

Must Be Filled Out By All Incoming Students Who Plan On Participating on a Varsity or JV Athletic Team

SPORTS MEDICINE MEDICAL HISTORY AND INFORMATION FORM

PLEASE RETURN BY AUGUST 1st

January Admits by December 20th

(PLEASE PRINT)

Sports Medicine, Department of Athletics, Elmira College, One Park Place, Elmira, NY 14901

Telephone 607-735-1752; Fax 607-735-1198 : Website: www.elmira.edu/athletics/sports_medicine

Athlete's Last Name	First Name	Middle Name	Class Year	
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Address	City	State	Country (If not U.S.A.)	Zip + 4
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College Dormitory	Room #	Cell Phone# / College Phone #	Email Address	
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Social Security # XXX / XX / _____	Sex: _____ Male _____ Female	Age _____	Date of Birth _____ / _____ / _____ Mon Day Year	
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Sports Participating In:

Father's Name	Home Phone	Father's Employer	Work Phone	
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Mother's Name	Home Phone	Mother's Employer	Work Phone	
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Emergency Contact Name	Address	Relationship	Home Phone	Work Phone
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INSURANCE INFORMATION

All students are required to have some form of health insurance. If you do not have health insurance you will be enrolled in the Elmira College Accident and Health Insurance Plan. If you are from a foreign country you should also enroll in this policy. The following is my current insurance information. If the insurance information should change, I will send a copy of my most recent card.

Name of Insurance Co. _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Subscriber's Name on Policy _____ ID# _____

Plan Name _____ Policy # _____ Group# _____ Other _____

Which best describes your insurance? Traditional (80/20) _____ HMO _____ PPO _____ Other _____

Is a referral for a specialist required? _____ Yes _____ No If yes, who needs to be called _____

Name of Primary Care Physician _____ Phone (_____) _____

Address _____ City _____ State _____ Zip Code _____

Please send a copy of your insurance card front and back

Please complete this form - Please Print

FAMILY MEDICAL HISTORY

Adopted: Yes ___ No ___

	Age	State of Health	Occupation	Age of Death	Cause of Death		Age	State of Health	Occupation	Age of Death	Cause of Death
Father						Brother					
Mother						Sister					

Has a close relative(s) ever been diagnosed with one of the following?

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Heart Disease			
Kidney Disease				Hypertrophic Cardiomyopathy			
Arthritis				Dilated Cardiomyopathy			
Cancer				Long QT Syndrome			
Epilepsy/Convulsions				Marfan Syndrome			
High Blood Pressure				Clinical Important Arrhythmias			

ATHLETE'S MEDICAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below.

HAVE YOU HAD?	YES	NO		YES	NO		YES	NO	ALLERGY TO:	YES	NO
ADHD/ADD			Frequent Depression			Nervousness			Medications(specify)		
Anemia			Gallbladder Trouble			Numbness			Insect Bites		
Arthritis			Gum/Tooth Trouble			Palpitations (heart)			Foods (specify)		
Asthma			Hay Fever			Pneumonia			Other (specify)		
Bleeding (Trait)			Head Injury			Rheumatic Fever					
Bowel Cramps			Headaches(recurrent)			Scarlet Fever			SURGERY:		
Chicken Pox			Heart Murmur			Seizures			Appendectomy		
Chronic Cough			Heat Exhaustion			Shortness of Breath			Tonsillectomy		
Diabetes			Heat Stroke			Sickle Cell Anemia			Hernia Repair		
Diarrhea (recurrent)			Hepatitis			Sinusitis			Other (describe)		
Dizziness			Hernia			Skin Disorder					
Ear Infections			High Blood Pressure			Stomach Ulcer			FEMALE ONLY:		
Eating Disorder			Insomnia			Stomach Trouble			Menstrual Problems		
Epilepsy			Intestinal Problems			Throat Infections			Irregular Periods		
Eye Trouble			Kidney Problems			Thyroid Disorder			Severe Cramps		
Fainting Spells			Malaria			Tuberculosis					
Frequent Anxiety			Mononucleosis			Tumor/Cancer					

Explain any yes answers from above: _____

Do you have a loss of or serious impairment of one of the following paired organs? If yes, please explain.
 Kidney Yes ___ No ___ _____
 Eye Yes ___ No ___ _____
 Lung Yes ___ No ___ _____
 Ovaries Yes ___ No ___ _____
 (female)
 Testicles Yes ___ No ___ _____
 (male)

Please list any current medications: prescription, over the counter, & herbal medications Including birth control pills.

Do you wear contacts: Yes ___ No ___ glasses: Yes ___ No ___ Do you have false teeth or a bridge: Yes ___ No ___

Anything else we should know about that was not mentioned? _____

CARDIAC QUESTIONS:

- Have you ever passed out do to exertion? Yes___ No___
- Have you ever been dizzy do to exertion? Yes___ No___
- Have you ever had chest pain/discomfort do to exertion? Yes___ No___
- Do you get more tired than your friends do during exercise? Yes___ No___
- Have you ever had a racing of your heart or skipped heartbeats? Yes___ No___
- Have you ever had unexplained shortness of breath do to exertion? Yes___ No___
- Have you ever had High Blood Pressure? Yes___ No___
- Have you ever had High Cholesterol? Yes___ No___
- Have you ever been told that you have a heart murmur? Yes___ No___
- Have you ever had an electrocardiogram, Echocardiogram or Cardiovascular Stress Test ? Yes___ No___
- Has a family member or close relative died of heart problems or of sudden death before age 50? Yes___ No___
- Has a physician ever denied or restricted your participation in sports for any heart problems? Yes___ No___

Explain "Yes" answers here: _____

PAST AND PRESENT INJURIES:

Have you ever injured (sprain, strain, dislocation, subluxation, contusion, separation, fracture, herniation, etc.) or consulted a physician about any of the following body parts?

BODY PART	YES	NO	DATE(S)	DETAILS
Head				
Neck				
Chest Wall (rib cage)				
Back				
Shoulder, Upper Arm				
Elbow				
Wrist, Lower Arm				
Hand, Fingers				
Pelvis, Hip				
Thigh				
Knee				
Lower Leg				
Ankle				
Foot, Toes				
Spleen, Kidney, or Liver				
Other				

	YES	NO	DATE(S)	DETAILS
Any X-Rays/MRI/ CT Scans?				
Any Hospitalizations or Surgery?				
Casts or Splints?				
Injections?				
Orthotics?				
Have you been advised to have surgery but declined?				
Has your physical activity been restricted in the past two years?				
In past five years have you experienced a concussion, been knocked unconscious, loss of memory				

Any additional pertinent information: _____

If you had surgery or are under the care of a physician within the past year, you must have a note from your physician releasing you to participate in athletics. If there are any restrictions, they must be noted.

ELMIRA COLLEGE ATHLETICS PARTICIPATION STATEMENT:

A. Participation Agreement

I certify that the answers to the questions above are correct and true to the best of my knowledge and understand that giving false information could disqualify me from competing in Intercollegiate Athletics at Elmira College. I also understand that having passed the physical examination (ELMIRA COLLEGE HEALTH FORM) and the preseason physical screening does not necessarily mean that I am physically qualified to participate in athletics, but only that the evaluator did not find a medical reason for disqualification from participation. In the event that I become injured or ill, I understand that I must refrain from practice or play until cleared by the appropriate clinical practitioners (College/Team Physicians) and/or their designated representative(s) (Certified Athletic Trainer, College Nurse or referred specialist) whether receiving medical treatments or not.

B. Assumption of Risk and Release

In consideration and as a condition of Elmira College’s permitting my participation in activities associated with an athletic team include, but are not limited to training, trying out, practicing, playing and traveling, I freely acknowledge that I am aware of and accept the risks associated with such participation. I also acknowledge that my participation is wholly voluntary and is not required in any way by Elmira College.

I fully realize and understand the dangers of participating in such activities and fully assume the risks associated with such participation, which may include, but not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, or result in death, and which may be caused in whole or in part by numerous factors, including my medical or physical condition, the actions or inactions of other athletes, the conditions of premises, and the negligence of the entity or released hereby. I waive, release and discharge for myself, my heirs, executors, administrators, legal representatives, assignees and successors in interest any and all rights or claims for injuries or losses of any description that I may have or which may hereafter accrue to me against Elmira College, its Trustees, employees, or agents, in connection with my participation in activities associated with an Elmira College athletic team.

C. Medical Consent to Treatment

I grant permission to physicians, athletic trainers, and/or medical practitioners or professionals associated, assisting, or employed in connection with Elmira College athletic programs or student-athletes, to render any preventative, emergency, surgical or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being, and to arrange for my hospitalization where reasonable and necessary, in circumstances connected with my participation in activities associated with an Elmira College athletic team.

This consent is not intended to, and does not, create a duty on the part of physicians, athletic trainers, and/or other medical practitioners or professionals associated, assisting, or employed in connection with Elmira College athletic programs or student-athletes, to render or arrange for such treatment or care.

D. Signature Approval

I have read, understand and approve Parts A, B and C of this Participation Statement. A photocopy of this Participation Statement will be deemed to have the same force and effect as the original.

Student Signature Age Date

(Only if Under 18)
Parent’s Name: _____

Parent’s Address: _____
Street # City State Zip Code

Telephone #: _____ Cell#: _____ Fax #: _____

Parent’s Signature (for students under age 18): _____

For Office Use Only:

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Date of Review: _____ Reviewer Initials: _____

Updated 4-4-11

