

ARCADIA UNIVERSITY ATHLETICS REPORT OF MEDICAL HISTORY

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB	SOCIAL SECURITY #
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HOME ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE
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PARENT / GUARDIAN	HOME PHONE	CELL PHONE
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Please answer all of the following questions	Yes	No
Have you been hospitalized or had surgery in the past 12 months?		
Has a doctor ever denied or restricted your participation in physical activity for any reason?		
Do you have an ongoing medical condition such as asthma or diabetes?		
Are you currently taking any prescription or non-prescription medications?		
Have you been knocked unconscious at anytime during the last 12 months?		
Do you smoke or use tobacco products?		
Do you drink alcohol?		
If you answered yes to any of the above questions please elaborate on the 2nd page		

Have you ever had or do you now have any of the following conditions?									
	Yes	No		Yes	No		Yes	No	
A heart murmur			Eye Injury			Ever have injuries to the following?			
High blood pressure			Impaired Vision			Neck			
A heart infection			Dental Problems			Shoulder			
Chest Pain			Missing Teeth			Arm or Elbow			
Heart Racing or Skipping			Do You Wear:			Wrist or fingers			
Marfan's Syndrome			Glasses or Contacts			Back			
Dizziness or Fainting			Neurological Injuries			Groin			
Breathing Problems			-Concussion			Thigh			
Heat Exhaustion or Heat Stroke			-Skull Fracture			Knee			
Frequent Headaches			- Loss of Consciousness			Lower Leg			
Mononucleosis			- Amnesia			Ankle or Foot			
Anemia			-Seizure Disorder			Allergies			
Chronic Cough			-Stroke			- Medications			
Lung Problems			Skin Conditions such as:			-Insects			
Stomach / Intestinal Problems			-MRSA			-Latex			
Spleen Injury			-Bacterial infection			-Other Allergies			
Hernia			Eating Disorder such as:			Females only:			
Seizure Disorder			-Anorexia			Changes in menstrual			
Urinary Problems			-Bulimia			Are you currently pregnant?			
Ear Injury			Are you missing one of these organs?			Do you have any medical conditions not listed above? List below			
Hearing Difficulty			-Lung						
Nose Injury			-Kidney						
Frequent Nose Bleeds			-Testicle						

FAMILY HISTORY

Have any of your relatives had the following?

Condition	Yes	No	Relationship
Sudden Death Before age 50?			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Cancer			
Marfan's Syndrome			
Asthma / Allergies			
Tuberculosis			
Alcohol / Drug Problems			
Depression			

Please comment on all "YES" answers here _____

I certify that the answers to the questions above are correct and true.

 Student-Athlete Signature

 Date

 Health Care Providers Signature (Acknowledging Review)

 Date

ARCADIA UNIVERSITY ATHLETIC CLEARANCE FORM

NCAA policies recommends that any student who intends to participate in intercollegiate athletic activities must have on file at the school a record of having passed a complete physical examination upon initial entrance into the school's intercollegiate athletic program. Arcadia University requires their athletes to complete a heart and lung screening and medical history form yearly. All athletes must have a completed health record on file in the Student Health Services Center *prior to participation*.

Name _____ DOB _____ Sport _____

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

	Normal	Abnormal / Comments
Head, Ears, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Metabolic/Endocrine		
Neurological		
Skin		
Psychiatric		
Musculoskeletal		

_____ **Has Satisfactorily** completed the examination to participate in athletics at Arcadia University.

_____ **Has Not** satisfactorily completed the examination and is not cleared to participate in athletics at Arcadia University. The following findings should be further evaluated prior to participation clearance:

Name of physician or nurse practitioner

Date

Signature of physician or nurse practitioner

Address

Phone

I the undersigned certify that the answers to the questions above are correct and true. I also understand that passing the physical exam does mean that I am physically qualified to engage in athletics, but that the examiner did not find a medical reason to disqualify me.

Student-Athlete Signature

Date

Student Athlete Authorization /Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

I, _____ herby authorize _____
Name of 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 the National Collegiate Athletic Association (NCAA) and its employees or agents.

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 the 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 provided to the Association and other groups with an information resource upon which base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA 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 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 HIPPA 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. 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 in any publication or disclosure or 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 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 and does not affect any action taken prior to that date.

Printed Name of Student-Athlete

Signature

Date

ARCADIA UNIVERSITY ATHLETIC TRAINING ROOM

INSURANCE VERIFICATION / EMERGENCY CONTACT FORM

Name _____ **Date of Birth** ____ / ____ / ____ **M / F**
Last First MI

Permanent/Home Address _____
City State Zip Code

Home Telephone (____) _____ **Cell** (____) _____

Male Parent/Guardian

Name _____

Employer _____

Employer Address _____

Employer's Telephone _____

Cell Phone _____

Female Parent/Guardian

Name _____

Employer _____

Employer Address _____

Employer's Telephone _____

Cell Phone _____

INSURANCE COMPANY _____

ADDRESS _____

TELEPHONE _____

POLICY # _____ **GROUP #** _____

POLICYHOLDER NAME _____ **RELATIONSHIP** _____

CURRENT MEDICAL CONDITIONS: _____

CURRENT MEDICATIONS: _____

KNOWN ALLERGIES: _____

Emergency Contact: _____ **Telephone:** (____) _____

Relationship: _____

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

ARCADIA UNIVERSITY ATHLETICS DEPARTMENT

I, _____, as parent, guardian or legal representative, attest that
(name, please print)

_____ has insurance coverage under a current, in force insurance
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics.

If there is a material change in coverage or expiration of coverage, I agree to notify Arcadia University of this development and update the insurance information I have on file with Arcadia University.

I understand and agree that Arcadia University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Arcadia University if the student-athlete fails to remain insured during the intercollegiate school year.

(signature of parent/guardian)

(date)

(signature of student-athlete)

(date)

**THIS FORM MUST BE SIGNED AND RETURNED TO ARCADIA
UNIVERSITY ATHLETIC TRAINING ROOM WITH COMPLETE
MEDICAL CLEARANCE PACKET**

**YOU MUST INCLUDE A COPY (FRONT AND BACK)
OF YOUR CURRENT INSURANCE CARD**