

NOTRE DAME DE NAMUR UNIVERSITY
Medical History

Name: _____ SSN#: _____ Date: _____
Date of Birth: ___/___/___ Age: _____ Sport: _____

****THIS INFORMATION WILL BE KEPT CONFIDENTIAL****

GENERAL

Have you ever been advised by a physician **not** to participate in the sport in which you are planning to participate at NDNU? YES NO

Medications (ANY/ALL medications prescribed by a physician) YES NO

If YES, please list **type** and **dose**: _____

Glasses/Contacts: YES NO

Hearing Impairment? YES NO

Do you wear any dental appliance? YES NO

If YES, what type? _____ **Temporary or Permanent?**

Absent or non-functioning organ? YES NO

If YES, please indicate which organ: _____

Allergies YES NO

If YES, please list (seasonal or specific, i.e. bee stings, foods, etc): _____

Asthma YES NO

Inhaler (Type: _____) YES NO

General surgery in the last 5 years? YES NO

If YES, please indicate type, anatomical site and date: _____

Any history of heat illness? YES NO

Ever been treated for an eating disorder? YES NO

Last Tetanus Shot _____

If you answered "YES" to any of the above, please explain: _____

Is there ANY reason you CAN NOT undergo a diagnostic test such as MRI, CT Scan, etc.?

Answer YES if you have metal implants (including piercings)

anywhere in your body. YES NO

****FEMALE ATHLETES ONLY****

Menstrual periods occur regularly, approximately every 28 days?

YES NO

If NO, please describe _____

When was your last period? _____

How many periods have you had in the last 12 months? _____ 6 months? _____

Have you ever missed 3 or more consecutive months of your menstrual periods? YES NO

If yes, how many consecutive months have you missed your period? _____

Does your menstrual cycle change with a change in the intensity, frequency or duration of training?

YES NO

Pain for ____ days during your menstrual period

Ever been treated for a menstrual disorder? YES NO

If YES, please describe _____

Have you ever been treated for anemia (low hemoglobin or iron)? YES NO

****FEMALE ATHLETES ONLY****

Is there any history of osteoporosis (thinning of the bones) in your family?

YES NO

Do you take any medications during your menstrual periods?

YES NO

If YES, please list _____

Ever had problems with heavy bleeding? YES NO

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

If YES, please describe _____

DISEASE & ILLNESS

Epilepsy or history of epileptic seizure? YES NO

Diabetes? YES NO

If YES, please list type and medications, if any: _____

Been treated for any of the following in the **past 12 months?**

Hepatitis YES NO

Mononucleosis YES NO

Viral pneumonia YES NO

Any other infectious disease YES NO

If YES, please describe type and treatment: _____

Been treated for or diagnosed with any of the following:

Heart Murmur YES NO

Arrhythmia YES NO

Racing heart or Skipped beats YES NO

High blood pressure or high cholesterol YES NO

Sickle Cell Anemia YES NO

ANY sports-disqualifying cardiac condition YES NO

If you answered "YES" to any of the above, please explain: _____

Ever passed out/ had chest pain/ been dizzy during or after exercise? (Circle symptom **and** explain below)

YES NO

Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice?

YES NO

Do you ever have chest tightness?

YES NO

Have you ever had chest tightness, cough, wheezing, that made it difficult for you to participate in sports?

YES NO

Have you ever been treated/hospitalized for asthma?

YES NO

Have you ever had a seizure?

YES NO

Has any family member or relative younger than 50 years old:

Died of heart problems or sudden death before age 50?

YES NO

Died suddenly and unexpectedly?

YES NO

Been treated for recurrent fainting?

YES NO

Had unexplained seizure problems?

YES NO

Had unexplained drowning while swimming?

YES NO

Had unexplained car accident?

YES NO

Had heart transplantation?

YES NO

Had a pacemaker or defibrillator implanted?

YES NO

Been treated for an irregular heart beat?

YES NO

Had heart surgery?

YES NO

Has any family member or relative died from unexplained causes?

YES NO

Has anyone in your family been told they have Marfan's Syndrome?

YES NO

Has a physician ever denied or restricted your participation in sports due to any heart problems?

YES NO

Have you ever had an electrocardiogram (EKG) of your heart?

YES NO

Have you ever been told you had Rheumatic Fever?

YES NO

Do you have only one of two paired, functioning organs (eyes, kidneys, ovary, lung, ear)?

YES NO

Have you had a viral infection (i.e. mononucleosis, myocarditis, Hepatitis B or C, HIV/AIDS, etc) within the past six (6) months?

YES NO

Do you take any vitamins, dietary supplement, or ergogenic aids?

YES NO

Are you following a special diet which limits the intake of any foods?

YES NO

If no, are there any foods you do not eat? YES NO

If you answered "YES" to any of the above, please explain: _____

ORTHOPEDIC HISTORY***GENERAL***

Have you suffered any bone fractures within the last 4 years?

YES NO

Do you have a pin, screw, wire, or plate in your body as a result of bone or joint surgery?

YES NO

If YES to either of the above, please describe: _____

DOMINANT ARM RIGHT LEFT

DOMINANT LEG RIGHT LEFT

HEAD, NECK and BACK

Ever suffered a concussion? YES NO

If YES, how many, and when? _____

Ever lost consciousness from a head injury? YES NO

If YES, how many times, and when? _____

Suffer frequent or severe headaches? YES NO

If yes, how often? Every day 1-2 times/week 1-2 times/month

Do you have a history of migraine headaches?

YES NO

How Often? _____ Do you take any medications for migraines? _____

Please Describe _____

Ever been diagnosed with scoliosis, kyphosis, or lordosis? (Please circle appropriate condition)

YES NO

Ever had an injury to your neck or cervical spine involving nerves, vertebrae or intervertebral discs?

YES NO

Ever had an injury to your low back involving nerves, vertebrae or intervertebral discs?

YES NO

If YES to either question, please describe _____

Ever experienced numbness or tingling in your extremities after such an injury?

YES NO

ARMS LEGS

RIGHT LEFT BOTH

Ever had surgery to any part of your spine, including discs, nerves or vertebrae?

YES NO

Do you continue to experience Low Back Pain or Neck pain or symptoms?

YES NO

If YES, please describe _____

**UPPER EXTREMITY
SHOULDER**

Ever suffered a dislocation, separation or other injury that kept you out of activity for more than 1 week?

YES NO

RIGHT LEFT BOTH

Please describe _____

Ever had surgery after a shoulder injury? YES NO

RIGHT LEFT BOTH

If YES, date and procedure: _____

Ever suffered a sudden or overuse injury to your throwing arm?

YES NO

If YES, please describe _____

Do you CONTINUE to experience any problems associated with the above injuries?

YES NO N/A

ELBOW, WRIST, HAND

Ever suffered an injury to your elbow, including tendonitis and/or sprains or dislocations?

YES NO

RIGHT LEFT BOTH

If YES, please describe _____

Ever suffered an injury to your forearm or wrist?

YES NO

RIGHT LEFT BOTH

If YES, please describe _____

Ever suffered single OR recurrent sprains or dislocations of your finger or thumb?

YES NO

Digit: Thumb 1st 2nd 3rd Pinky

RIGHT LEFT BOTH

If YES, please describe _____

Ever undergone surgery to correct any of the above conditions?

Please describe _____

Do you CONTINUE to experience any problems associated with the above injuries?

YES NO N/A

LOWER EXTREMITY

HIP AND PELVIS

Ever injured ligaments, cartilage, or any other structures in your hip or pelvis?

YES NO

RIGHT LEFT BOTH

Ever suffered from a chronic injury (such as tendonitis, recurrent hip subluxations, recurrent hamstring and/or quadriceps strains, etc)?

YES NO

RIGHT LEFT BOTH

Ever suffered from “Athletic Pubalgia”, Sports Hernia, or Osteitis Pubis?

YES NO

RIGHT LEFT BOTH

Do you continue to experience pain in your hip and/or pelvis after exercise?

YES NO

RIGHT LEFT BOTH

Have you ever been advised to have surgery on your hip and/or pelvis (including “Athletic Pubalgia”, Sports Hernia, or Osteitis Pubis)?

YES NO

RIGHT LEFT BOTH

Has the surgery been completed?

YES NO

Please describe_____

Did you undergo rehabilitation after this procedure? YES NO

Do you CONTINUE to experience any problems associated with the above injuries?

YES NO N/A

KNEE

Ever injured ligaments, cartilage, or any other structures in your knee?

YES NO

RIGHT LEFT BOTH

Ever suffered from a chronic injury (such as tendonitis, recurrent kneecap subluxations, etc)?

YES NO

RIGHT LEFT BOTH

Do you continue to experience pain in your knee after exercise?

YES NO

RIGHT LEFT BOTH

Have you ever been advised to have surgery on your knee?

YES NO

RIGHT LEFT BOTH

Has the surgery been completed?

YES NO

Please describe_____

Did you undergo rehabilitation after this procedure? YES NO

Do you CONTINUE to experience any problems associated with the above injuries?

YES NO N/A

If YES, please describe_____

FOOT and ANKLE

Have you ever suffered or do you currently suffer from:

Severe ankle sprains?

YES NO

RIGHT LEFT BOTH

From weak ankles or recurrent ankle sprains? YES NO

RIGHT LEFT BOTH

Ankle fracture? YES NO
 RIGHT LEFT BOTH

Bone spurs (foot, heel, or ankle)? YES NO
 RIGHT LEFT BOTH

Stress reactions or stress fractures? YES NO
 RIGHT LEFT BOTH

Ever undergone surgery to repair any of the above?

YES NO

Please describe _____

Do you routinely get your ankle(s) taped and/or wear a brace?

YES NO
 RIGHT LEFT BOTH

Do you CONTINUE to experience any problems associated with the above injuries?

YES NO N/A

If YES, please describe _____

ALL STUDENT-ATHLETES SIGN BELOW**STUDENT-ATHLETE PRE-EXISTING MEDICAL CONDITION VERIFICATION******* SIGNATURE REQUIRED FOR PARTICIPATION *****

My signature below serves as verification that the responses on my medical history questionnaire are correct to the best of my knowledge and belief. I understand that my responses will be used for the purpose of determining my fitness to participate in _____
(sport)

at Notre Dame de Namur University. I also understand that if I am eligible for coverage, the school's intercollegiate athletic accident insurance may limit or exclude benefits for injury or aggravation of an undisclosed pre-existing medical condition which would have disqualified me from participation in intercollegiate athletics, as determined by a physician.

Athlete signature

Date

Parent/Guardian signature (if required)

PERMISSION FOR MEDICAL CARE***** SIGNATURE REQUIRED FOR PARTICIPATION *****

In the event I sustain an injury while participating in Notre Dame de Namur University athletics, which requires any surgery, medical intervention, x-ray or other diagnostic evaluation, permission is hereby granted to the appropriate physician to proceed with any such form of treatment.

In the event an emergency arises during a practice session or competition, permission is granted to the athletic training staff to provide emergency first aid and care to the athlete prior to his/her transfer to a medical facility.

I understand that follow-up care will be provided under the guidance of the treating physician, following the policies and procedures set forth by the Notre Dame de Namur University Athletic Training staff.

Athlete signature

Date

Parent/Guardian signature (if required)

RELEASE OF RECORDS FROM NOTRE DAME DE NAMUR UNIVERSITY*****SIGNATURE REQUIRED FOR PARTICIPATION*****

By signing below I give my consent for the Notre Dame de Namur University Team Physician or Athletic Trainer to release such information regarding medical history, record of injury or surgery record of serious illness, and rehabilitation results as may be requested by representatives of educational institutions, amateur athletic organizations, or professional sports clubs seeking such information. In addition, treating physicians occasionally request pertinent information.

I understand a record will be kept of all individuals requesting such information and the date of the request. This information is confidential, and will be released by the parties in charge of the information only to those individuals or organizations mentioned above. Furthermore, I understand that treatment is not conditioned on obtaining authorization. Finally, I am aware that the potential exists for the information released to those individuals or organizations mentioned above to be re-disclosed by the recipient. This release remains valid by me until revoked in writing.

 Athlete signature

 Date

 Parent/Guardian signature (if required)
RELEASE OF RECORDS TO NOTRE DAME DE NAMUR UNIVERSITY

I hereby authorize the designated Team Physician or Athletic Trainer to request any medical or non-medical information pertinent to my intercollegiate competition at Notre Dame de Namur University. Such information would be requested only for the purpose of determining treatment and/or fitness to participate in intercollegiate athletics. This release remains valid by me until revoked in writing.

Records to be released only to: *NOTRE DAME DE NAMUR UNIVERSITY*
ATHLETIC TRAINING ROOM
1500 RALSTON AVE
BELMONT, CA 94002
(650) 508-3448/3437
Fax: (650) 508-3691

 Athlete signature

 Date

 Parent/Guardian signature (if required)

ASSUMPTION OF RISK

I am aware that participation in organized athletic competition, while providing a positive educational experience that can benefit my social, emotional, and physical development, also involves risk. This risk may include serious injury that could result in permanent disability, deformity, complete or partial paralysis, brain damage, or even death. I recognize that adhering to the following guidelines can minimize, but that the potential for serious injury and its adverse consequences will exist regardless of the most stringent preventative measures.

As a student-athlete at Notre Dame de Namur University, I can minimize the risk of injury to myself and other participants by:

1. Making sure I am properly conditioned for the sport in which I will participate.
2. Follow instructions of my coaches, and conditioning protocol.
3. Obey safety rules particular to my sport.
4. Wear protective equipment appropriate for my sport.
5. Report injuries, regardless of how minor they appear, the day they occur.

Athlete signature

Date

Parent/Guardian signature (if required)

AGREEMENT TO HOLD HARMLESS

In consideration of Notre Dame de Namur University permitting me to try out for _____, and to engage in all activities related to the team, including but not (sport)

limited to try-out, practicing or participating in competition, I hereby assume all the risks associated with participation and agree to hold harmless Notre Dame de Namur University, its employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the above-mentioned team. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Athlete signature

Date

Parent/Guardian signature (if required)

Notre Dame de Namur University
Department of Athletics
Athletic Training Room
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect April 14, 2003. These guidelines regulate the release of an individual's Personal Health Information (PHI) as it relates to electronic transactions (insurance billing, enrollment, and eligibility verification). These guidelines do not affect NDNU Athletic Training. However, an additional component of the HIPAA Guidelines regulates the release of PHI (including information specific to a student-athlete's health, i.e., injury specifics, treatments, imaging results, etc) by any healthcare provider. This guideline does allow for release of information in order to facilitate treatment, such as communicating with a host Athletic Trainer, requesting test results, etc., but requires an authorization from the individual.

So what do those guidelines mean?

Under these guidelines:

- Every student-athlete is required to sign the "Authorization to Release Information" and "Authorization to Request Information" in the medical history paperwork, which allows the Athletic Training Staff to communicate with physicians, insurance companies, host athletic trainers, and other healthcare providers for the purposes of facilitating treatment of any injury. One signature covers requests for an entire year.
- The Athletic Training Staff is still allowed to communicate with the student-athlete's respective coach and the Strength and Conditioning Coach regarding a specific injury and the student-athlete's status.
- Athletic Department staff (all coaches and staff privy to an athlete's health status) are no longer allowed to disseminate information to others without express consent of the individual.
 - An example: a volleyball coach can not provide information to a basketball coach regarding a volleyball player's injury which identifies the individual.
 - A member of the Athletic Training Staff cannot communicate with a basketball coach regarding a soccer player.
 - Athletic Training Staff cannot release information to athletes regarding teammates' or other athletes' health status
- Any information released to the media must be at the consent of the student-athlete. These releases are **by incident**, and are not covered under the authorizations mentioned above.

In accordance with the Health Insurance Portability and Accountability Act of 1996, NDNU Athletic Training endeavors to ensure that the privacy of the student-athletes is not compromised. Therefore:

- All Personal Health Information collected by the Athletic Training Staff will be stored securely, both in hard copy and electronically.
- Upon request, student-athletes may, at any time, view the information stored in the Athletic Training Room.
- Information will be released by the Athletic Training Staff only in order to facilitate treatment, i.e., treatment protocols to host athletic trainers, injury/medical history to physicians or other healthcare providers.
- Information may be requested of physicians or other healthcare providers who have treated athletes in the past in order to facilitate treatment within the NDNU Athletic Training Room.
- A detailed log will be kept of all outside requests for an Athlete's PHI (i.e. requests from representatives of educational institutions, amateur athletic organizations, or professional sports clubs). Athletes will be notified upon receipt of such a request by the Athletic Training Staff.

I have read and understand the above Policy on Privacy Practices:

Athlete signature

Date

Parent/Guardian signature (if required)

**ACKNOWLEDGEMENT OF NOTRE DAME DE NAMUR UNIVERSITY ATHLETIC
DEPARTMENT INSURANCE POLICY**

By signing below I acknowledge my understanding of the Notre Dame de Namur University Athletic Department Insurance Policy: I understand that in order to participate in any conditioning session, practice, or competition as a Notre Dame de Namur University Athlete that I am required to have, and provide proof of Primary Insurance to the Notre Dame de Namur University Athletic Department. I understand that, in the event I sustain an injury while participating in any form as an athlete at Notre Dame de Namur University, the costs associated with this injury will be billed to my personal health insurance. In the event that costs exceed the maximum allowable amount for my primary insurance policy, the difference will be billed to an insurance carrier retained by Notre Dame de Namur University.

Furthermore, I/We hereby certify that the foregoing answers are true, complete and correct to the best of my/our knowledge. I/we also hereby authorize any Insurance Company, Organization, Physician, Surgeon, Pharmacy, or other health care provider to release any information with respect to injury, treatment, or insurance. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Athlete signature

Date

Parent/Guardian signature (if required)

**NDNU ATHLETICS
EMERGENCY CONTACT INFORMATION**

The following information is needed in the event of an emergency while you are traveling with your team.
PLEASE FILL OUT COMPLETELY

Name: _____ Sport: _____ Season: _____
Gender: _____ Date of Birth: _____ Age: _____

TO BE COMPLETED BY ATHLETIC TRAINING STAFF			
RBP: _____	RHR: _____	Ht: _____	Wt.: _____

MEDICAL HISTORY

Medical Conditions: _____

(Including Allergies) _____

Medications: _____

EMERGENCY CONTACT

PARENT/SPOUSE/GUARDIAN NAME: _____

RELATIONSHIP: _____

PRIMARY PHONE: (____) _____

Please circle one: HOME CELL WORK

SECONDARY PHONE: (____) _____

Please circle one: HOME CELL WORK

ADDRESS _____

(Street and Number)

_____ ZIP _____

(City)

(State)

IF PARENT/GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

NAME _____

RELATIONSHIP: _____

PRIMARY PHONE: (____) _____

Please circle one: HOME CELL WORK

SECONDARY PHONE: (____) _____

Please circle one: HOME CELL WORK

INSURANCE

Company: _____ Type (circle one): HMO PPO Other

Policy Number: _____

Address: _____ Phone: _____

Primary/Family Physician

NAME: _____ PHONE: (____) _____

ADDRESS _____

(Street and Number)

(City)_____
(State)

ZIP _____

Orthopedic Physician

NAME: _____ PHONE: (____) _____

ADDRESS _____

(Street and Number)

(City)_____
(State)

ZIP _____