



**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 (completed by physician)
- Student-Athlete Health 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

***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 may not participate 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
Athletic Department
ATTN: Head Athletic Trainer
2500 W. North Avenue
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)

 Physician's Signature Phone Number: _____ Date: _____

Coppin State University Sports Medicine Department
Returning Student-Athlete Re-Certification Health Questionnaire

Name: _____ Social Security #: _____
Last First MI

Date of Birth: _____ Sport(s): _____ Date: _____

Permanent Address: _____

Local Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____
Name Relationships to Athlete Phone Number

Since your last physical examination: Fall _____, or Spring _____, have you had any of the following:
 (If yes, explain on the back of this page:

1. Had a serious injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Had an unfavorable reaction to a drug, antibiotic and/or medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Had any fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Do you have only one of two paired functioning organs such as eye, kidney, ovary, or testicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Had a concussion and/or head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Been unconscious for any other reason than anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Do you require any daily medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Had a neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Been diagnosed with asthma? If so, when _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Had a back injury or back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Had trouble with coughing, wheezing, or breathing during or after exercises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Had a history of burners, stingers, and numbness in neck, shoulders, and/or hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Been diagnosed with diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Had a shoulder injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	28. Experienced seizures or convulsions and/or been diagnosed with epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Had a knee injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	29. Been diagnosed with high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Had an ankle injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	30. Been diagnosed with kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Had an operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	31. Been diagnosed with a hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are you currently undergoing physical therapy or rehabilitation for an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	32. Do you require any special equipment to participate in athletics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do you have any medical problems which we should be aware?	<input type="checkbox"/> Yes <input type="checkbox"/> No	33. Have you been hospitalized or had a major illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you have an incompletely healed injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Are you currently taking any short course medications for any illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you wear contact, glasses, and/or safety glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	35. Do you have any concerns regarding drugs, tobacco, and/or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Had frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	36. Have you had a history of anorexia bulimia (forced vomiting), and/or any other eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Had a heat related illness?(heat cramps, heat exhaustion, and/or heat stroke)	<input type="checkbox"/> Yes <input type="checkbox"/> No	37. Do you take vitamins, amino acids, creatine, dietary supplements, and/or anabolic steroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. While exercising, has your heart ever "skipped" a beat, suffered from a racing heart, severe chest pain or lightheadedness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	38. Do you know of, or do you believe there is any health reason why you should not participate in intercollegiate athletics at Coppin State University?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have a history of heart murmur, mitral valve prolapse, or death within your family less than 50 years of age?	<input type="checkbox"/> Yes <input type="checkbox"/> No	39. Have you ever felt dizzy or passed out during or after exercises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Had a dental injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	40. Had a tattoo or body piercing within the last year? If so, when _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Females Only:

- When was your first menstrual period? _____
- 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?

- How many periods have you had in the last year? _____
- What was the longest time between periods in the last year?

Is yes to any of the Questions, please explain:

I hereby affirm that all statements on the following pages are true and correct to the best of my knowledge and that no answers or information has been withheld pertaining to my past and present physical, mental, and injury status, If any information is false or omitted in reference to my medical and orthopedic history, I fully understand that Coppin State University is not responsible for any unknown injury or illness.

Student-Athlete Name (Print)

Date

Student-Athlete Signature

Parent/Guardian (If athlete is under 18)

Date

Parent/Guardian Signature

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: <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Type of Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO
<input type="checkbox"/> Indemnity <input type="checkbox"/> Other: _____	<input type="checkbox"/> Indemnity <input type="checkbox"/> Other: _____
Primary Care Physician: _____	Primary Care Physician: _____
Physician Phone #: _____	Physician Phone #: _____
Is preauthorization for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is preauthorization for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number: _____	Phone Number: _____
Is your son/daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your son/daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> 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 years of age)

Date

Parent/Guardian Signature

Witness

Date

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-INSURANCE

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

To Claims Department:

I, _____, am a full-time college student at
(Name)
Coppin State University, participating in _____. My social
(Sport)
security number is _____ and my date of birth is _____.
(SS#)

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