NOTRE DAME DE NAMUR UNIVERSITY
Annual Medical History Update

Name:________________________________ SSN#:____________________ Date:________________

Date of Birth:___/___/____ Age:____ Sport:____

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

GENERAL HEALTH

In the past year, have you had (or are you currently taking):

Medications: YES NO
(Please answer YES if you are taking ANY medications prescribed by a physician)
If YES, please list type and dose:____

Asthma YES NO
Inhaler (Type:_______________) YES NO

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

Are you currently taking, or have you in the last year taken any vitamins, dietary supplement, or ergogenic aids?
YES NO
If YES, please explain:____

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 YES, please explain:____

CARDIOVASCULAR HISTORY

In the past year, have you had:

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

Unusual or unexplained shortness of breath during or after exercise/practice?
YES NO

Has any family member or relative died of heart problems or sudden death before age 50?
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

If YES, please explain:____

MEDICAL HISTORY

In the past year, have you had:

An allergic reaction severe enough to require hospital treatment?
YES NO

Any blunt injury to the chest?
YES NO

Skull fracture, concussion, or loss of consciousness due to head injury?
YES NO

Heat illness (i.e. heat exhaustion or heat stroke) YES NO

If YES, please explain:____

Continued

ORTHOPEDIC HISTORY

In the past year, have you had:

Any neck or back injury? YES NO

Broken bones or joint dislocations? YES NO

An orthopedic visit at the request of the Athletic Trainer?
YES NO

Surgery?
YES NO

Physical Therapy? YES NO

If YES to any of the above, please explain, including body part, procedure done, and all pertinent details:

___

___

FEMALES ONLY

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

In the past year, have you had:

Menstrual periods occur regularly, approximately every 28 days?
YES NO

If NO, please describe___

Have you gone 3 or more months without menstruation?
YES NO

If YES, how many consecutive months have you missed your period?___

Does your menstrual cycle change with a change in intensity, frequency or duration of training?
YES NO

If YES, does it become (circle appropriate response):

Lighter / Heavier / Shorter / Longer / Disappear

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 STAFF
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)

HEALTH INSURANCE INFORMATION

Name:________________________ **Date of Birth:_____________**
SSN#:________________________ **Date:_____________________**

PRIMARY INSURANCE CO. ____

Card Holder__________________ Card Holder's SSN_______________________________

Policy Number____________________________________

Address of Insurance Co. ____

____

Phone Number (___)_____________ Type of Plan: HMO____ PPO___ Other____

Please describe:________________

(If Applicable)
SECONDARY INSURANCE CO. ____
Card Holder__________________ Card Holder's SSN_______________________________
Policy Number____________________________________
Address of Insurance Co. ____

____
Phone Number (___)_____________ Type of Plan: HMO____ PPO___ Other____
Please describe:________________

Does your insurance require: A second opinion for surgery? Y N
Pre-authorization? Y N

DENTAL INSURANCE CO. ____
Card Holder__________________ Card Holder's SSN_______________________________
Policy Number____________________________________
Address of Insurance Co. ____

____
Phone Number (___)_____________ Type of Plan: HMO____ PPO___ Other____
Please describe:________________

Does your insurance require: A second opinion for surgery? Y N
Pre-authorization? Y N

Are you fully covered under one of the above policies? Y___ N___
Are you partially covered or not covered due to policy limitations? Y___ N___
Does the above policy cover athletic injuries? Y___ N___
If YES, please explain:____

____

If the athlete has medical insurance coverage as an eligible dependent from a parent's previous marriage, as mandated in a divorce decree, please give details for filing a claim:______________

____

____

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)

____ ZIP______________
(City) (State)

Orthopedic Physician

NAME:___________________________________ PHONE: (____)___________________

ADDRESS____
(Street and Number)

____ ZIP______________
(City) (State)