



SAINT JOSEPH'S UNIVERSITY

DEPARTMENT OF ATHLETICS – SPORTS MEDICINE

ATHLETE INFORMATION QUESTIONNAIRE

NAME _____ SPORT _____

YEAR EXPECTED TO GRADUATE _____ SS# _____

LOCAL at SCHOOL ADDRESS:

HOME ADDRESS:

PHONE:

PHONE:

PARENT/GUARDIAN NAME(S): _____

MEDICATION HISTORY

Please list any medication, supplements, etc. that you are currently taken or have taken in the last 30 days:

Do you have any of the following allergies?

Bee sting YES NO

Drug YES NO

If yes, _____



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Student-Athlete Authorization/Consent for Disclosure of Protected Health Information to Saint Joseph's University and the Atlantic 10 Conference

I, _____, hereby authorize Saint Joseph's University
(print name)

And its physicians, athletic trainer and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletic to the Atlantic 10 conference, media outlets or professional sports organizations and its employees or agents.

I understand that my protected health information regarding my medical history, record of surgery, record of illness and rehabilitation results will be used by the University, Conference and/or media outlet to assist the organization he/she represents.

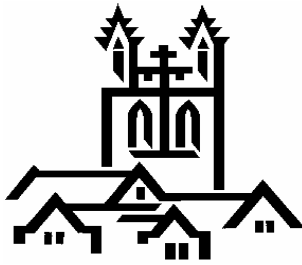
I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization 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 benefits (if applicable) on whether I provide consent or authorization requested for this disclosure. I 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 Saint Joseph's University and the Atlantic 10 are not covered under the Buckley Amendment or HIPAA and that these regulations will not apply to the conference and media outlet's use or disclosure of my injury/illness information.

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

Name (printed) _____ Date _____

Signature _____



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MEDICAL HISTORY QUESTIONNAIRE

NAME _____

DATE OF BIRTH _____

Please circle YES or NO and provide details as requested on BOTH sides of this form. All information is confidential.

1. Are you allergic to any medications or beestings?
NO YES (list) _____
2. Do you take any medication on a permanent or semi-permanent basis (steroids, Birth control pill, anti-inflammatories, antibiotics, etc.)
NO YES (list) _____
3. Have you ever had an epileptic seizure?
NO YES (date of last seizure) _____
4. Have you ever been told by a physician you have epilepsy?
NO YES (list) _____
5. Have you ever been treated for diabetes?
NO YES (list) _____
6. Have you ever been told by a physician that you are anemic?
NO YES (list) _____
7. Have you ever been told by a physician you have sickle cell anemia?
NO YES (list) _____
8. Have you ever been told by a physician you have sickle cell trait?
NO YES (list) _____
9. Do you have or have you ever had high blood pressure?
NO YES (list) _____
10. Do you have or have you had any of the following diseases?
NO YES (date) _____ heart disease (heart murmur, rheumatic fever)
NO YES (date) _____ lung disease (pneumonia, tuberculosis)
NO YES (date) _____ kidney disease (infections)
NO YES (date) _____ liver disease (mononucleosis, hepatitis)
11. Have you ever been told by a physician you have asthma?
NO YES (medication) _____
12. Have you ever had a hernia
NO YES Has it been repaired? (date) _____

13. Have you ever been “knocked out”?
 NO YES (dates) _____
14. Have you ever had a concussion or head injury?
 NO YES (dates) _____
15. Have you ever had to stay overnight in the hospital due to a head injury
 NO YES (dates) _____
16. Have you ever had an neck injury involving bones, nerves or discs that disables you for a week or longer?
 NO YES (dates) _____
17. Do you wear glasses or contact lenses
 NO YES
18. Do you wear any of the following dental appliances?
 _____ permanent bridge _____ permanent crown/jacket _____ full plate
 _____ braces _____ permanent retainer _____ removable retainer
19. Have you had a broken bone or fracture in the last five years?
 NO YES (dates) _____
20. Have you had a shoulder injury in the last five years?
 NO YES (dates) _____
21. Have you ever had shoulder surgery?
 NO YES (dates/kind) _____
22. Have you ever injured your back?
 NO YES (dates) _____
23. Do you presently have back pain?
 NO YES ___ seldom ___ occasionally ___ frequently ___ with vigorous exercise ___ with heavy lifting
24. Have you injured your knee in the last five years?
 NO YES (dates) _____
25. Have you ever been told by a physician, trainer, or therapist that you injured:
 _____ cartilage/meniscus _____ ligaments
26. Have you ever had knee surgery?
 NO YES (dates and kind) _____
27. Have you ever had a severe ankle sprain in the last five years?
 NO YES (dates) _____
28. Do you have any metal implants in your body (screw, pin, plate, etc.)?
 NO YES (dates, where) _____
29. Do you have any medical conditions we should be aware of
 NO YES (details) _____
30. Is there any family history of chronic health problems
 NO YES (specify) _____

31. Has anyone in your family died suddenly?
 NO YES If YES, whom _____



PARTICIPANTS SIGNATURE _____ DATE _____



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NAME _____ D.O.B. _____ SPORT _____

BP _____ TEMP _____ PULSE _____ RESP _____ HT _____ WT _____

VISION: OK ___ INVESTIGATION ___ ALLERGIES _____

CURRENT MEDICATION _____

MEDICAL EXAMINATION			
BODY PART	OKAY (✓)	PROBLEM	COMMENT
Eyes			
ENT			
Head/Neck			
Skin/Scalp			
Lymphatics			
Thorax			
Lungs			
Heart			
Abdomen			
Hernia			
Neurological			

Physician Signature _____ Date _____

ORTHOPEDIC EXAMINATION			
BODY PART	OKAY (✓)	PROBLEM	COMMENT
Neck			
Shoulder			
Elbow			
Hand/Wrist			
Back			
Knee			
Feet			
Flexibility			
Other			

Physician Signature _____ Date _____