**Coppin State University**____________________________________________________________

**Sports Medicine Department 2500 W. North Ave. Baltimore, MD 21216 Tel (410) 951-3728 Fax (410)951-6928**


Dear Parent/Guardian:

The Athletic Training Staff at Coppin State University is continuously working to provide our student-athletes with the highest quality medical services. In order for us to accomplish this goal, we require pertinent information from you and your family physician that will assist us in the event that your son or daughter becomes ill or injured while participating in an organized practice or intercollegiate athletic event.

Enclosed with this letter are forms which will provide us with information about any past medical illness or injuries your son and daughter has sustained. Also, the forms provide us with necessary information in case of an injury or illness. We cannot express how important it is to complete each form in its entirety. We ask that each form be completed and signed to insure your son and daughter's participation in an organized practice or competition.

Each Medical Packet should include:

- ☐ Physical Examination (be completed by physician)
- ☐ Student-Athlete Health History Questionnaire Form
- ☐ Medical Authorization/ Assumption of Risk
- ☐ Insurance/Emergency Contact Form
- ☐ Medical Records Release Form
- ☐ Letter of Non-Insurance (Must be notarized)
- ☐ Copy of Health Insurance
- ☐ Sickle Cell Trait Form
- ☐ Concussion Statement
- ☐ Under 18-years old student-athlete waiver/policy (If applicable)

***If the student-athlete had has any surgery, serious injury (fracture, impair organs, hospitalized and etc) or illness (heart related, experience chest pain, severe asthma, hospitalized. etc) last 5 years, please see his or her primary physician and obtain the doctor's note and clearance forms. If this documentation is missing at physical, she or he cannot be cleared by our team physician.**

Student-athletes my not participated in any athletic organized practice or intercollegiate athletic contest until these documents have been completed and accepted by a member of Coppin State University Athletic Training Staff. These documents should be completed and returned to the Athletic Training Staff before your Pre-participation Examination. Your Coach will contact you with the date of your Pre-participation examination. Once these forms are completed please send to the address below or bring them on the day of your Pre-participation Examination.

Coppin State University<br>
Athletic Department<br>
ATTN: Head Athletic Trainer<br>
2500 W. North Avenue<br>
Baltimore, MD 21216

If you have any question or concerns, please feel free to contact the athletic training staff, (410) 951-3728. Your cooperation and support is greatly appreciated.

## COPPIN STATE UNIVERSITY
## GENERAL PHYSICAL EXAMINATION

Name: ______________________________ Date of Exam: ________________
Last First MI

Social Security #: ____________________ Date of Birth: ___________ Sport: _________________

Sex: ☐ Female ☐ Male Height (in.) ______ Weight (lb) ________ BP ____/____ Pulse ___________
Vision: R 20/ ___ L 20/ ___ Corrected ☐ Yes ☐ No Pupils: Equal _______ Unequal _______

**Medical**

| Examination | Normal | Abnormal | Comments |
|---|---|---|---|
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Throat | | | |
| Mouth | | | |
| Thorax | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Pulses | | | |
| Lung | | | |
| Abdomen | | | |
| Genitalia | | | |
| Skin | | | |

**Musculoskeletal**

| Examination | Normal | Abnormal | Comments |
|---|---|---|---|
| Neck | | | |
| Back | | | |
| Shoulder/Upper Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

Urine: Protein ______________ Glucose ____________ HGH: ____________________________

**Medical Clearance**

☐ Cleared with no limitations
☐ Cleared with limitations ________________________________________________
☐ Not Cleared for: __________________________ Reason: ____________________________________

_________________________
Physician's Name

_________________________

_______________________________________________
Physician's Address (Street, City, State, Zip code)

Phone Number: ___________________ Date:___________

Physician’s Signature

**Coppin State University**

**Department of Athletics**

# Student Athlete Health Questionnaire Form

**The information contained within this medical history will only be used by the Sports Medicine Department of Coppin State University for the purpose of determining if you will pose a health threat/risk to yourself on the athletic field, court, or track. This information will be discussed with you in detail later in you physical examination. This information will remain CONFIDENTIAL at all times.**

(Please print clearly in BLUE or BLACK INK ONLY)

Name: ________________________________________ Date: ____________________
Last First MI

Social Security #: ______________ Date of Birth: ___________ Sex: ☐ Female ☐ Male
Race: ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other____________
Sport(s): __________________ Position(s): _____________ Semester Entering: ☐ Fall ☐ Spring 20______
Did you play this sport this past season? ☐ Yes, Where: ______________ ☐ No, Reason _______________
Status: ☐ Freshman ☐ Transfer ☐ Other Height: _________ Weight: ________

Permanent Address:

_____________________________________________________________________
Street City State Zip

___________________________
Home Phone

Local Address:

_____________________________________________________________________
Street City State Zip

___________________________ ___________________________
Home Phone Cellular

Father's Name: ___________________________________ Age: ___________________
If Deceased, Cause of Death _______________________ Age @ Death ___________
Father's Occupation _______________________________
Address (if different from parent address):

_____________________________________________________________________
Street City State Zip

___________________________ ___________________________
Home Phone Work Phone

Mother's Name: ___________________________________ Age: ___________________
If Deceased, Cause of Death _______________________ Age @ Death ___________
Mother's Occupation _______________________________
Address (if different from parent address):

_____________________________________________________________________
Street City State Zip

___________________________ ___________________________
Home Phone Work Phone



**Student-Athlete's Initial __________**

## I. Cardio vascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise/practice? ☐ Yes ☐ No
- Please Describe ____________________

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise/practice? ☐ Yes ☐ No
- Please Describe ____________________

Have you ever had the feeling of your heart racing or skipping beats during or after exercise/practice? ☐ Yes ☐ No
- Please Describe ____________________

Do you get tired more quickly than your teammates/friends do during exercise/practice? ☐ Yes ☐ No
- Please Describe ____________________

Have you ever been told that you have a heart murmur? ☐ Yes ☐ No
- Please Describe ____________________

Has nay family mumber of relative died or heart problems and/or sudden death before age 50? ☐ Yes ☐ No
- Please Describe ____________________

Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular problems? ☐ Yes ☐ No
- Please Describe ____________________

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ Yes ☐ No
- Dates/Places Describe ____________________

Does anyone in your family have a history of high blood pressure? ☐ Yes ☐ No
- Please Describe ____________________

Have you ever been told that you have/had high blood pressure? ☐ Yes ☐ No
- Please Describe ____________________

Do you anyone in your family have a history of high blood cholesterol? ☐ Yes ☐ No
- Please Describe ____________________

Have you even been told that you have/had hight blood cholesterol? ☐ Yes ☐ No
- Please Describe ____________________

## II. Allergies:

Have you ever been diagnosed with seasonal allergies? ☐ Yes ☐ No
- Please Describe ____________________

Are you presently taking/have you previously taken any allergy medications? ☐ Yes ☐ No
- Please Describe ____________________

Are you allergic to and/or ever had an unfavorable/allergic reaction to any medications? ☐ Yes ☐ No
- Please Describe ____________________

Are you allergic to and/or ever had an unfavorable/allergic reaction to any food items? ☐ Yes ☐ No
- Please Describe ____________________

Are you allergic to and/or ever had an unfavorable/allergic reaction to bee stings, insect bites, etc.? ☐ Yes ☐ No
- Please Describe ____________________

## III. Asthma

Have you ever been diagnosed with asthma and/or exercised induced asthma? ☐ Yes ☐ No
- Date(s)? ____________________
- Please Describe ____________________

Are you presently taking/have you preciously taken any asthma medication/use an inhaler? ☐ Yes ☐ No
- Date(s)? ____________________
- Please Describe ____________________

How many times do you use your rescue inhaler (e.g. Albuterol, proventil, etc.) during an average week? ____________

How many acute asthma attacks have you had in the past 2 months? ☐ Yes ☐ No
- Date(s)? ____________________
- Please Describe ____________________

Have you ever been hospitalized as a result of asthma and/or exercised induced asthma? ☐ Yes ☐ No
- Date(s)? ____________________
- Please Describe ____________________

Have you ever been advised NOT participate in athletic activities due to asthma or any related condition ☐ Yes ☐ No
- Date(s)? ____________________
- Please Describe ____________________



**Student-Athlete's Initial** ____________

## IV. Head Injuries/Concussion:

Have you ever suffered a head injury/concussion (no matter how minor)?
Have you ever been advised NOT participate in athletic activities due to asthma or any related condition ☐ Yes ☐ No
- ♦ Date(s)? ______
- ♦ Please Describe ______

Have you ever been evaluated by a doctor for a head injury/concussion? ☐ Yes ☐ No
- ♦ Date(s)? ______
- ♦ Please Describe ______

Were any diagnostic tests performed? ☐ Yes ☐ No
☐ X-ray ☐ MRI ☐ CT-Scan☐ Neuropsychological Testing ☐ Other ______
Have you ever been hospitalized, knock out, become unconscious, and/or lost your memory due to a head injury/concussion?
☐ Yes ☐ No
- ♦ Please Describe ______

Have you ever been advised not to participate in athletic activities due to a head injury/concussion? ☐ Yes ☐ No
- ♦ Please Describe ______

Do you stuffer from headaches? ☐ Yes ☐ No
- ♦ When? ☐ Everyday ☐ 1-2 times/week ☐ 1-2 times/month
- ♦ Where are your headaches located? ☐ Left side of head ☐ Right side of head ☐ Front of head Back of head ☐ All over your head

Do you have a history of Migraines? ☐ Yes ☐ No
- ♦ How often ______ Please Describe ______
- ♦Medications taken for Migraines? ______

Have you had headaches for more than three months? ☐ Yes ☐ No
- ♦If yes, please explain ______

## V. Eye:

When was your last eye exam? ______
- ♦ Findings? ______

Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ Yes ☐ No
- ♦ List Date(s) time (e.g. practices or games) missed ______
- ♦ Please Describe ______

Were any diagnostic tests performed? ☐ Yes ☐ No
☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______
Have you ever been hospitalized and/or seen an Ophthalmologist for an eye injury? ☐ Yes ☐ No
- ♦ Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to an eye injury? ☐ Yes ☐ No
- ♦ Please Describe ______

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ Yes ☐ No
- ♦ Please Describe ______

Do you routinely wear glasses? ☐ Yes ☐ No
Do you routinely war contact lenses? ☐ Yes ☐ No Type ______
Do you require any special devices/equipment? ☐ Yes ☐ No Type ______

## VI. Ear/ Nose/ Throat:

Have you ever suffered an injury to your ear(s), Nose, and/or throat? ☐ Yes ☐ No
- ♦ List date(s) Time (e.g. practices or games) missed ______
- ♦ Please Describe ______

Were any diagnostic tests performed? ☐ Yes ☐ No
☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ______
Have you ever been hospitalized for a ear, nose, and/or throat injury? ☐ Yes ☐ No
- ♦ Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to a ear, nose, and/or throat injury? ☐ Yes ☐ No
- ♦ Please Describe ______


**Student-Athlete's Initial** ______

## VII. Dental:

When was your last dental exam? ____________________

♦ Findings? ____________________

Have you ever suffered an injury to your mouth, jaws, and/or teeth? ☐ Yes ☐ No

♦ List date(s) Time (e.g. practices or games) missed ____________________

♦ Please Describe ____________________

Were any diagnostic tests performed? ☐ Yes ☐ No

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other ____________________

Have you ever been hospitalized for a mouth, jaw, and/or tooth injury? ☐ Yes ☐ No

♦ Please Describe ____________________

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## VIII. Cervical Spine/Neck:

Have you ever suffered an injury to your cervical spine and/or neck? ☐ Yes ☐ No

♦ List date(s) Time (e.g. practices or games) missed ____________________

♦ Please Describe ____________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a cervical spine/neck injury? ☐ Yes ☐ No

♦ When? ____________ Where? ____________________

♦ Please Describe ____________________

Have you ever had "Burners", "Stinger", or Brachial plexus injuries? ☐ Yes ☐ No

♦ How many? ____________ Date(s) ____________________

Have you ever experience numbness and/or tingling in your arms/fingers? ☐ Yes ☐ No

♦ List date(s) ____________________

♦ Please Describe ____________________

Have you ever had surgery or any kind on your cervical spine/neck? ☐ Yes ☐ No

♦ When? ____________ Surgeon? ____________________

♦ Please Describe ____________________

Have you ever been advised NOT to participate in athletic activities due to a cervical spine/neck injury? ☐ Yes ☐ No

♦ Please Describe ____________________

Do you presently wear a neck roll/collar, "Cowboy collar" or Helmet restrictor plate? ☐ Yes ☐ No

Have you ever worn or been advised to wear a neck roll, neck collar, "Cowboy Collar", and/or helmet restrictor plate?

☐ Yes ☐ No If yes, please explain ____________________

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## IV. Shoulder/Upper Arms:

Have you ever suffered and injury to your shoulder/upper arm? ☐ Yes ☐ No

♦ List date(s) Time (e.g. practices or games) missed ____________________

♦ Please Describe ____________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a shoulder/upper arm injury? ☐ Yes ☐ No

♦ When? ____________ Where? ____________________

♦ Please Describe ____________________

Have you ever had surgery or any kind on your shoulder/upper arm? ☐ Yes ☐ No

♦ When? ____________ Surgeon? ____________________

♦ Please Describe ____________________

Have you ever been advised NOT to participate in athletic activities due to a shoulder/upper arm injury? ☐ Yes ☐ No

♦ Please Describe ____________________



**Student-Athlete's Initial** __________

## X. Elbow/Forearm:

Have you ever suffered and injury to your elbow/forearm? ☐ Yes ☐ No

- List date(s) Time (e.g. practices or games) missed ____________________
- Please Describe ____________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a your elbow/forearm injury? ☐ Yes ☐ No

- When? ____________ Where? ____________
- Please Describe ____________________

Have you ever had surgery or any kind on your elbow/forearm? ☐ Yes ☐ No

- When? ____________ Surgeon? ____________
- Please Describe ____________________

Have you ever been advised NOT to participate in athletic activities due to a elbow/forearm injury? ☐ Yes ☐ No

- Please Describe ____________________

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## XI. Wrist, Hand, & Fingers:

Have you ever suffered and injury to your wrist, hand, and/or fingers? ☐ Yes ☐ No

- List date(s) Time (e.g. practices or games) missed ____________________
- Please Describe ____________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a your wrist, hand, and/or fingers injury? ☐ Yes ☐ No

- When? ____________ Where? ____________
- Please Describe ____________________

Have you ever had surgery or any kind on your wrist, hand, and/or fingers? ☐ Yes ☐ No

- When? ____________ Surgeon? ____________
- Please Describe ____________________

Have you ever been advised NOT to participate in athletic activities due to a wrist, hand, and/or fingers injury? ☐ Yes ☐ No

- Please Describe ____________________

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## XII. Spine/Low Back/ Sacroiliac Joint:

Have you ever suffered and injury to your spine/low back/ sacroiliac joint? ☐ Yes ☐ No

- List date(s) Time (e.g. practices or games) missed ____________________
- Please Describe ____________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a your spine/low back/ sacroiliac joint injury? ☐ Yes ☐ No

- When? ____________ Where? ____________
- Please Describe ____________________

Have you ever had surgery or any kind on your spine/low back/ sacroiliac joint? ☐ Yes ☐ No

- When? ____________ Surgeon? ____________
- Please Describe ____________________

Have you ever been advised NOT to participate in athletic activities due to a spine/low back/ sacroiliac joint injury?

☐ Yes ☐ No

- Please Describe ____________________

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**Student-Athlete's Initial** ____________

## XIII. Hip/Groin:

Have you ever suffered and injury to your hip/groin? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______
- ♦ Please Describe ______

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a hip/groin injury? ☐ Yes ☐ No

- ♦ When? ______ Where? ______
- ♦ Please Describe ______

Have you ever had surgery or any kind on your hip/groin? ☐ Yes ☐ No

- ♦ When? ______ Surgeon? ______
- ♦ Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to a hip/groin injury? ☐ Yes ☐ No

- ♦ Please Describe ______

## XIV. Thigh/Hamstring/Quadriceps:

Have you ever suffered and injury to your thigh/hamstring/quadriceps? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______
- ♦ Please Describe ______

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a thigh/hamstring/quadriceps injury? ☐ Yes ☐ No

- ♦ When? ______ Where? ______
- ♦ Please Describe ______

Have you ever had surgery or any kind on thigh/hamstring/quadriceps? ☐ Yes ☐ No

- ♦ When? ______ Surgeon? ______
- ♦ Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to a thigh/hamstring/quadriceps injury? ☐ Yes ☐ No

- ♦ Please Describe ______

## XV. Knee/Patellar:

Have you ever suffered and injury to your knee and/or patellar (kneecap)? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______
- ♦ Please Describe ______

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a knee and/or patellar injury? ☐ Yes ☐ No

- ♦ When? ______ Where? ______
- ♦ Please Describe ______

Have you ever had surgery or any kind on knee and/or patellar? ☐ Yes ☐ No

- ♦ When? ______ Surgeon? ______
- ♦ Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to a knee and/or patellar (kneecap) injury?

☐ Yes ☐ No

- ♦ Please Describe ______



**Student-Athlete's Initial** ______

## XVI. Ankle/Lower Leg:

Have you ever suffered and injury to your ankle/lower leg? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______________________________
- ♦ Please Describe ______________________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a ankle/lower leg injury? ☐ Yes ☐ No

- ♦ When? ________________ Where? ________________
- ♦ Please Describe ______________________________

Have you ever had surgery or any kind on ankle/lower leg? ☐ Yes ☐ No

- ♦ When? ________________ Surgeon? ________________
- ♦ Please Describe ______________________________

Have you ever been advised NOT to participate in athletic activities due to a ankle/lower leg injury?

☐ Yes ☐ No

- ♦ Please Describe ______________________________

Do you presently ☐ Tape your ankle(s) ☐ Use ankle brace(s) ☐ Other ________________

- ♦ Please Describe ______________________________

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## XII. Foot/Toes:

Have you ever suffered and injury to your foot/toes? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______________________________
- ♦ Please Describe ______________________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery or any kind on foot/toes? ☐ Yes ☐ No

- ♦ When? ________________ Surgeon? ________________
- ♦ Please Describe ______________________________

Have you ever been advised NOT to participate in athletic activities due to a foot/toes injury? ☐ Yes ☐ No

- ♦ Please Describe ______________________________

---

## XIII. Ribs/Thorax/Chest:

Have you ever suffered and injury to your ribs/thorax/chest? ☐ Yes ☐ No

- ♦ List date(s) Time (e.g. practices or games) missed ______________________________
- ♦ Please Describe ______________________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)

☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery or any kind on ribs/thorax/chest? ☐ Yes ☐ No

- ♦ When? ________________ Surgeon? ________________
- ♦ Please Describe ______________________________

Have you ever been advised NOT to participate in athletic activities due to a ribs/thorax/chest injury? ☐ Yes ☐ No

- ♦ Please Describe ______________________________

---

## XIX. Abdomen:

Have you ever been diagnosed with a problem with your stomach, abdomen, intestines, or rectum? ☐ Yes ☐ No
- ♦ List date(s) Time (e.g. practices or games) missed ______________________
- ♦ Please Describe ______________________

Have you ever suffered and injury to your abdomen? ☐ Yes ☐ No
- ♦ List date(s) Time (e.g. practices or games) missed ______________________
- ♦ Please Describe ______________________

Were any diagnostic test performed? ☐ Yes ☐ No (check all that apply)
☐X-ray ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery or any kind on an abdomen injury? ☐ Yes ☐ No
- ♦ When? ____________ Surgeon? ______________
- ♦ Please Describe ______________________

Do you routinely suffer from severe or recurrent abdominal pain? ☐ Yes ☐ No ♦
Please Describe ______________________

Do you routinely Suffer from chronic or recurrent diarrhea? ☐ Yes ☐ No ♦
Please Describe ______________________

Do you have only one of two paired, functioning organs (e.G. kidney, testicle, ovary, etc.)? ☐ Yes ☐ No ♦
Please Describe ______________________

Have you ever been advised NOT to participate in athletic activities due to a ribs/thorax/chest injury? ☐ Yes ☐ No
- ♦ Please Describe ______________________

## XX. Medical Testing:

Have you ever been diagnosed with a communicable disease (.g. STD, HIV, Hepatitis A, B, or C, Herpes simplex, Syphyllis, Tuberculosis)? ☐ Yes ☐ No
- ♦ List date(s) ______________________
- ♦ Please Describe ______________________

## XXI. Dermatological:

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ Yes ☐ No
- ♦ Please Describe ______________________

Have you ever been under the care of a dermatologist for any condition? ☐ Yes ☐ No
- ♦ Please Describe ______________________

Have you ever been advised NOT to participate in athletic activities due to a ribs/thorax/chest injury? ☐ Yes ☐ No
- ♦ Please Describe ______________________

## XXII. Prescription Medications:

Please list **ALL** prescription & Over-the Counter medications that you are **CURRENTLY** taking or **HAVE TAKEN** in the PAST **TWO (2) years**, and for what purpose:

| Medication | Purpose | Dosage | Date(s) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## XIII. Supplements/Ergogenic Aids:

Please list **ALL** supplements/ergogenic aids that you are **CURRENTLY** taking or **HAVE TAKEN** in the past TWO (2) year, and for what purpose:

| Supplement | Purpose | Dosage | Date(s) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## XXIV. Heat Related Problems:

Have you ever suffered from a heat related injury? ☐ Yes ☐ No (check all that apply)

- ☐ Heat cramps Date(s) ______
- ☐ Heat syncope (Fainting) Date(s) ______
- ☐ Heat exhaustion Date(s) ______
- ☐ Heat stroke Date(s) ______

Have you ever received intravenous fluid (IV) for a heat related problem? ☐ Yes ☐ No

- Date(s) ______

Have you ever been hospitalized for a heat-related problem? ☐ Yes ☐ No

- Date(s) ______

Have you ever been advised NOT to participate in athletic activities due to a heat related injury? ☐ Yes ☐ No

- Please Describe ______

## XXV. Diabetic History:

Have you ever been diagnosed with diabetes? ☐ Yes ☐ No

- Date(s) ______

Are you presently taking or have you taken any diabetic medications? ☐ Yes ☐ No

Medication Form Dosage Frequency

______

______

Do you daily monitor your blood sugar level? ☐ Yes ☐ No

- How many times per day? ______ What is your average level? ______

Have you had you A1C level checked within the last three(3) months? ☐ Yes ☐ No Level ______

Have you had any hypoglycemic episodes (low blood sugar) within the last Twelve (12) months? ☐ Yes ☐ No

- Please Describe ______

Have you ever been advised NOT to participate in athletic activities due to diabetes? ☐ Yes ☐ No

- Please Describe ______

Please lest any precautions that you take and/or additional information NOT mentioned above:

______

______

## XXVI. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ Yes ☐ No

- Date? ______ Result? ______

Does any member of your family carry the Sickle Cell Trait/have Sickle Cell Anemia that you are aware of? ☐ Yes ☐ No

- Please Describe ______

Have you ever advised that you carry the Sickle Cell Trait/have Sickle Cell Anemia? ☐ Yes ☐ No

- Please Describe ______



**Student-Athlete's Initial** ______

## XXVII. For Females Only:

At what age did you have your fist menstrual period? ________________________________

Have you had menstrual periods within the past 12 months?

- If yes, how many? ____________________ When was your most recent menstrual period?________________
- How much time do you usually have from the start of one period to the start of another? _________________________
- What was the longest time between menstrual periods within the past year? ___________________________________

Do you have painful or heavy menstrual periods? ☐ Yes ☐ No

Do you take any medications during your menstrual periods? ☐ Yes ☐ No

If yes, what? ________________________________________________________________

Do you take birth control pills? ☐ Yes ☐ No

If yes, what brand? ___________________________________________________________

Have you ever had any problems with your breasts? ☐ Yes ☐ No

Have you had a pelvic examination within the last year? ☐ Yes ☐ No

**XXVIII. Please Answer:** (all questions are strictly Confidential & will not be shared with parents or coaches!)

☐ Yes ☐ No Have you ever had any injury or illness other than those already noted?
☐ Yes ☐ No Do you have any ongoing or chronic illness?
☐ Yes ☐ No Have you ever been hospitalized overnight?
☐ Yes ☐ No Have you ever been told by a physician to restrict your sports activity or not to participate in sport?
☐ Yes ☐ No Are you currently under a physicians care for any medical conditions?
☐ Yes ☐ No Have you consulted and/or been under the care of chiropractor or, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past fie (5) years?
☐ Yes ☐ No Have you ever had a rash or hives develop during and/or after exercise?
☐ Yes ☐ No Do you cough, wheeze, or have trouble breathing during or after exercise/practice?
☐ Yes ☐ No Have you ever been told that you have kidney disease?
☐ Yes ☐ No Have you ever had rubella ("German Measles") and/or Rubeola ("red measles")?
☐ Yes ☐ No Have you ever had a stomach and/or duodenal ulcer?
☐ Yes ☐ No Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ Yes ☐ No Have you ever had seizures, convulsions, and/or epilepsy?
☐ Yes ☐ No Have you ever had gall bladder disease and/or a urinary problem?
☐ Yes ☐ No Do you have ringing in your ears or trouble hearing?
☐ Yes ☐ No Do you have frequent ear infections or nosebleeds?
☐ Yes ☐ No Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ Yes ☐ No Do you require any special equipment (brace, neck rolls, dental, orthotics, hearing aids, etc.)?
☐ Yes ☐ No Have you ever had the chickenpox? If yes, when? ______________________________________________
☐ Yes ☐ No Are you aware of any reasons why you should not participate in intercollegiate athletics at Coppin State University at this time?
☐ Yes ☐ No Have you had a tetanus booster within the past five (5) years? If yes, when? _________________________
☐ Yes ☐ No Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? __________
☐ Yes ☐ No Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
☐ Yes ☐ No Do you use alcohol? If yes, how often? _________________________________________________________
☐ Yes ☐ No Have you ever used/tried marijuana, cocaine, or any other illicit "street" drugs?
☐ Yes ☐ No Do you have any questions regarding drugs, tobacco, or alcohol?
☐ Yes ☐ No Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
☐ Yes ☐ No Have you had a weight change (loss or gain) of greater than 10 pounds in the last year?
☐ Yes ☐ No Are you a vegetarian? If yes, what type? _______________________________________________________
☐ Yes ☐ No Do you regularly lose weight to participate in your sport?
☐ Yes ☐ No Do you want to weight more or less than you presently do?
☐ Yes ☐ No Have you ever felt forced to limit your food intake due to concerns about your weight and/or any other eating disorders?
☐ Yes ☐ No Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ Yes ☐ No Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered **YES** to any of the above, please explain:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Please describe below any further injury information, which is knowledgeable to you and not required in this form.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through twelve (12) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

______________________________ Student-Athlete Signature

______________ Date

______________________________ Student-Athlete Print Name

______________________________ Parent/Guardian Signature (if under 18 years of age)

______________ Date

______________________________ Parent/Guardian Print Name

______________________________ Witness

______________ Date

**Reviewed By:**

______________________________ Reviewer's Signature

______________ Date

______________________________ Reviewer's Print Name



**Student-Athlete's Initial __________**

# COPPIN STATE UNIVERSITY SPORTS MEDICINE DEPARTMENT

## Health Insurance Information/Authorization

Student-Athlete's Name ____________________________________________ Social Security No. ________________________________

Sex ☐ Male ☐ Female Date of Birth ____________________ Sport ________________________________________

Permanent Address ________________________________________________________________________________________

Local Address ____________________________________________________________________________________________

Home Phone # ________________________________________ Cell Phone # ________________________________________

Medications currently taking? ____________________________________________________________________________

Allergies/Asthma? ________________________________________________________________________________________

| FATHER'S/GUARDIAN'S INFORMATION | MOTHER'S/ GUARDIAN'S INFORMATION |
|---|---|
| Name:________________________________ | Name:________________________________ |
| SS No.______________ DOB:________________ | SS No.______________ DOB:________________ |
| Home Address:____________________________ | Home Address:____________________________ |
| ________________________________________ | ________________________________________ |
| Home Phone:__________________ | Home Phone:____________________ |
| Employer:________________________________ | Employer:________________________________ |
| Employer Address:________________________ | Employer Address:________________________ |
| ________________________________________ | ________________________________________ |
| Work Phone:______________________________ | Work Phone:______________________________ |
| Insurance Company:_______________________ | Insurance Company:_______________________ |
| Policy/ID #:_____________________________ | Policy/ID #:_____________________________ |
| Group #:_________________________________ | Group #:_________________________________ |
| Insurance Company Phone:_________________ | Insurance Company Phone:_________________ |
| Type of Insurance: ☐ HMO ☐ PPO | Type of Insurance: ☐ HMO ☐ PPO |
| ☐ Indemnity ☐ Other:_____________________ | ☐ Indemnity ☐ Other:_____________________ |
| Primary Care Physician:__________________ | Primary Care Physician:__________________ |
| Physician Phone #:_______________________ | Physician Phone #:_______________________ |
| Is preauthorization for medical/diagnostic services? | Is preauthorization for medical/diagnostic services? |
| ☐ Yes ☐ No | ☐ Yes ☐ No |
| Phone Number:____________________________ | Phone Number:____________________________ |
| Is your son/daughter covered under this policy? | Is your son/daughter covered under this policy? |
| ☐ Yes ☐ No | ☐Yes ☐ No |

**Please Read Carefully!**

- Coppin State University Department of Intercollegiate Athletics' accident policy provides insurance for student-athletes **with injuries occurring only when participating in the play or practice of intercollegiate athletics.** This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will Coppin State University's Department of Athletics' insurance carrier consider payment for any remaining balances.
- I hereby authorize Coppin State University Department of Intercollegiate Athletics, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, the Coppin State Department of intercollegiate Athletics & their excess insurance company in a timely manner.
- I hereby authorize Coppin State University Department of Intercollegiate Athletic and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or precious confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize Coppin State University Sports Medicine Department and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify Coppin State University Sports Medicine Department immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.
- I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

- The requested information is for insurance reasons only. The information will remain confidential and used only by the Coppin Athletic Training Staff

| Policy Holder's Signature:_______________ | Date:_______ |
|---|---|
| Student Athlete's Signature:_______________ | Date:_______ |

## Coppin State University
## Health Insurance Portability and Accountability Act Release

The Insurance Portability and Accountability Act of HIPAA was created "to protect individuals" personal health information and gives patients increased access to their medical records". Under this law, the Coppin State University Athletic Training Staff will not be able to speak anyone in regards to any injury or condition sustained while participating in intercollegiate athletics unless a release is signed.
Therefore, I give authorization to release medical information when necessary as if relates to participation in my sport to the members of the coaching staff for the sport in which I participate, athletic department administration, team physician, team physician's staff, Coppin State University secondary insurance agent and my parent/legal guardian.
Certain medical information may not be released to the above noted persons on an incident specified basis. If there is any information related to your health that you do not want release, please submit a request in writing.
I understand the Coppin State University athletic training staff will no release information about my health to any other persons, except those designated, including members of the media unless permission is obtained from me on an incident specific basis.

_______________________________
Student-Athlete's (Print)

_______________________________ _______________
Student-Athlete's Signature Date

_______________________________ _______________
Parent/Guardian's Signature (If student-athlete is under 18) Date

# COPPIN STATE UNIVERSITY SPORTS MEDICINE DEPARTMENT

**Medical Examination & Authorization Wavier**

I, the undersigned, hereby acknowledge, affirm, and represent the following:

**A. PRESENT PHYSICAL CONDITION**:
I have previously warranted and represented to Coppin State University Athletic Department that I am in excellent physical condition. Upon reporting to Coppin State University, I completed a "Health History Questionnaire" form and was examined by a Coppin State University Team and/or consulting physician and/or his/her designee. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history; that my Health History Questionnaire Form was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to and discussed with an Coppin State University Team and/or consulting physician and/or his/her designee; and that I am not suffering from any complains, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition.

**B. FUTURE COMPLAINS:**
I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complains, re-injuries, and aggravations of old injuries must be immediately reported to Coppin State's Team physician, and/or a member of Coppin State University Sports Medicine Department, no matter how minor or insignificant I may deem them to be.

**C. MEDICAL TREATMENT:**
I hereby authorize Coppin State University team physicians, athletic trainers, and designated medical staff to examine and treat any injuries, which may occur, while participating in intercollegiate athletics for Coppin State University. I authorize the team physicians athletic trainers, and designated medical staff to communicate with athletic department officials and coaching staff regarding their findings and recommendations. I further understand that the team physician and/or his/her designee have the authority to eliminate me from participation as a student-athlete due to an injury/illness, and/or due to undue liability risk of Coppin State University.

**D. STATEMENT OF MEDICAL INSURANCE:**
I understand that as a student-athlete at Coppin State University (CSU), I should be covered by some type of individual health insurance before participating in any strength and conditioning session, practice, game and/or competition. This insurance shall be considered the **PRIMARY** insurance coverage for all athletic related injuries. I understand that the CSU Department of Intercollegiate Athletics and the National Collegiate Athletic Association (NCAA) will provide a medical and catastrophic insurance program for student-athletes injured in practice, games or competitions, and/or related travel that was supervised by approved University coaching staff and approved by the Director of Athletics according to NCAA regulations. The CSU Department of Intercollegiate Athletics" insurance will be used as secondary coverage for any athletically related injuries that are not covered by your primary insurance. Additionally, any claims made against the CSU Athletic Insurance policy needs to be submitted within 90 days of the occurrence of the injury. In addition, the CSU Department of Intercollegiate Athletics insurance only covers student-athletes while they are under the direct supervision of member of our athletics" coaching staff or sports medicine staff. Any injuries sustained while competing in an intramural activity, unsupervised off-season conditioning, out-of-season conditioning, or any other recreational activity will not be covered by the CSU Athletic Insurance. Any medical expenses associated with these activities will be the sole responsibility of the student-athlete. In addition, I further understand an agree that the insurance of the CSU Department of Intercollegiate Athletics is not effective for an aggravation or re-injury to a preexisting injury, and therefore, the State of Maryland, Coppin State University, and their officers, employees, and agents will not be liable for any expenses resulting from such injury, regardless of its disclosure to the team physician(s) and/or members of the Sports Medicine Department.

**Student-Athlete's Initials ____________**

## E. AGREEMENT TO PARTICIPATE:

I am aware that playing, practicing, training, and/or the involvement in any sports can be a dangerous activity involving MANY RISKS OF INJURY, including but no limited to a potential catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Because of the aforementioned dangers of participating in any athletic activity, I recognize the importance of following all instructions of the coaching staff, strengthening and conditioning staff, and/or Sports Medicine Department. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics.

I acknowledge that I am participating in these activities voluntarily. Assuming all risk of loss, damage, illness, or death that I may sustain while participating in intercollegiate athletics for Coppin State University, and in consideration of the right to participate in such programs, including, but not limited to trying out, practicing/or participating in intercollegiate athletics. I agree to refrain from instituting any claim, demand, action, or cause of action for damages, costs, restitution or compensation against the State of Maryland, the Board of Regents of the University of Maryland System, Coppin State University, the University Department of Athletics and their respective offices, agents, coaches, volunteers, or employees, for any injury or loss which may occurs as result of perspiration in Coppin State University athletics.

I hereby attest that I have read and fully understand the Coppin State University Sports Medicine Department's Medical Examination and Authorization Wavier. Further, I agree to abide by all the requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences.

Student-Athlete Signature ______________________ Date ______________

Student-Athlete Print Name ______________________ Date ______________

Parent/Guardian Signature (if under 18 yeas of age) ______________________ Date ______________

Parent/Guardian Signature ______________________

Witness ______________________ Date ______________



**Student-Athlete's Initials** ___________

# COPPIN STATE UNIVERSITY

## MEDICAL RECORDS RELEASE AUTHORIZATION FORM

I, ____________________________, hereby authorize and request any nurse, physician, physical therapist, athletic trainer, practitioner, student health services, or any hospital/clinic where I have been treated and /or evaluated to send Coppin State University through its designated athletic training staff (certified athletic trainers, team physicians) a complete copy of all medical records pertinent to my medical condition, including all physical examinations, physician's records, athletic trainer's records, physical therapy records, rehabilitation, diagnosis, treatment, history and prognosis of all injuries. This includes diagnostic tests, copies of findings, X-rays, and consultations, This authorization shall cover all past, present, and future medical conditions which might affect my athletic career for Coppin State University. A copy of this authorization shall be considered as effective and valid as the original for one year, and may be executed by the Athletic Training Staff at Coppin State University at any future date pertaining to my condition.

_________________________________ _______________________

Student-Athlete's Signature Date

_________________________________

Social Security Number

_________________________________ _______________________

Parent/Guardian's Signature (If student-athlete is under 18) Date

_________________________________ _______________________

Witness Date

COPPIN STATE UNIVERSITY SPORTS MEDICINE DEPARTMENT
LETTER OF NON-INSURNACE

2500 W. North Avenue
Baltimore, MD 21216
Phone: (410)951-3728
Fax: (410)951-3717

To Claims Department:

I, ________________________________ (Name), am a full-time college student at Coppin State University, participating in _____________________ (Sport). My social security number is _____________________ (SS#) and my date of birth is _________________. I am currently not covered under any medical insurance policy other than full-time student coverage.

______________________________________
Parent/Guardians' Signature

_____________________
Date

______________________________________
Student Athlete's Signature

_____________________
Date

PLEASE HAVE THIS FORM NOTARIZED

**Health Insurance Card (COPY)**
Student-Athlete's Name ___________________________________ TEAM ____________________________
Policy Holder Name ______________________________________

| **Attach the Front Side** |
|---|
| **Attach the Back Side** |

# Sickle Cell Trait Testing

The NCAA is mandating that all incoming student-athletes must be tested for sickle cell trait or show proof of a prior test. In accordance with this legislation the Coppin State University Athletic Department is mandating that all student-athletes must be tested for sickle cell trait, show proof of a prior test prior to any athletic activity.
If identified as carrying the abnormal hemoglobin, you can continue to participate in your respective sport without significant restrictions. Care would be taken and restrictions imposed only if you had an active febrile infection or one that affected your respiratory system, if you were training at altitude, or in extreme weather conditions (especially heat). Ensuring adequate hydration during practice and competition, and training at reasonable exertion levels is another important factor in preventing adverse health issues.

Procedure:

1. Contact their parents/guardian and your pediatrician (at birth) and get documentation showing what your sickle cell trait status is.

❖ Infants born after 1984 were tested for the sickle cell trait and therefore the documentation should be available from your family pediatrician.

Or

2. Schedule an appointment with either your family physician/ health clinic or with the Coppin State University Student Health Clinic to have the sickle cell trait testing done.

❖ This test needs to be in the form of a blood test.

# Sickle Cell Trait Verification Form

Student-Athlete: ____________________________ Date of Birth: ____________ Sport: ___________________

## Complete section A or B whichever you apply.

## A: *Student-athlete has already tested for the sickle cell trait.*

I, _________________________ have attached lab report (documentation showing what my sickle cell trait status with this form.
Student-Athlete Signature: ___________________________ Date: ____________________________
(If under 18, parents' signature)

Physician must be complete below this section.
Coppin State Team Physician and/or my family physician has reviewed and verified above the athlete's lab report.
Sickle cell Trait **Positive** _________ Date of Test ______________
Sickle cell Trait **Negative** _________

Physician's Name: _________________________ Physician's Address: ________________________________

Physician's Signature: _______________________ Physician's Phone Number: __________________________

***If no attach the proof or test result with this form, this verification will be denied.**

---

## B: *Student-athlete will be taken for sickle cell trait.*

I, ___________________________________ affirm that I have been informed by a physician as to my Sickle Cell Trait Status, and/or have undergone the sickle cell trait screening, in the form of a blood test, at ________________________. (Medical Facility Name)

Student-Athlete Signature: __________________________________ Date: _________________________
(If under 18, parents' signature)

Physician must be complete below this section.
I verify that the above named individual has been tested for Sickle cell Trait. The result of this test was;

Sickle cell Trait **Positive** _________ Date of Test ______________
Sickle cell Trait **Negative** _________

Physician's Name: ___________________ Physician's Address: ________________________________

Physician's Signature: _________________ Physician's Phone Number: __________________________

***Test result should be provided to Coppin Sports Medicine before the physical day. Or the verification will be denied.**

# Coppin State University
## Sports Medicine
## Concussion Statement

☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

☐ I have read and understand the *NCAA Concussion Fact Sheet.*
After reading the NCAA Concussion fact sheet, I am aware of the following information:

_________ Initial — A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.

_________ Initial — A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

_________ Initial — You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_________ Initial — If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.

_________ Initial — I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

_________ Initial — Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

_________ Initial — In rare cases, repeat concussions can cause permanent brain damage, and even death.

_______________________________________ _______________________ _______________________

Signature of Student-Athlete Sport Date

_______________________________________

Printed name of Student-Athlete

Coppin State University Sports Medicine

# UNDER 18-YEARS-OLD STUDENT-ATHLETE MEDCIAL WAIVER

The following documentation is to be read carefully. Your parent or guardian must sign.
If you elect not to sign any portion of these documents, please write "Refuse to Sign", then date and initial in the space provided for signature.

## *MEDICAL CONSENT*

I hereby grant permission to the Coppin State University Athletic Training Staff and Team Physicians/Consultant to render to my son/daughter, or myself, any treatment or medical care deemed reasonably necessary. This includes preventive care, first aid, rehabilitation and emergency treatment. Also if deemed necessary, I grant permission for hospitalization.

_____________________________________________ _________________________________________
STUDENT ATHLETE, PRINT NAME DATE STUDENT ATHLETE, SIGNATURE DATE

_____________________________________________ _________________________________________
PARENT/GUARDIAN, PRINT NAME DATE PARENT/GUARDIAN, SIGNATURE DATE

### ***SHARED RESPONSIBILITY FOR SPORTS SAFETY***

I realize that participation in athletics entails a risk of injury, and that I share responsibility for minimizing the risk of injury to others and myself. I must promptly report any injury I have suffered to my athletic trainers. I must give the athletic trainers and coaches a full, honest understanding of my physical condition. I must advise my athletic trainers of any medications that I am taking.

I understand that I must report any problems in the condition or usefulness of equipment that I use. Finally I know that it is important for me to listen to coaches' instructions. I must try, as best I can, to abide by instructions, and guidelines relating to safety, and to avoiding injuries and accidents in my athletic activity.

I have read the above shared responsibility statement. I understand that there is certain inherent risk involved in participating in athletics at Coppin State University.

_____________________________________________
__________________________________________
STUDENT ATHLETE, PRINT NAME DATE STUDENT ATHLETE, SIGNATURE DATE

_____________________________________________
__________________________________________
PARENT/GUARDIAN, PRINT NAME DATE PARENT/GUARDIAN, SIGNATURE
DATE

# Under 18 year-old Student-Athlete Policy and Procedure

**Parents/Guardians' Responsibility**

1. Please review carefully all medical paperwork and sign these forms.
2. Provide all medical documents from their physician if your son/daughter has been illness, serious injuries, surgeries, physical or/and mental disabilities and any other health concerns.
3. Provide all past and current prescription medications, supplements, and ergogenic aids information. Need to state the Name, Purpose, Dosage, and Date(s).
4. Provide allergies information. All allergies history including food and OTC medication.
5. If you would not agree and follow the team physician's advice/instructions and be willing to see other physicians, all medical fees will be on your own.
6. It is your choice that you have your son/daughter takes the prescription that our team physician has prescribed. Even if your son/daughter's condition gets worse, it is your risk and responsibility. We will not take any further medical coverage.

**All requested documentation should be submitted in written format with physician's signature before physical.**

**Oral communication is not accepted.**

If you fail to do so, your son/daughter will not participate in athletics at Coppin State University. And also, Coppin State University will not be held responsible including financially if your son/daughter faces any health issues/injuries.

**Sports Medicine Procedure**

Notify the student-athlete's parents/guardian that the following medical services are requested/ referred by team physician.

- Dispense prescription drugs
- Lab tests (blood work, X-ray, MRI, Bone scan, CT scan)
- Visiting specialists outside of campus
- Visiting Emergency Room (if authorized)
- Pregnancy