SAN DIEGO STATE
ATHLETIC TRAINING

Medical Questionnaire for Returning Athletes

Name: _____ Red ID # _____ Cell Phone:_____

Date: _____ Year at SDSU: 2nd, 3rd, 4th, 5th, 6th Sport: _____

Since your last physical or returning medical questionnaire:

1. Have you experienced 1) chest pain/discomfort with exertion 2) fainting/near fainting or 3) excessive, unexpected or unexplained shortness of breath or fatigue associated with exercise? Yes_____ No_____
   If yes, please explain:_____
   _____
2. Have you been diagnosed with a heart condition or murmur or increased systemic blood pressure? Yes____ No____
   If yes, please explain:_____
   _____
3. Have you become aware of any premature deaths (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) younger than 50 yrs old or specific knowledge of the occurrence of certain conditions (e.g. hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan Syndrome, or clinically important arrhythmias)? Yes____ No____ If yes, please explain:_____
   _____
4. Have you had any surgery, developed a new drug allergy or new illness requiring the care of a physician since your last physical exam or questionnaire? Yes____ No____ If yes, please explain:_____
   _____
5. Have you been injured OR has any physician recommended you limit your sports participation since your season ended or during the summer, including Sickle Cell Trait diagnosis? Yes____ No____. If yes, please explain:_____
   _____
   _____
6. Please list any medications or nutritional supplements you are currently taking:_____
   _____
7. Do you feel you need to see a physician? Yes____ No____. If yes, please explain:_____
   _____
   _____
8. Do you currently have any symptoms of injury or illness? Yes ___ No ____ If yes, please explain:_____
   _____
   _____
9. Do you take any medications for ADHD and/or anabolic steroids for any reason? Yes___ No___
   If yes, please explain:_____
10. In the past year have you been diagnosed with an eating disorder or do you have any concerns regarding eating habits that you would like to discuss with a physician? Yes____ No____
    If yes, please explain:_____

Athlete name: _____Athlete Signature: _____Date:_____

Office Use Only:

Ht:____ Wt:____ Wt change in last year:____ BP:____/____ Pulse:____ Temp:____° SCT:_____

□ Reviewed/No action □ Action Required Initials/Date:____/_____

SAN DIEGO STATE
ATHLETIC TRAINING

CONSENT TO MEDICAL TREATMENT FOR ADULTS (18 years & older)

Student-Athlete's Name (printed) _____ Date of Birth _____ Red ID # _____

To be read and signed by the Adult Student-Athlete:
I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide diagnostic tests or treatment that is deemed advisable, and is to be provided by medical practitioners of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff and health care professionals to proceed with medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance or any specific diagnosis or treatment that may be required.

Signature _____ Date _____

PARENTAL CONSENT TO MEDICAL TREATMENT FOR A MINOR

Please choose an option below and sign for Minor Student-Athletes:

☐ I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide my minor (less than 18 years or age) son or daughter diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff and health care professionals to proceed with medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance or any specific diagnosis or treatment that may be required.

Parent/Guardian Name (printed) _____ Signature of Parent/Guardian _____

☐ I may choose a person employed at San Diego State University to serve as a "designated agent" to consent for treatment of my minor son or daughter. This person can then sign any consent forms that may be necessary for diagnosis or treatment of my child, whether at SDSU Student Health Services or another medical facility. (This designated agent can be any adult into whose care the minor has been entrusted. You may identify the authorized adult by titles and employer [for example, Director or Patient Services & Medical Records of SDSU Student Health Services] rather than by name.)

The undersigned parent/guardian of _____ a minor authorizes _____ as an agent for the undersigned, to consent to any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or any outside physicians or facilities as needed. This authorization is given in advance or any specific diagnosis or treatment that may be required.

Parent/Guardian Name (printed) _____ Signature of Parent/Guardian _____

FOR STUDENT HEALTH SERVICES USE ONLY

Telephone consent to treat the above named student-athlete was given by:

Name (printed) _____ Relationship to Patient _____ Phone Number _____

Director of Pt. Services Medical Records or Designee Signature _____ Witness Signature _____

SAN DIEGO STATE
ATHLETIC TRAINING

Attention Deficit Hyperactivity Disorder Information Form

Please check the appropriate box and sign:

○ I have never been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). Please print and sign your name below and return this form to us. **You do not need to read or complete the rest of this form.**

○ I have been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). **Please read and complete the NCAA medical exemption documentation form (Page 6 of this packet.)** This needs to be done yearly – last year's records are not enough.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

DO NOT COMPLETE THE FOLLOWING FORM IF YOU HAVE NEVER BEEN DIAGNOSED OR TREATED FOR ADHD

SAN DIEGO STATE
ATHLETIC TRAINING

NCAA Medical Exception Documentation Form
To Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
And Treatment with Banned Stimulant Medication

- Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
- Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (See Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting)

To be completed by SDSU Athletic Medicine Staff

Institution Name: San Diego State University

Institutional Representative Submitting Form:

Name:_____

Title:_____

Email:_____

Phone:_____

Student-Athlete Name:_____

Student-Athlete DOB:_____

To Be Completed by Student-Athlete's Medical Provider

Current Treating Physician (print name):_____Specialty:_____

Office Address:_____

Physician's Signature:_____Date:_____

Check off that documentation representing each of the items below is attached to this report

- o Diagnosis
- o Medication(s) and Dosage
- o Blood Pressure and pulse readings and comments.
- o Note that alternative non-banned medications have been considered, and comments.
- o Follow up orders.
- o Date of clinical evaluation:_____

Attach a written report summary of a comprehensive clinical evaluation. Please note this includes the original clinical notes of diagnostic evaluation

The evaluation should include individual and family history. Address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation such as completed ADHD Rating Scale(s) (e.g.) Connors, ASRS, CAARS) scores. The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or part, in reliance upon the accuracy or veracity of the information provided hereunder.

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Background:
This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

Participating in varsity intercollegiate sports by its nature puts an athlete in the public eye. Television, internet and print media will be following and reporting on the team and sometimes on individual athletes. They are often interested in illnesses or injuries that will result in missed game time or limit performance.

As a varsity athlete you enter into an agreement with the Athletic Department with unique rights and responsibilities as described in the Student Athlete Handbook. Sharing medical information about your injuries or illnesses with coaches and other Athletic Department administrators is helpful (such as when a coach is planning a roster for an upcoming competition) and sometimes necessary (such as when applying for a "medical redshirt"). Personal health information must be sent to the Mountain West Conference when applying for a medical redshirt.

Often other athletes are within hearing distance while you are being treated in the athletic training room or on the field for your athletic injuries and illnesses.

Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:
Athletic injuries and illnesses: This may refer to any injury or illness that impacts your ability to play and/or perform for San Diego State University's varsity intercollegiate sports. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities. If a professional team requests information about your *athletic injuries and illnesses* we will release such information to the team ONLY if you give us specific written consent.

Athletic Medicine Staff: This refers to all persons working under the direction of the Medical Director of Athletic Medicine and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, athletic training students, and administrative assistant for medical billing.

Consent:

I, _____, acknowledge that I have read and understand the
Name of Student Athlete

Background and Definitions above.

SAN DIEGO STATE
ATHLETIC TRAINING

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

I, _____, hereby authorize San Diego State University and its
Name of Student Athlete
athletic medicine staff (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my *athletic injuries and illnesses* to the following groups/persons:

List A: Groups/Persons

- SDSU Athletic Department Administrators including but not limited to coaches, compliance officer, and Director of Media Relations
- Media outlets and their employees or agents (such as newspapers and television)
- Parents or guardians
- Mountain West Conference and its employees or agents
- NCAA Injury Surveillance System (ISS)

This information may be sent to one or more of the above groups/persons by unsecured electronic means such as e-mail, fax, or text messages.

I understand that the information released may have different purposes and is dependent on to whom the information is released. These purposes may include but are not limited to:

List B: Purposes

- Athletic Department operations
- Answering media questions
- Explaining the typical course of an injury or illness to another athlete
- Informing concerned parents or guardians
- Asking the MWC to grant a medical redshirt (hardship) or exemption
- Allowing the NCAA to track injury statistics

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy (FERPA) 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 my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics. I also understand that the media outlets, Mountain West Conference, parents and guardians, and other varsity athletes are not covered by the Buckley Amendment or HIPAA and that this policy does not apply to their use or disclosure of my *athletic injury or illness* information.

The authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending a written notification to the director of athletic medicine at SDSU at the address below. I understand that the revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

AWARENESS OF RISK STATEMENT

In an effort to recognize the responsibility for sports safety of administrators, coaches, physicians, athletic trainers and student athletes, I, the undersigned, am aware that there is a certain risk of injury involved in my participation in Intercollegiate Athletics at San Diego State University. I understand that this includes the risk of spinal cord or brain injury that may result in paralysis and the possibility of permanent injury. I accept the responsibility for reporting my injuries and illnesses to San Diego State University's medical staff, including signs and symptoms of concussions.

I have been informed that the San Diego State University Intercollegiate Athletics insurance has provisions which require that I report current and previous injuries to the athletic trainer immediately.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

SAN DIEGO STATE
ATHLETIC TRAINING

ALLERGIES _____

Insurance Information Form

****ATHLETE'S INFORMATION****

NAME (Last) _____ (First)_____ (MI)_____ SPORT _____

SOC SEC # _____ RED ID #_____ CELLPHONE _____ DOB _____

EMAIL ADDRESS_____

PERMANENT ADDRESS (Street)_____(City)_____(State)____(Zip)_____

LOCAL ADDRESS (Street)_____(City)_____(State)____(Zip)_____

****PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION****

NAME (Last) _____ (First) _____ RELATION _____ PHONE _____

****INSURANCE INFORMATION****

Attach copy of insurance card

PRIMARY Insurance Company _____

Policy Holder Name _____

Policy Holder DOB _____

Policy Holder SS# _____

Policy Holder Employee and Employer's address:

_____

_____

Group # _____

Policy # _____

Phone # _____ Fax #_____

Billing Address (Street, City, State, Zip Code)

_____

HMO (O Y O N) PPO (O Y O N) Military (O Y O N)

Insurance covers prescriptions (O Y O N)

Attach copy of insurance card

DENTAL Insurance Company _____

Policy Holder Name _____

Policy Holder DOB _____

Policy Holder SS# _____

Policy Holder Employee and Employer's address:

_____

_____

Group # _____

Policy # _____

Phone # _____ Fax # _____

Billing Address (Street, City, State, Zip Code)

_____

HMO (O Y O N) PPO (O Y O N) Military (O Y O N)

Insurance covers prescriptions (O Y O N)

Primary Care Physician's Name (if applicable)_____Phone_____

****NOTE TO PARENT/GUARDIAN AND ATHLETE****

I understand this insurance information must be COMPLETELY and ACCURATELY provided and on file with the Athletic Training Department before me or my son/daughter will be allowed to participate in athletics.

Athlete name:_____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____

SAN DIEGO STATE
ATHLETIC TRAINING

AZTEC ATHLETIC MEDICINE
HEALTH INSURANCE RELEASE AUTHORIZATION

TO: HEALTH INSURANCE CARRIER _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ PHONE _____ FAX _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE INFORMATION REGARDING MY HEALTH INSURANCE INFORMATION AS LISTED BELOW TO:

Aztec Athletic Medicine - San Diego State
5302 55th Street
San Diego, CA 92182-4313

Telephone (619) 594-5551 Fax (619) 594-7654

THIS RELEASE COVERS ALL HEALTH INSURANCE INFORMATION INCLUDING BUT NOT LIMITED TO:

PRIMARY CARE PROVIDER; ELIGIBILITY & BENEFITS; DEDUCTIBLE LEVEL AND AMOUNT MET; COPAYS; EXPLANATION OF BENEFITS (EOB)

THIS AUTHORIZATION WILL REMAIN VALID UNTIL REVOKED BY ME IN WRITING. A COPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

1. POLICY HOLDER NAME _____ SS#____-____-_____

SIGNATURE OF POLICY HOLDER _____ DATE _____

2. PATIENT NAME _____ SS#____-____-_____

SIGNATURE OF PATIENT _____ DATE _____

Intercollegiate Athletic Accident Policy

SDSU, like most NCAA Athletic Departments, provides an athletic insurance policy for its student-athletes. This is the *SDSU Intercollegiate Athletic Accident Policy.* This policy will cover medical costs related to injuries that occur while participating in supervised practice or competition for SDSU. Our athletic accident policy is a secondary insurance. Thus, if a student-athlete is covered by a personal, family or private insurance policy it will be used first. Medical expenses will not be paid by our secondary insurance policy until any existing personal medical insurance is exhausted.

In order for an injury to qualify for coverage under the SDSU athletic accident insurance policy, the student-athlete must have their medical care coordinated and authorized by our Athletic Medicine staff of Athletic Trainers and Team Physicians. The Athletic Medicine staff will coordinate all necessary care for the athletically related injuries. Here are some steps in the process of what happens following an injury:

- Medical claims or expenses for the student-athlete, resulting from an accident injury during supervised scheduled university athletic activity, practice or competition, will be filed first with the student-athlete's primary insurance.
- After the claim is processed by the primary insurance the policyholder (which in most cases is the parent) will receive an "Explanation of Benefits" (EOB) from the insurance company. The EOB is a summary of expenses paid or not paid by the insurance company.
- The EOB needs to be forwarded as soon as possible to SDSU Athletic Insurance Coordinator:

  Athletic Training Room - San Diego State Athletics
  c/o Kristen Paulius
  5302 55th Street
  San Diego, CA 92182-4313

- In the event the primary insurance sends a check for payment of an athletic related expense to the parent or policy holder, it should be sent to Kristen Paulius or to the medical provider as promptly as possible.
- There should be no out-of-pocket expenses for any remaining balances for the injury that occurs during scheduled and supervised university athletic activity, practice, or SDSU competition.
- If the student-athlete has no primary insurance, the medical expenses will be forwarded to SDSU.

The SDSU intercollegiate athletic accident policy will only cover ***authorized*** expenses during the 2 years (104 weeks) following the date of injury. The limit of insurance coverage is $75,000 per injury. Expenses beyond $75,000 will be submitted to the NCAA Catastrophic Injury policy for review.

It is very important to understand that this is not a comprehensive insurance policy. For example, if the athlete requires surgery for an appendicitis or hospitalization for a kidney infection, these expenses would not be covered. It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover expenses which are not managed by the SDSU intercollegiate athletic accident policy.

SAN DIEGO STATE
ATHLETIC TRAINING

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