competition, I acknowledge my responsibility and obligation to inform the nearest member of the Hofstra University Sports Medicine Staff of any injury or illness that I may suffer during the activity. I will also allow any member of the Sports Medicine Staff to appropriately evaluate me in order to assess my ability to continue playing on that day.

This obligation to inform the Sports Medicine Staff includes any direct or indirect hit to my head that causes a headache, dizziness, confusion, or any other symptoms. **I will review the NCAA education materials on Concussion so I am familiar with concussion symptoms.** If I am diagnosed with a concussion, I acknowledge that it is an essential part of my treatment plan after a concussion to honestly report any symptoms that may still be present. Failure to do so may lead to an increased risk for another concussion, a more severe injury which could lead to my death, or permanent negative effects on my brain function.

If I have any questions or concerns regarding the Responsibility for Reporting Injuries and Illnesses policy I will communicate them with either Evan Malings, Head Athletic Trainer of Hofstra University, or Dr. Michael Yorio, Medical Director for Hofstra University's Department of Athletics.

Name: _____ Date: _____

Designated Athletic Trainer: _____ Head Coach: _____

Signature: _____

Signature of Guardian (if under 18): _____

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

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_____

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

SPORTS MEDICINE

INSURANCE INFORMATION 2011-2012

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 _____

HOFSTRA UNIVERSITY

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: _____

_____