

**SAINT PETER'S COLLEGE SPORTS MEDICINE
ATHLETE INFORMATION
(ALL LINES NEED TO BE FILLED OUT COMPLETELY)**

Name: _____ Date: _____ Sport: _____

SS# _____ Date of Birth: _____ Eligibility Year: Fr So Jr Sr 5th

Home Address: _____

City, State, Zip Code: _____

Home Phone: _____

SPC Campus Address/Room Number: _____

Cellular/SPC Campus Phone: _____

(Please update us if you change your cell phone number)

Parent/Guardian Name(s): _____ Relationship: _____

Address: _____

City, State, Zip Code: _____

Daytime Phone: _____ Nighttime Phone: _____

In an emergency when a parent/guardian cannot be reached call _____

Relationship _____ Phone number _____

INSURANCE INFORMATION

(ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD)

Insurance Company: _____

Address: _____

City, State, Zip Code: _____

Insurance Company Phone: _____ Name of Policy Holder: _____

Policy Holder Birthday: _____ Policy Holder SS# _____

Policy # _____ Group # _____

Name of parents/guardians employer: _____

HMO PPO

MEMORANDUM

Dear Saint Peter’s College Student-Athlete:

Effective for the 2010-2011 academic year, the NCAA requires that all athletes participating in Division I sports must have sickle cell testing performed, show proof of sickle cell testing, or sign a waiver demonstrating that they understand the importance of testing for sickle cell, decline testing, and thereby release their educational institution from any liability related to declining testing.

Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells. Sickle cell trait is a common condition that afflicts more than three million Americans. Although sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait. Sickle cell trait is usually benign, but during or after exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape), which can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse, personal injury, and/or DEATH from the rapid breakdown of muscles starved of blood.

What happens if I test positive? Athletes that are sickle cell trait positive are able to participate in sports, often with no modifications whatsoever. Individuals that test positive for sickle cell trait will have a confirmatory test performed, and if positive, will be counseled on what can be done to avoid complications.

Sickle cell testing could be performed by a physician of your choice prior to the school year and your athletic physical. In many states, testing is done at birth, so check with your pediatrician and/or hospital to see if you were previously tested. If testing is done prior to the school year or was performed at birth, you must obtain at your expense a copy of your test results and provide it to Saint Peter’s College on or before the time of your athletic physical. Please note that Saint Peter’s College Sports Medicine Department will help arrange the opportunity for sickle cell testing, but at the student athletes’ expense. Please sign below, and if choosing to waive testing, this confirms that you understand the importance of testing and that the NCAA required that it be performed, have declined, and release Saint Peter’s College from any and all liability related to your waiver of such testing. If you are under 18 years old, a parent or guardian must sign and write their name.

Name of Student Athlete: _____ Sport: _____

Signature _____ Class: _____

Signature/Name of parent or guardian (if student-athlete is < 18 years old)

_____ Date _____

Agreement to Sickle Cell Testing and Production of Testing Result

I agree to submit to and pay for sickle cell testing to be set up by Saint Peter’s College Sports Medicine Department and agree to a release of the test results to Saint Peter’s College on or before the time of my athletic physical.

I agree to schedule, submit to and pay for sickle cell testing on my own accord and with a physician of my choice prior to the school year and my athletic physical. I agree to obtain a copy of the test results at my expense and provide it to Saint Peter’s College on or before the time of my athletic physical.

I was tested for sickle cell trait at the time of my birth. I agree to obtain a copy of the test results at my expense and provide it to Saint Peter’s College on or before the time of my athletic physical.

Signature _____ Date _____

Signature/Name of parent or guardian (if student-athlete is < 18 years old)

_____ Date _____

Waiver of Sickle Cell Testing

I do not wish to have sickle cell testing performed, understanding the NCAA requirement and the information provided by Saint Peter’s College in the attached memorandum. I voluntarily and knowingly release Saint Peter’s College from any and all liability related to this waiver of sickle cell testing.

Signature _____ Date _____

Signature/Name of parent or guardian (if SA < 18 yrs old)

_____ Date _____

**SAINT PETER'S COLLEGE SPORTS MEDICINE
ANNUAL HEALTH QUESTIONNAIRE**

Name: _____ SS# _____

Sport: _____ Date of Birth: _____

Family Physician: _____ Physician Phone: _____

Sex: M or F Eligibility Year: Fr So Jr Sr 5th

If you answer yes to any questions, please explain in the space provided below.

	YES	NO
Are there any confidential medical concerns you would like to discuss with the team physician?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies (medications, bees, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts or glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you tire more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped beats?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family died of heart problems or a sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any skin problems (itching, moles, breaking out)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been knocked out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stinger or burner?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had arm/leg paralysis, numbness or tingling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had heat cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use special pads or braces for activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use, or have you used cocaine, anabolic steroids, or other stimulants/supplements?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever injured (sprained, dislocated, fractured, etc.): *check if yes*

Foot <input type="checkbox"/>	Hip <input type="checkbox"/>	Neck <input type="checkbox"/>	Elbow <input type="checkbox"/>	Hand <input type="checkbox"/>
Ankle <input type="checkbox"/>	Thigh <input type="checkbox"/>	Chest <input type="checkbox"/>	Arm <input type="checkbox"/>	Wrist <input type="checkbox"/>
Shin/calf <input type="checkbox"/>	Knee <input type="checkbox"/>	Back <input type="checkbox"/>	Shoulder <input type="checkbox"/>	Forearm <input type="checkbox"/>

Have you ever had: *check if yes*

Mononucleosis <input type="checkbox"/>	Stomach ulcer <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Enlarged Spleen <input type="checkbox"/>
Hepatitis <input type="checkbox"/>	Asthma <input type="checkbox"/>	Eye injuries <input type="checkbox"/>	Headaches (frequent) <input type="checkbox"/>
Heart Infection <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Arthritis <input type="checkbox"/>	

Are you missing or do you have an abnormality of any of the following: *check if yes*

Eye <input type="checkbox"/>	Ear <input type="checkbox"/>	Kidney <input type="checkbox"/>	Testicle <input type="checkbox"/>	Spleen <input type="checkbox"/>
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When was your last tetanus shot? Date: _____

Please explain any YES answers

Athlete's Signature: _____ Date: _____

**SAINT PETER'S COLLEGE SPORTS MEDICINE
INCOMING ATHLETE INITIAL HEALTH QUESTIONNAIRE**

Name: _____ SS# _____

Sport: _____ Date of Birth: _____

Family Physician: _____ Physician Phone: _____

Sex: M or F Eligibility Year: Fr So Jr Sr 5th

SPECIFIC MEDICAL QUESTIONS

1. Have you been under the care of a physician, at any time, in the past **THREE** years?

If **YES**, explain: _____

2. Have you ever had any **SURGERY(S)** (including pin, plate, screw, fracture)?

Date: _____ Injury: _____

3. Have you ever had any **MAJOR** injuries resulting from sports participation?

If **YES**, explain: _____

4. Have you ever had any **MAJOR** injuries not related to sports activity?

If **YES**, explain: _____

5. Have you ever had an illness to any of the following organs? If **YES**, explain:

Eyes: _____

Ears: _____

Heart: _____

Lungs: _____

Kidneys: _____

Reproductive Organs: _____

Liver: _____

Other: _____

6. Immunizations

Tetanus: _____

Date of last booster: _____

DISEASES & ILLNESSES (Have you ever suffered from or been told by a physician or parent that you have had...)

- | | | | | | |
|------------------|--------------------------|--------------|--------------------------|-------------------------|--------------------------|
| Chickenpox | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Marfans Syndrome | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | Measles | <input type="checkbox"/> |
| Mononucleosis | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | Rheumatic Heart Disease | <input type="checkbox"/> |
| Scarlet Fever | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | | |

ALLERGIES/MEDICATIONS

- Do you have...

Asthma	<input type="checkbox"/>	If so, what type of medication/inhaler? _____
Hay Fever	<input type="checkbox"/>	
Food Allergies	<input type="checkbox"/>	If so, what? _____
Medication Allergies	<input type="checkbox"/>	If so, what? _____
Bee Sting Allergies	<input type="checkbox"/>	If so, do you carry an EPI-PEN? _____
Other	<input type="checkbox"/>	_____
- Do you wear a medical alert tag? Yes No
If YES, explain: _____
- Have you ever been tested for Sickle Cell Anemia Trait? Yes No
If YES, give date: _____ and explain results: _____
- Are you presently on any medications? Yes No
If YES, list, state dosage, and explain: _____

HEAD & NECK

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever had a head/neck injury that has interrupted your athletic participation? If YES, how long were you inactive? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, are they severe? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you become dizzy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been knocked unconscious/suffered from a concussion in the past three years? If YES, give date: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been knocked unconscious more than once?
If YES, how often? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been hospitalized for a head injury?
If YES, when? _____ and how long? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever suffered from a pinched nerve of the arm, a Burner/Stinger, or whiplash? If YES, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been hospitalized for a neck injury?
If YES, when? _____ and how long? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you suffer from pain, stiffness, or limited movement of the neck?
If **YES**, describe: _____
9. Have you ever been **X-RAYED** for a head or neck injury?

DENTAL

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you wear any dental appliances (braces, plates, caps, etc)?
If YES , describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. When were you last examined by a Dentist (regular dental care)?
Date: _____ | | |

EYES

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you wear contacts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you wear either of the above during sport participation?
If the answers above are YES , name the prescribing consultant? | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Prescriber

Address (include city & state)

Phone (include area code)

NOSE

- | | YES | NO |
|---------------------------------------|--------------------------|--------------------------|
| 1. Have you ever fractures your nose? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you suffer from... | | |
| Sinus Problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Nose Bleeds? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nasal Blockage? | <input type="checkbox"/> | <input type="checkbox"/> |
| Deviated Septum? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Breathing? | <input type="checkbox"/> | <input type="checkbox"/> |

HEART

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has it been more than 2 years since you had a physical exam that
Include a blood pressure reading and listening to the heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have your parents or has a physician ever told you that you have a
heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you experienced chest pains, fainting, or racing heartbeat in the
Past 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has anyone in your family died suddenly under age of 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a physician diagnosed anyone in your family with an abnormally
thickened heart or Marfan Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use, or have you used cocaine, anabolic steroids, or other
Stimulants/supplements? If YES , explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |

7. Have you ever had any testing done on your heart?
8. Do you have chest pains during or after athletic activity?

SKELETAL STRUCTURE

Shoulder

- | | CIRCLE ONE | YES | NO |
|---|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from a shoulder injury that has incapacitated you for more than two weeks during the past three years? If YES , describe _____ | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever suffered from: | CIRCLE ONE | YES | NO |
| Separated Shoulder | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Dislocated Shoulder | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Burner or Stinger | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | |

Elbow

- | | CIRCLE ONE | YES | NO |
|---------------------------------|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from: | | | |
| Sprains | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperextensions | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Dislocations | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | right/left | <input type="checkbox"/> | <input type="checkbox"/> |

Wrist & Hand

- | | CIRCLE ONE | YES | NO |
|---------------------------------|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from: | | | |
| Fractures | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Sprains | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Dislocations | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | |

Hip

- | | CIRCLE ONE | YES | NO |
|---------------------------------|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from: | | | |
| A hip injury | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Bursitis or tendonitis | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Groin strain | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | |

Knee

- | | CIRCLE ONE | YES | NO |
|---|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from a knee injury? If YES , when? _____ | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Were you told you had: | | | |
| A ligament injury | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| A meniscus (cartilage) injury | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Osgood-Schlatter's Disease | right/left | <input type="checkbox"/> | <input type="checkbox"/> |

Back

- | | | YES | NO |
|---|--|--------------------------|--------------------------|
| 1. Have you ever suffered from a back injury?
If YES , did you see a physician? (explain) _____
Was your back x-rayed? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you experience frequent back pain? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever suffered from an injury to the vertebral column? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been told you have Scoliosis? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there a history of back pain in your family? | | <input type="checkbox"/> | <input type="checkbox"/> |

Lower Leg (shin)

- | | CIRCLE ONE | YES | NO |
|--|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from Shin Splints? | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had a Stress Fracture? | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever broken your leg? | right/left | <input type="checkbox"/> | <input type="checkbox"/> |

Ankle

- | | CIRCLE ONE | YES | NO |
|---|-------------------|--------------------------|--------------------------|
| 1. Have you sprained an ankle in the past 3 years
which incapacitated you for more than two weeks? | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had an injury involving the Achilles
Tendon? | right/left | <input type="checkbox"/> | <input type="checkbox"/> |

Foot

- | | CIRCLE ONE | YES | NO |
|---------------------------------|-------------------|--------------------------|--------------------------|
| 1. Have you ever suffered from: | | | |
| Fractures | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Sprains | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Arch Problems | right/left | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | | |

Please list and explain any problem which was not included in the questions above:

Athlete's Signature: _____ Date: _____

**SAINT PETER'S COLLEGE SPORTS MEDICINE
AUTHORIZATION/CONSENT FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I, _____, (print student athlete's name) hereby authorize the disclosure and/or use of my protected health information, and any related information regarding any injury or illness that arises during my training for and participation in intercollegiate athletics at Saint Peter's College. This medical information will be used for purposes including, but not limited to:

- By the physicians, athletic trainers, sports medicine staff and other health care personnel representing Saint Peter's College athletics to discuss caring for my injury.
- To disclose my protected health information to someone involved in my care such as parents/guardians, spouse, and coaching staff.
- Notification to sports information staff, members of the media, athletic and/or academic university administrators, and chaplains and/or clergy members.
- My medical treatment, including provision, coordination, or management of health-care and related services to me by one or more health-care providers. Such providers may include hospitals, medical clinics, and laboratories.
- Payment activities related to my injury or illness may be discussed with medical insurance coordinators and insurance carriers. Payment information may be disclosed to an individual assisting in the payment for my care such as parents/guardians.
- Injury tracking according to the NCAA Injury Surveillance System.
- When required by federal, state, or local law, or for judicial and administrative proceedings.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Saint Peter's College. I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Education 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 once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA 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. However, if I do, it will not have an effect on actions Saint Peter's College or Saint Peter's College Athletics took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires six years from the date it is signed.

Name of Student-Athlete

Signature of Student-Athlete

Date

Social Security Number

Date of Birth

Sport

Name of Parent/Guardian

Signature of Parent/Guardian

Date

**SAINT PETER'S COLLEGE SPORTS MEDICINE
INFORMED AND MEDICAL CONSENT**

*(Read, sign and return this consent form to the Sports Medicine Department.
If you are under 18 years of age, your parent/guardian must also sign)*

I, _____, (print athlete's name), am aware that trying out, practicing, or playing in any sport can be a dangerous activity involving many risks or injury. I understand that the dangers and risks include, but are not limited to, death, serious head, neck, and spinal injuries, paralysis, injuries or impairment to the musculoskeletal system, or other aspects of the body, general health and well being.

Because of the dangers of participating in sports, I recognize the importance of following the instructions of the athletic department personal regarding playing techniques, training, rules of the sport/team equipment, and to obey such rules. I also acknowledge that some sports are classified as violent sports involving an even greater risk of injury than other sports. I further realize that I am expected to report all injuries/illnesses I may have sustained during periods of official, organized athletic participation (including all regularly scheduled practices and competitions) and throughout the calendar year (regardless of how they occurred), to an athletic trainer, team physician, or coach.

I hereby authorize the Saint Peter's College Athletic Trainers, and their staff, who are under the direction and guidance of the Saint Peter's College Team Physicians, to render to myself (son/daughter) any preventive measures for injuries, first aid, treatment, rehabilitation, or emergency treatment that they deem reasonable and necessary to the health and well being of the student athlete. This includes all practices, competitions, and travel.

I also grant permission for hospitalization at an accredited hospital when necessary for executing such.

I also grant permission to the Saint Peter's College Sports Medicine Department (athletic training staff, affiliated physicians and administrative assistants, and school nurse) full disclosure of all my medical information. I also grant permission to the respective coaching staff, AGIA Insurance Company, athletic administrators, and guardians full disclosure of my medical information.

By signing this form, I understand that this authorization is valid for one year from the date signed and must be re-instated the following year.

***** PLEASE NOTE: IN ALL INJURY SITUATIONS OCCURING TO A SAINT PETER'S COLLEGE ATHLETE, THE FINAL DECISION ON PLAYING STATUS WILL BE DETERMINED BY A MEMBER OF THE SAINT PETER'S COLLEGE SPORTS MEDICINE STAFF*****

Athlete's Signature: _____ Date: _____ Sport: _____

Parent/Guardian Signature: _____ Athlete's SS# _____

**SAINT PETER'S COLLEGE SPORTS MEDICINE
INITIAL PRE-PARTICIPATION EVALUATION**

Name: _____ Sport: _____

This section is to be filled out by sports medicine staff. Please do not write below this line.

Height: _____ Weight: _____

Blood Pressure: _____ Heart Rate: _____

	Normal	Findings	Follow-Up	Initials
HEENT				
Heart				
Lungs				
Abdomen				
Upper Extremity				
Lower Extremity				
Neck				
Back				
Other				

Recommendations

Cleared for all sports Requires follow-up before clearance

Restricted to: Limited contact/impact Non-contact strenuous
Moderately strenuous Non-strenuous

Comments: _____

Physician Name: _____ Signature: _____ Date: _____

Saint Peter's College Athletic Injury Insurance Information

- Saint Peter's College carries a rider insurance plan on all its' student athletes. The plan acts as an addition to any insurance already held by the athlete or parent/guardian. The athlete is required to have insurance prior to participation. If a policy is not presently held, then the athlete or parent/guardian may purchase one through the college, cost of which is included in tuition.

- If a policy is already held, the athlete must supply a copy of the front and back of their insurance card and all pertinent insurance information at the time of physicals. ****Note:** Once a student turns 18 years old, most insurance companies will require a copy of a schedule and/or letter from the college notifying them that the athlete is a full time student. Actual policies differ, so contact your insurance provider. If your insurance coverage changes during the school year, you must provide the Sports Medicine Department with a copy of your new card.

- In all cases, athletes that are injured while participating in Saint Peter's College athletics will receive coverage by our insurance plan. Authorization for medical services required as a result of these injuries must be obtained in advance of such services. The Athletics Department will not assume any liability in covering medical service expenses without prior approval by the Sports Medicine Department.

- The Athletics' injury insurance policy states **"...an explanation of benefits and itemized bills must be provided to the insurance company prior to payment of bills."** In other words, the Saint Peter's College insurance will require notification from the athlete's primary insurance of benefits paid and a bill stipulating all charges with a description of those charges from the care provider. It is the **athlete/parent/guardian's responsibility** to obtain these forms and forward them to the Saint Peter's College Athletic Trainer immediately upon receipt. Failure to do so will result in delay of payment and penalties issued by the provider.

- Any charges associated with a second opinion obtained by the athlete/parent/guardian from a physician outside of the Saint Peter's College Sports Medicine Department is not covered under the Athletic Injury Insurance. ****Charges are the sole responsibility of the athlete/parent/guardian.**

- Saint Peter's College Athletic Injury Insurance Provider:

BMI Benefits, LLC
P.O. Box 511
Matawan, NJ 07747
1-800-445-3126