



Sports Medicine

Medical Packet

Student-Athlete and Parents/Guardians:
Please complete ALL forms in this packet and mail to:

Department of Intercollegiate Athletics
Attention: Brent Walters
Athletic Training
200 High Street
Glennville, WV 26351

Please make sure that **all signatures** of parent/guardian are fully completed.

Please make sure to attach a **copy of the FRONT & BACK** of health insurance including any prescription, dental, or vision insurance cards.

Incomplete packets and/or packets missing signatures **will be returned**.
Student-athletes will **not be able to participate** until all forms are fully completed.

If you have any questions regarding medical paperwork please call:
Brent Walters
at
304-462-7361 x7223



INSURANCE & PERSONAL INFORMATION FORM
PERSONAL INFORMATION

Please print all information, except signatures. This form must be signed and completed in order to participate.

Name _____ Date of Birth ____/____/____ Sport _____
S.S. # _____ - _____ - _____ Nickname _____ Marital Status _____
Local Address _____ City _____ State _____ Zip _____
Local Phone _____ Cellular _____ Permanent _____
Permanent Address _____ City _____ State _____ Zip _____

PARENT/GUARDIAN INFORMATION

Father/Guardian _____	Mother/Guardian _____
Address _____	Address _____
Home Phone _____	Home Phone _____
SS # _____ D.O.B. _____	SS # _____ D.O.B. _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____

EMERGENCY INFORMATION (In The Event Parents/Guardians Can Not Be Reached)

Name _____ Relation to Athlete _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work _____ Cellular _____

INSURANCE INFORMATION

Primary Insurance (Circle One): HMO PPO NEITHER Policy Holder's Name _____
Insurance Company Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Policy # _____ Group # _____
Deductible Amount _____ Date Coverage Begins _____ Termination Date _____

Secondary Insurance (Circle One): HMO PPO NEITHER Policy Holder's Name _____
Insurance Company Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Policy # _____ Group # _____
Deductible Amount _____ Date Coverage Begins _____ Termination Date _____

ALLERGIES

Please list all allergies to medications, foods, stings, and bites _____

_____ I hereby authorize the Athletic Department to file a claim in my behalf for the athletic injury sustained by (dependent) under the above group medical policy. Further, I agree to consent that any amounts payable under this policy be paid to the medical provider or to the Glenville State College Athletic Department as shown.

_____ My son/daughter is not covered under my personal health insurance. Therefore, I hereby authorize the Glenville State College, and its representatives to inspect or secure copies of case history, laboratory reports, diagnosis, x-rays, and any other data in relation to any medical claim. This authorization may be photo copied and any photocopies should be deemed as valid and applicable as the original.

INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD AND COPIES OF RELATED CARDS

Signature of Policy Holder _____ Date _____



SPORTS MEDICINE

MEDICAL HISTORY PACKET

Sport _____

Last Name _____ First _____ Middle _____ Date _____

S.S. Number _____ Date of Birth _____ Age Sex _____ Marital Status _____

Place of Birth _____

ALLERGIES

	Yes	No
Aspirin		
Codeine		
Sulfa		
Anti-inflammatory		
Penicillin		
Hay Fever		

	Yes	No
Insect Bites/Stings		
Tetanus Antitoxin/Serums		
Nail Polish/Cosmetics		
Foods:		
Foods:		
Other:		

IMMUNIZATIONS

	Completed	Not Completed	Date of Injection	
Tetanus/Diphtheria				
Measles, Mumps, Rubella (MMR)			1.	2.
Measles and Rubella (MR)			1.	2.
Influenza				
Hepatitis				

FAMILY HISTORY

(has any blood relative **EVER** had any of the following)

	Yes	No	Comments
Sudden Death (before age 55)			
Blood Diseases (Sickle Cell, Leukemia)			
Diabetes			
Epilepsy			
Cancer			
Heart Disease			
High Blood Pressure			
Mental Disorders (anxiety/depression)			
Stroke			
Tuberculosis			
Drug and/or Alcohol Dependency			

Have you **EVER** had or **CURRENTLY HAVE** any of the following medical conditions?
 If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
High Blood Pressure			
Pericarditis			
Heart Disease			
Tumor, Growth, Cyst			
Cancer			
Hepatitis			
Pleurisy			
Pneumonia			
Respiratory Infection/Bronchitis			
Tuberculosis			
Malaria			
Mononucleosis			
Measles			
Mumps			
Rubella			
Chicken Pox			
Asthma			
Exercise Induced Asthma			
Sinus Infection			
Nasal Polyps			
Nose Fracture			
Amnesia			
Seizure Disorder			
Thyroid Disease			
Skin Disease			
Diabetes			
Sickle Cell Anemia/Trait			
Anemia			
Blood Disease			
Blood Clots			
Kidney Disease			
Kidney Stones			
Blood in urine			
Frequent Urinary Infections			
Hearing Defect/Loss			
Muscular Disease			
Birth Defects			
Appendicitis			
Stomach Ulcer (Peptic)			
Gastrointestinal Bleeding			
Hemorrhoids			
Hernia			
Arthritis			
Herpes (Oral or Genital)			
Sexually Transmitted Disease			
Car or Air Sickness			
Mental Disorder (anxiety, depression)			
Drug/Alcohol Dependency			
Attention Deficit Disorder (ADD)			

INTERNAL

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments (organ/problem)
Were you born with a complete and functional set of paired organs? (eyes, ears, kidneys, ovaries/testicles, lungs)			
Have you ever had surgery to repair any organs? (hernia, tonsils, appendix, spleen, etc.)			
Physican's name and address:			
Have you ever had surgery to remove any organs? (hernia, tonsils, appendix, spleen, etc.)			
Physican's name and addresss:			

CARDIAC

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Have you ever felt dizzy, light-headed, or passed out during or after exercise?			
Have you ever had chest pain/discomfort while exercising?			
Have you ever had irregular heart beats, heart palpatations or felt like your heart skipped a beat?			
Have you ever been told you have a heart murmur?			
Have you ever been treated by a cardiologist?			
Have you ever had an eco-cardiogram, stress test, or any other heart tests?			
Have you ever been told that you have increased blood pressure?			
Have you or anyone in your family ever been told that they have Marfan's Syndrome? If yes, who?			

ORTHOPEDIC

Have you ever sprained/strained, fractured, dislocated, x-rays, MRI, CT Scan, surgery, pinched nerves, had repeated swelling or pain, or had any other injury of any of the following areas of the body? If yes, please explain include the side of the body, specific injury, and date of injury.

	Yes	No	Comments
Head			
Neck			
Elbows			
Wrists			
Hands/Fingers			
Shoulders			
Upper Arms/Forearms			
Chest Wall			
Lower Back			
Pelvis/Hips			
Thighs			
Lower Legs			
Knees			
Ankles			
Feet/Toes			

HEAT

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Have you ever had trouble with dehydration?			
Have you ever experienced heat cramps?			
Have you ever been hospitalized for heat related problems?			
Have you ever required an IV for heat related problems?			
Have you ever required oral medication for heat related problems?			

HEAD

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Do you have a problem with frequent headaches, blurry vision or dizziness?			
Have you ever been told you have migraine headaches?			
Have you ever had a concussion?			
If yes,			
How many?			
When was the last one?			
Did you lose consciousness?			

VISION, DENTAL, and HEARING

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Do you wear corrective lens? Contacts or glasses?			
Do you have to wear corrective lens during sport participation?			
Have you ever had an injury to your eyes?			
Do you have a bridge or false teeth?			
Have you ever fractured a tooth?			
Have you ever had a tooth knocked out?			
Do you wear a mouth guard?			
Do you wear orthodontic appliances?			
Have you ever worn hearing aids?			

The undersigned, herewith,

- Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given written permission by the attending physician to resume participation.

- Certifies that the answers to those questions are correct and true.

- Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.

- Fully realizes the Glenville State College Athletic Department cannot be held responsible for any previous medical condition(s) that he/she might have.

Student Athlete Signature _____ Date _____

Parent/Guardian Signature _____ Date _____



SPORTS MEDICINE

REFERRAL POLICY

Upon sending an athlete to a medical facility outside of the athletic training room, athletes must follow the referral protocol in order for the Glenville State College to be financially responsible for charges that are not paid by the athlete's primary insurance. The following is the referral protocol:

1. Upon determination of sending the athlete to a medical facility the athletic trainer will give the athlete a REFERRAL SLIP that MUST be taken to the appointment.
2. The referral slip is only valid for the specific provider stated on the slip
3. The referral slip is only valid on the date printed
4. The referral slip is only valid for the reason/problem stated on the slip
5. A copy of the front and back of the athlete's insurance card must accompany the referral slip at the time of the visit (insurance card copies will be provided by the athletic trainer).

A referral slip is REQUIRED for ALL visits in order for the Glenville State College Athletic Department to be financially responsible.

If an athlete goes to a medical facility without a referral slip or does not follow the procedures above, 100% of the medical charges for the visit becomes the total responsibility of the athlete and/or the athlete's parents/guardians. Be advised that ER visits without referral/approval by the Glenville State College Sports Medicine program will be the sole responsibility of the athlete.

I have read and understand the insurance coverage and referral procedures that are stated above. I understand and agree with the coverage and procedures outlined and have forwarded this information on to my parents and/or legal guardian for their awareness of the policies and procedures of the Glenville State College Athletic Department regarding insurance and referral information.

Athlete Name *(Please Print)* _____ Sport _____ Date _____

Athlete Signature _____ Date of Birth _____ Social Security Number _____

Parent/Guardian Signature _____ Date _____



GLENVILLE STATE

SPORTS MEDICINE

Authorization for Release of Protected Health Information

Please print all information except when signatures are required

Student Athlete Name _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

I hereby authorize the physicians, athletic trainers, sports medicine staff and all other health care personnel representing the Glenville State College and the Glenville State College Athletic Department to receive my protected health information for diagnosis and/or treatment purposes for intercollegiate athletic participation.

I understand that my authorization/consent releases the following information: *(Please check one of the following)*

- Complete Medical Records
- Records concerning the following injury/illness _____
- Records for the period between ____/____/____ to ____/____/____.
- Records confined to the following information: *(Please check all that apply)*
 - Medical Condition
 - Medical Status
 - Athletic Participation Status
 - Prognosis
 - Consultation
 - Operative Notes
 - Discharge Summary
 - Lab Reports
 - Pathology Reports
 - EKG/echocardiogram
 - Medications
 - History and Physical
 - X-ray Reports
 - MRI/CT Reports
 - Progress Notes
 - Other: _____

I understand that my protected health 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 (Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or Buckley Amendment. I understand that I may revoke this authorization/consent at any time by notifying in writing the Director of Sports Medicine, but if I do, it will not have any effect on actions the Glenville State College or the Glenville State College Athletic Department took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent shall expire one year from the date it is signed.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete at the Glenville State College. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Athlete _____ Date _____

Signature of Parent/Guardian (if athlete is under 18) _____ Date _____



Authorization for Disclosure of Protected Health Information

Please print all information except when signatures are required

Student Athlete Name _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing the Glenville State College Athletic Department to release information regarding my protected health information and any related information regarding any injury or illness during my participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to:

All of the following parties may receive my protected health information:
 Or (Please check all appropriate boxes in which protected health information MAY be released)

- | | |
|---|---|
| <input type="checkbox"/> Health Care Providers | <input type="checkbox"/> Athletic Coaches |
| <input type="checkbox"/> Parents/Guardians | <input type="checkbox"/> Strength and Conditioning Coaches |
| <input type="checkbox"/> Hospitals and/or Medical Clinics | <input type="checkbox"/> Medical Insurance Coordinators |
| <input type="checkbox"/> Insurance Carriers | <input type="checkbox"/> Medical Supply Vendors |
| <input type="checkbox"/> Academic Counselors | <input type="checkbox"/> Athletic/University Administrators |
| <input type="checkbox"/> NCAA Injury Surveillance System | <input type="checkbox"/> Sports Information Staff |
| <input type="checkbox"/> Members of the media | <input type="checkbox"/> WVIAC |
| <input type="checkbox"/> NCAA | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Professional Sports Teams | |

I understand that my authorization/consent for the disclosure of my protected health information is a condition for my participation in intercollegiate athletics at the Glenville State College. I understand that my protected health 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 (Buckley Amendment) and may not be disclosed without either my authorization under HIPPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying, in writing, the Director of Sports Medicine, but if I do so, it will not have any effect on actions the Glenville State College or the Glenville State College Athletic Department took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent shall expire one year from the date it is signed.

Signature of Athlete _____ Date _____

Signature of Parent/Guardian (if athlete is under 18) _____ Date _____



**SPORTS MEDICINE
ASSUMPTION OF RISK - FOOTBALL**

Warning, Agreement to Obey Instructions, Release Assumption of Risk, and Agreement to Hold Harmless

I recognize that playing and practicing in football can be a dangerous activity involving **MANY RISKS OF INJURY**. I also understand that the dangers and risks of playing or practicing to play and participate in football, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health, and well-being. I understand that the dangers and risks of playing or practicing to play and participate in football may not only result in serious injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life.

The following warning appears on all football helmets to inform each user that football is a dangerous sport:

Do Not use this helmet to butt, ram or spear an opposing player. This is in violation of the football rules and can result in severe head, brain, and/or neck injury, paralysis or death to you and possible injury to your opponent. There is a risk these injuries may also occur as a result of accidental contact without intent to butt, ram or spear. No helmet can prevent all such injuries.

In consideration of the Glenville State College Athletic Association permitting me to participate for the Glenville State College football team and to engage in all activities related to the team, including but not limited to, trying out, practicing or playing and/or participating in football, I hereby assume all risks associated with participating and agree to hold Glenville State College, 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 Glenville State College football team. The terms hereof shall serve as a release and assumption of risk of my heirs, estate, executor, administrator, assignees, and for all members of my family.

Signature of Student Athlete _____

Student Athlete Name (*Please Print*) _____ Date _____

Signature of Parent/Guardian _____

Parent/Guardian Name (*Please Print*) _____ Date _____

