

NEW ATHLETE Sport Club Info Packet:

An athlete should fill out all forms listed below if he/she did not participate in any sport club program during the 2007-2008 school year

Athlete Name: _____

Sport Club: _____

- Athlete Info Form
- Physical Form with Physician's Business Card attached
- Health History Form
- Medical Consent form (signed portion only - keep the rest!)
- DMV Pull Form
- Copy of Drivers License (or red ID if you don't have a license)
- Proof of Car Insurance (if you have car insurance)

Reminder: All athletes must be registered ARC members.

Incomplete packets will not be accepted

Sport Clubs Athlete Information Form

Date: Please print legibly

Athlete Name: Last First

Sport Club:

Local Address: Street City State Zip Code

E-mail Address:

Phone Number: Birthdate: RED ID Number:

Emergency Contact: Last First

Relationship: Phone Number (including area code):

Health Insurance Mark here if you have no insurance

Primary Insurance Company:		CHECK ONE <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Policy Number:	Name of Policy Holder:	

Car Insurance Mark here if you have no insurance

Owner's Name:	
Insurance Company:	
Policy Number:	Policy Expires:

Note to Athlete & Parent/Guardian

I understand this insurance information must be COMPLETELY and ACCURATELY provided and on file with the Recreational Sports Office before I/my son/daughter will be allowed to participate in athletics. I further understand that any medical expenses resulting from an ACCIDENTAL INJURY while participating in a scheduled university athletic activity will not be paid under the accident insurance policy carried by SDSU until any existing policy I have covering these expenses is exhausted. If I do not have insurance, payments will be made according to the schedule of benefits of the SDSU intercollegiate athletic accident policy. I understand the limits of insurance coverage under SDSU's insurance policy will be for 52 weeks or \$25,000 per injury, whichever comes first. I further understand that failure to report injuries to Associated Students Recreational Sports personnel or to university athletic medical personnel or to meet scheduled medical appointments may void university responsibility for medical expenses resulting from athletic injuries.

By initialing this box, the athlete or parent (If under 18 years old) is agreeing to the above conditions.

I hereby grant permission to the Team Physician at SDSU and those professional personnel designated by them to treat myself/my child in the event of athletic injury. In the event of serious injury and if unable to contact me, this consent is to include any and all emergency procedures deemed necessary by the attending physician.

By initialing this box, the athlete or parent (If under 18 years old) is agreeing to the above conditions.

Personal Vehicle Release Agreement

I, _____ (student name) from the _____ Club hereby certify that I understand and agree that San Diego State University (SDSU) and Associated Students are not responsible for transporting students to events sponsored by SDSU. I further agree that if I utilize a private vehicle to transport fellow students and/or SDSU staff members to such events, I will have in effect at the time a policy of automobile insurance providing the MINIMUM COVERAGE REQUIRED BY THE STATE OF CALIFORNIA. I further understand that I will observe all laws, rules, regulations, and ordinances relating to the operation of motor vehicles. I also understand that in the event of damage to my personal vehicle or vehicles of other involved parties, my personal insurance coverage applies. I verify that the vehicle in use is adequate for the work to be performed and is equipped with one seat belt per passenger, and is in safe mechanical condition. It is the responsibility of the athlete to **COPY THEIR LICENSE AND PROOF OF INSURANCE AND ATTACH IT TO THIS FORM.**

By initialing this box, the athlete or parent (If under 18 years old) is agreeing to the above conditions.

**San Diego State University
Athletic Medical Examination-Sport Clubs**

Name: _____
Sport: _____

Red ID# _____ - _____ - _____
Eligibility: Fresh Soph Jr Sr 5th Year

If Ht. > 6'0" male or 5'10" female measure:
Symph to floor = _____ arm span _____
UB/LB ratio _____ **is is not** < 0.89
Arm span/height _____ **is is not** > 1.05

I. I have not had any illness or injury; or developed any new symptoms since I completed the Health History Form on _____
Signature: _____

II. Healthy History Form reviewed (Physician Initials _____)

EXAM: Height: _____ Weight: _____ (%) Pulse: _____ BP: _____/_____
Vision: R 20/____ L 20/____ Corrected Y N Pupils: Equal Unequal

Normal	Abnormal Findings	Dr. Initials
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Medical			
Appearance			
Eye/Ears/Nose/Throat			
Neuro			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL Medical exam performed by:

Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/Ankle			
Foot			

Orthopedic exam performed by:

CLEARANCE:

- Cleared - Based on my examination of this patient, I determine he/she can fully participate in intercollegiate athletics at SDSU
- Cleared after completing rehabilitation for:

- Not cleared for: Reason:
- Clearance decision deferred pending further work-up or obtaining records

COMMENTS and RECOMMENDATIONS: _____

**ATTACH PHYSICIAN'S BUSINESS
CARD HERE**
(physical is invalid without business card)

Signature of physician _____ Date _____

Preparticipation Physical Evaluation

Date of Exam: _____

Name: _____	Sex: _____	Age: _____	Date of Birth: _____
Red ID#: _____	Sport(s): _____		
Local Address: _____	Phone: _____		

**Explain "Yes" answers below.
Circle questions you don't know the answer to.**

	YES	NO		YES	NO																
1. Has a doctor ever denied or restricted your participation in sports for any reason? Why _____	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, What? _____	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have an rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion? If so, when was your last one? _____ How many have you had? _____ Any current problems? _____	<input type="checkbox"/>	<input type="checkbox"/>																
9. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>																
10. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>																
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>																
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%;">Head</td> <td style="width:12.5%;">Neck</td> <td style="width:12.5%;">Shoulder</td> <td style="width:12.5%;">Upper Arm</td> <td style="width:12.5%;">Elbow</td> <td style="width:12.5%;">Forearm</td> <td style="width:12.5%;">Hand/ fingers</td> <td style="width:12.5%;">Chest</td> </tr> <tr> <td>Upper Back</td> <td>Lower Back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/ shin</td> <td>Ankle</td> <td>Foot/ toes</td> </tr> </table>	Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest	Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ shin	Ankle	Foot/ toes			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ fingers	Chest														
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ shin	Ankle	Foot/ toes														
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommend you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>																
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>																
22. Do you regularly use a brace or an assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>																
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY:																		
			47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>																
			48. How old were you when you had your first menstrual period?																		
			49. How many periods have you had in the last 12 months?																		

Explain "Yes" Answers Here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: _____ Signature of Parent/Guardian: _____

Date: _____



SDSU Associated Students – Athletic Medicine Notice of Privacy Practices

Effective: August 15, 2006

Updated: August 15, 2006

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

Your information is personal and private.

We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. A medical record documenting the care of your athletic related and non-athletic related injuries and illnesses will be kept in a secure confidential area in the training room. This notice applies to all of the records kept on file in the Athletic training room

Athletic Medicine Staff refers to all persons working under the direction of the Medical Director of Athletic Medicine and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, graduate assistant athletic trainers, student athletic trainers, and registered dietitians. In addition it includes administrative assistants with Associated Students who handle medical billing.

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

SDSU Athletic Medicine staff may use or share your information for reasons directly connected to your treatment, payment for that health treatment or health plan operations. The information we use and share includes, but is not limited to: your name, address, personal facts, medical care given to you, and your medical history. Some actions we may take while caring for you include: checking your insurance eligibility and enrollment; approving and paying for health care services; checking the quality of care that you receive; and coordinating the care you receive. Some examples include:

For treatment: You may need medical treatment that requires us to get approvals from a health plan for consultations with specialists or surgeons. We will share information with doctors, hospitals, insurance companies and others in order to get you the care you need.

For payment: SDSU Associated Students acts as a secondary insurance program for injuries and illnesses associated with your participation in varsity athletics. Your personal insurance plan is always used first. Athletic Medicine staff determines which care is covered by our secondary insurance and if appropriate, arranges to pay for our portion of the medical bill. When we do this, we share information with the doctors, clinics, and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.

For health care operations: We may use information in your health record to judge the quality of the health care you receive. We also may use this information in audits, planning, and general administration.

B. OTHER USES FOR YOUR HEALTH INFORMATION

1. Your medical information regarding injuries or illnesses associated with your participation in Sport Clubs at SDSU may be shared with coaches, associated students administration, and others as stated in a separate release, *Sport Club Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses*.
2. Sometimes a court will order us to release your health information. We also will give information to a court, investigator, or lawyer under certain circumstances. This may involve disclosure and discussion of your health information with the University Risk Manager or attorneys employed/retained to represent the University.
3. You or your doctor, hospital, and other health care providers may appeal decisions made about claims for your health care. Your health information may be used to make these appeal decisions.
4. We also may share your health information with agencies and organizations that check how our athletic medicine department is providing services.
5. We must share your health information with government agencies when they are checking on how we are meeting privacy rules.
6. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.
7. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.

C. WHEN WRITTEN PERMISSION IS NEEDED

If we want to use your information for any purpose not listed in this notice, we must get your written permission. If you give us your permission, you may cancel or revoke it in writing at any time.

D. WHAT ARE YOUR PRIVACY RIGHTS?

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.
- You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

E. COMPLAINTS If you believe that we have not protected your privacy and you wish to complain, you may file a complaint (or grievance) by calling or writing the Director of Associated Students, 55th St , San Diego, CA 92182-4701, (619) 594-7269.



SDSU Associated Students

Sport Clubs Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Background:

This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

As a club athlete you enter into an agreement with Associated Students with unique rights and responsibilities. Sharing medical information about your injuries or illnesses with coaches and other Associated Students administrators is helpful (such as when a coach is planning a roster for an upcoming competition).

Often other athletes are within hearing distance while you are being treated in the training room or on the field for your athletic injuries and illnesses.

Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:

Athletic injuries and illnesses : This may refer to any injury or illness that impacts your ability to play and/or perform for San Diego State University's Sport Clubs. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities.

Athletic Medicine Staff: This refers to all persons working under the direction of the Medical Director of Athletic Medicine and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, graduate assistant athletic trainers, student athletic trainers, registered dietician, and Associated Students administrative assistants who handle medical billing.

Consent:

I, _____, acknowledge that I have read and understand the
Name of Sport Club **Athlete**

Background and Definitions above and that I have been given a copy of, read and understand a separate document “SDSU Associated Students – Notice of Privacy Practices”

I, _____, hereby authorize San Diego State University
Name of Sport Club **Athlete**

and its *athletic medicine staff* (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my *athletic injuries and illnesses* to the following groups/persons:

List A: Groups/Persons

1. Associated Students Associate Director
2. SDSU Associated Students Department Administrators including but not limited to
3. Teammates and other Sport Club athletes
4. Parents or guardians

I understand that the information released may have different purposes and is dependant on to whom the information is released. These purposes may include but are not limited to:

List B: Purposes

1. Associated Students Department operations
2. Explaining the typical course of an injury or illness to a coach or another athlete
3. Informing concerned parents or guardians

I understand that my injury/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 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 requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in Sport Club teams.

****Turn page****

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 Associated Students. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Printed Name of Sport Club Athlete

Signature of Sport Club Athlete

Date

Sport Club Team