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Student-Athlete Information and Medical History (Incoming Students)

(All information will be kept confidential)

Student-Athlete Information:

Name: ___________________________________ Today's Date: ___________________

Sport(s): __________________________________ Birthdate: ____________ Age: _____

Year in School (circle): Fresh. Soph. Jun. Sen. Grad. Sex (circle): Male Female

Status (circle): US Citizen International Resident Asylum Other: _________________

Local Address: _______________________ City: __________ State: ____ Zip: ______

E-mail: _____________________________________ Cell: ________________________

Marital Status: Single Married Divorced Widowed Separated

Spouse Name: _______________________________ Cell: ________________________

Guardian / Emergency Contact Information:

Name:	Name:
Relationship:	Relationship:
Address:	Address:
City:	City:
State / Zip Code:	State / Zip Code:
E-mail:	E-mail:
Cell:	Cell:

Primary Family Physician & Secondary Medical Professional Contact Information:

Name:	Address:
E-mail:	City:
Phone:	State / Zip Code:

Speciality (Psychologist, Physical Therapist, etc.):	
Name:	Address:
E-mail:	City:
Phone:	State / Zip Code:

Allergies (medications, food, environmental, insects, etc.):

Allergy:	Reaction:

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Medications / Shots (taken on a regular basis):

Medication:	Dose:	Frequency (daily, 2x daily, etc.):

Personal Medical History:

Date of last medical examination/physical by a physician/doctor: ________________________

Do you, or have you, had any of the following conditions? If so, please explain below.

Condition:	Y	N
Sinus Infection		
Asthma / Exercise Induced Asthma		
Fatigue / Shortness of Breath		
Chronic Colds / Cough		
Chicken Pox		
Pneumonia		
Hepatitis		
Diabetes		
Jaundice		
Marfan Syndrome		
Tuberculosis (“TB”)		
Mononucleosis (“Mono”)		
Sickle Cell Disease		
Anemia / Low Iron		
Bronchitis		
Recurrent Strep Throat		
Recurrent Tonsillitis		
Rheumatic Fever		
MRSA / Staph Infection		
Hives		
Eczema		
Psoriasis		
Ulcers		
Hemorrhoids		
Recurrent Diarrhea		
Urinary Tract Infection		
Recent Rapid Loss / Increase Weight		
Eating Disorder		

Condition:	Y	N
Heat Related Illness (Hyperthermia)		
High Blood Pressure (Hypertension)		
High Cholesterol		
Heart Murmur or Palpitations		
Chest Pains or Discomfort		
Family History of Sudden Death		
Sudden Cardiac Arrest		
Heart Attack		
Stroke		
Dizziness / Fainting		
Frequent Headaches / Migraines		
Head Injury / Concussion		
Epilepsy / Seizures		
Hearing Loss / Impairment		
Glasses During Practice/Competition		
Contacts During Practice/Competition		
Wear Dental Appliance		
Shoe Orthotics		
Nose Bleeds		
Blood Clots		
Joint Disease / Arthritis		
Abdominal Pain		
Hernia / Hernia Surgery		
Tonsillectomy		
Appendectomy		
Cancer		
Recently Pregnant (Women only)		
Other (list all below):		

Condition:	Explanation:

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Orthopedic Injuries / Surgeries (within the past two years):

(i.e. Neck, Back, Shoulder, Arm, Elbow, Wrist, Hand, Finger, Hip, Leg, Knee, Ankle, Foot, Toe, etc.)

Injury:	Date(s):	Comments:

Please review the following areas of concerns. If you answer yes, please explain below.

Areas of Concern:	Yes	No
Have you ever been advised by a medical doctor to not participate in sport(s)?		
Have you had any injury / illness which required surgery or hospitalization?		
Do you have any pins, screws, or plates in your body (e.g. Spinal Fusion)?		
Do you require any special braces, splints, or pads for physical activities?		
Do you have any other medical concerns other than those listed previously?		

Explanation(s): ____

____

____

____

____

Drugs, Supplements, and Miscellaneous Agents:

Have you ever used the following:	Never	Occasionally	Frequently
Alcohol (Beer, Wine, Liquor, etc.)			
Cigarettes, Cigars, Pipes, Hookah, E-Cigs/Vapes			
Tobacco (Snuff, Chewing, Dip, etc.)			
Energy Drinks / Caffeine Drinks			
Weight Loss Pills			
Stimulants (Amphetamines, Cocaine, etc.)			
Depressants (Xanex, Opium, Heroin, etc.)			
Psychoactive / Hallucinogens (Ecstasy/MDMA, Cannabis/Marijuana, LSD, Peyote/Mescaline, etc.)			
Pre-Workout Supplements			
Performance-Enhancing Drugs (Anabolic Steroids, Creatine, Human Growth Hormone “HGH”, etc.)			
Other:			
Other:			

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Mental Health Concerns:

Do you, or have you, had any of the following conditions? If so, please explain below.

Condition:	Y	N
Stress Disorder		
Depression Disorder		
Anxiety Disorder		
Sleeping Disorder		
Mental Illness		
Suicidal Thoughts		
Attention Deficit with hyperactivity		
Attention Deficit without hyperactivity		

Condition:	Y	N
Feelings of Isolation / Loneliness		
Regularly Homesick		
Anger or Short Temper		
Mood Swings		
Constant Fatigue		
Low Self-Esteem		
Other:		
Other:		

Condition:	Explanation:

Female Concerns (Women Only):

Please review the following areas of concerns. If you answer yes, please explain below.

Areas of Concern:	Yes	No
Are your periods currently regular (every 24-35 days)?		
Have you had a history of period irregularity (too frequent, or absence of period)?		
Have you experienced amenorrhea (no periods for 3 months or more)?		
Is there a history of osteoporosis in your family?		
Do you have a history of fractures (e.g. stress fractures)?		

Explanation(s): ____
____
____
____

I certify that all the above information is true and accurate to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in intercollegiate athletics and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.

Student Signature: ____ Date: _____________

Parent Signature (if under 18): _______________________________ Date: _____________

Physical Examination Page 1 of 3

Name: ___________________________________ Today's Date: ___________________

Year in School (circle): Fresh. Soph. Jun. Sen. Grad. Sex (circle): Male Female

Sport(s): _________________________________ Birthdate: ____________ Age: _____

Must be completed by M.D. or D.O. (No Exceptions)

Height: __________ Weight: _________ Body Composition: ____________________

Pulse: ___________ Blood Pressure: _____ / _____ (_____ / _____, _____ / _____)

Vision: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal Unequal

Medical	Normal	Abnormal	Initial
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Pulses			
Lungs			
Abdomen			
Genitalia (Males only)			
Skin			
Dental			

Musculoskeletal	Normal	Abnormal	Initial
Neck			
Back			
Shoulders/Arms			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Posture			
Flexibility			
Strength			

Extended musculoskeletal exam on the following pages…

Physical Examination Page 2 of 3

Name: ________________________________ Today's Date: _________________

Sport(s): ______________________________ Birthdate: ___________ Age: _____

Left	Standing	Right
Limited mobility / Pain / Hypermobile	Shoulder Flexion	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder Abduction	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder ER Apley's	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shoulder IR Apley's	Limited mobility / Pain / Hypermobile
Pain	Cross body Abd, then elbow to foreheard	Pain
	Cervical Flex	Limited mobility / Pain / Hypermobile
	Cervical Ext	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Cervical SB	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Cervical Rot	Limited mobility / Pain / Hypermobile
	Trunk Flex	Limited mobility / Pain / Hypermobile
	Trunk Ext	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Trunk SB	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Trunk Rot	Limited mobility / Pain / Hypermobile
Genu Valgus / Not on Target / Pain	S/L hop in 1 spot 3x5	Genu Valgus / Not on Target / Pain

Left	Supine	Right
Limited mobility / Pain / Hypermobile	Hip 90/90 IR	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Hip 90/90 ER	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Hamstring 90/90	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	SKTC	Limited mobility / Pain / Hypermobile
Limited arc compared to right / Throwing Arm	Shldr IR/ER arc of motion	Limited arc compared to left / Throwing Arm
Limited mobility / Pain / Hypermobile	Shldr IR @ 90` abd	Limited mobility / Pain / Hypermobile
Limited mobility / Pain / Hypermobile	Shldr ER @ 90` abd	Limited mobility / Pain / Hypermobile

	Prone	
Poor low abdominals / Lordosis Hip Drop R L	Plank	__ Min ____ Sec _____% Scapular Winging R L
	Superman UE in Y not W	Core Weakness
	Press up / Cobra	Pain
Quad Tightness	Prayer Position	Pain
Pain	Duck Walk	Pain

18-25 years of age, collegiate self-described athletes mean time held in plank position is…
Females: 1 minute, 46.15 seconds Males: 1 minutes, 57.66 seconds

Females: 25% = 1 min, 13.5 secs 50% = 1 min, 35 secs 75% = 2 mins, 2.5 secs

Males: 25% = 1 min, 24 secs 50% = 1 min, 50 secs 75% = 2 mins, 15 secs

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Physical Examination Page 3 of 3

Name: ___________________________________ Today's Date: ___________________

Sport(s): _________________________________ Birthdate: ____________ Age: _____

Left		Beighton	Right	
0	1	Passive Extension 5th finger greater than 90 degrees	0	1
0	1	Passive Flexion of the thumb to the forearm	0	1
0	1	Hyperextension of the elbow beyond 10 degrees	0	1
0	1	Hyperextension of the knee beyond 10 degrees	0	1
0	1	Flexion of trunk w/ knees fully extended & palms on the floor	**Score:**	**/9**

Must be completed by M.D. or D.O. (No Exceptions)

Circe: **Cleared** / **Not Cleared** Reason: ______________________________________

Recommendations / Restrictions / Limitations:

____

____

____

Name of the Physician (print/type): ____

Address: _______________________________________ Phone: _____________________

Physician Signature: ____

Medical Stamp Required →

Florida National University (the “University”)
Shared Responsibility for Sport Safety Acknowledgement (the “Acknowledgement”)

While benefits from intercollegiate athletic participation can be great, I acknowledge that there are also serious risks involved in competition and preparation for competition. I understand that as a student-athlete at Florida National University, I may at any time receive an injury while participating in the athletic program. I also understand that the responsibility for sport safety is a shared effort between administrators, coaches, physicians, athletic trainers, and student-athletes.

Both participants and parent(s) are hereby advised that participation in athletics may lead to serious injuries and bodily harm, including the possibility of permanet physical or mental disability partial or complete paralysis, or death. By signing below, I acknowledge that I have been informed of the risks associated with sports participation, and that it is my responsibilty to help prevent injuries, comply with directions and instructions given by University athletic staff, and constantly be aware of such risks and the prevention of injury to myself and to others.

I have read this acknowledgement and agree to assume responsibility for such risks while participating in athletics all or in connection with the University. In the event that I am in need of medical care, I have primary insurance coverage in effect and will take full and complete responsibility to keep my insurance policy premiums paid while I am a student-athlete. I understand that the University offers secondary / supplementary insurance that can be billed for remaining medical expenses after my primary insurance has been processed. I also understand that any medical care balance remaining after all applicable insurance has been processed is solely my responsibility to pay, and that the University has no liability, therefore, I am aware that if I let my primary insurance lapse for any reason, I will be ineligble to participate in any athletic activities (i.e. practices or intercollegiate competitions).

Student Name (print): ____

Student Signature: ____ Date: ________________

Parent Signature (if under 18): _______________________________ Date: ________________

Insurance Protocol

All student-athletes are required to have continuous primary insurance coverage in order to participate in any Florida National Univeristy athletic activities. International students are required to purchase the primary insurance plan through Relation: https://fnu.mycare26.com/

Full information can be found on the FNU Athletic Training webpage: www.fnu.edu/athletic-training/

Student-Athlete Insurance Information

Name: ______________________________ Birthdate: ____________________ SS#: __________________

Insurance Company: ____

Policy Holder's Name: ____

Insurance Address: __________________________________ City, State, Zip: ________________________

Policy #: ____ Group #: ______________________________

Name of Employer: __________________________________ City, State, Zip: ________________________

Deductible: Y N Amount: ________________________ Copay: _______________________________

Type of Insurance: HMA PPO POS HAS

Primary Physician: __________________________________ City/State: _____________________________

Are you covered by any other policy? Yes No (if yes, please submit copy of card)

Please provide a copy of your insurance card (both front and back of the card)

Statement of Authenticity:

I attest that the above information is correct and truthful. I understand that any changes to the above information must be reported to the FNU Athletic Department immediately, and that any lapses in coverage will result in the denial of any and all claims by the secondary insurance policy held by FNU. I understand that this information will be treated confidentially within the offices of Florida National University and those associated directly with student-athlete health care that may require this information. These offices include, but may not be limited to, admissions, student services, athletics and/or a patient approved medical provider.

By signing below, the undersigned student-athlete, hereby acknowledges that the above information is true and accurate to the best of their knowledge and in consideration of their participation in organized athletics, to hereby agree to abide by the requirements of the insurance protocol cited above.

Student Signature: ____ Date: _________________

Parent Signature (if under 18): ________________________________ Date: _________________

Medical Consent / Permission for Treatment

I hereby grant permission to Florida National University personnel, school physicians, athletic training / sports medicine staff, and other physicians designated by the University to provide me with any medical care, treatment, first-aid, rehabititative, or emergency treatments they deem necessary to my health and well-being, including inquries into medical conditions occuring as a result of, during, or in connection with Universiy athletics. Permission is also granted for the athletic training staff to make decisions concerning the need for medical referral and rehabilitation programs for any possible injury.

Student Name (print): ____

Student Signature: ____ Date: ________________

I have the following medical conditions, allergies, implanted devices, special instructions, and/or am taking the following medications which may impact on the emergency medical treatment that I may receive (please print clearly and legibly):

____

____

____

Parental Permission (required if student-athlete is under 18 years of age)

I hereby give my consent for my minor child, or ward, to participate in Florida National University intercollegiate athletic events. I have read all documents in full and agree to all terms contained herein. I understand the consequences of participation in athletics, and understand and consent to the possible need for medical care as described in this acknowledgement. I grant permission for any and all treatment deamed necessary for conditions arising during participation in such athletic activities, including medical or surgical treatment recommended by a medical doctor. I understand that in the event of an emergency, efforts will be made to contact me before treatment.

Parent Name (print): ____

Parent Signature: ____ Date: __________________

Address: ____ Phone: _________________

Student-Athlete Consent Forms

Authorization to Obtain Information

I AUTHORIZE any physician, medical practitioner, hospital, clinic or medical facility, insurance or reinsuring company, the Medical Information Bureau, Inc, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical treatment to me and to give to me and give to Florida National University's Department of Athletics, Athletic Training Staff, INSURANCE COMPANY or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by Florida National University's INSURANCE COMPANY to determine eligiblity for insurance and eligbility for benefits under an existing policy. Any information obtained will not be released to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

Authorization for Release of Medical Records

I hereby grant Florida National University Athletic Training Staff permissions to release, if necessary, all information and records, which relate to present and past medical history to the proper agencies (insurance companies, doctor outside Florida National University Staff and proffesional teams.)

I KNOW that I may request a copy of this Authorization.

I AGREE that a photograghic opy of this Authorization shall be as valid as the original.

I UNDERSTAND that I may revoke the authorization at any time in writing to the Athletic Training Staff. I also understand that any release which has been made prior to my revocation and which was made based upon this authorization shall not constitue a breach of my right to confidentiality.

I AGREE that unless revoked in writing, this authoraztion shall be valid as the original.

I have read and understand the above stated policies.

Student Name (print): ____

Student Signature: ____ Date: _________________

Parent Signature (if under 18): _________________________________ Date: _________________

Florida National University Mild Traumatic Brain Injury (MTBI) Policy

FNU will use standardized initial assessment protocol for MTBI. This form may or may not be used as a sideline assessment tool, but should be reviewed as soon as possible. Note it is your responsibility to report all injuries and illnesses to the athletic training staff and/or team physician, including MTBI. Any student-athlete suspected of having a MTBI will be removed immediately from athletic activities.

If it is determined that a student-athlete has sustained a MTBI, the athletic training staff will perform an assessment 3-5 days after the injury. If the student-athlete passes the examination, they are required to see a physician for clearance. After clearance, the athletic training staff and student-athlete will adhere to the guidelines set forth by the overseeing physician regarding a return to athletic activities.

Concussion and Injury Reporting Acknowledgement

Please read the Heads Up Concussion Fact Sheets found on the following two pages.

After reading and understanding the Heads Up Concussion Fact Sheets, you should be aware that…

- A concussion is a type of traumatic brain injury, which may not seem serious at first, however it requires proper medical attention to assess the extent of the injury
- You cannot see a concussion, but you might notice some of the signs or symptoms right away; other signs or symptoms can show up hours or weeks after the injury first occurred and worsen over time
- A concussion can affect your ability to perform everyday activities beyond athletic activities
- If you suspect a teammate of having a concussion, you are responsible for reporting the injury
- You will not return to athletic activities (i.e. practices, competition) if you have received a blow to the head or body that results in concussion-like symptoms
- You should wear necessary protective equipment for activities that can reduce the risk of MTBI
- Your brain needs time to heal from the MTBI, and you are more likely to have a repeat concussion if you return to play before your signs or symptoms have dissipated
- In rare cases, repeat concussions can cause permanent brain damage and death

I, the undersigned student-athlete at Florida National University, acknowledge the requirement of student-athletes by accepting the responsibility for reporting their personal injuries and illnesses to the Florida National University Athletic Training Staff, which may include, but is not limited to, signs and symptoms of MTBI / concussions. Furthermore, I acknowledge that I have received the Heads Up Concussion Fact Sheets education materials (located on the following two pages).

Student Name (print): ____

Student Signature: ____ Date: _________________

Parent Signature (if under 18): _______________________________ Date: _________________

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CONCUSSION FACT SHEET FOR PARENTS

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY PARENTS/ GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

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DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY
   A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.
2. KEEP YOUR CHILD OUT OF PLAY.
   Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - while the brain is still healing - risk a greater chance of having a second concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION.
   Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

HOW CAN I HELP MY CHILD RETURN TO SCHOOL SAFELY AFTER A CONCUSSION?

Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Receive help with schoolwork
- Reduce time spent reading, writing, or on the computer

Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. As your child's symptoms decrease, the extra help or support can be removed gradually.

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).