

Pre-Season Physical Information Packet

Dear returning student-athlete and/or parent/guardian,

The Athletic Training Staff would like to welcome you back to SUNY New Paltz. Our staff works to provide all student-athletes with special care while placing special emphasis on the prevention, recognition, treatment, and rehabilitation of injuries sustained during athletic competition. In order to provide you with utmost of care, we need your cooperation in responding to our requests of you.

In accordance with guidelines established by the NCAA and the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all students are required to have the accompanying pre-season packet documented with the Athletic Training department **before** any participation may take place in their chosen sport. Part of this requirement includes a physical examination and a complete documentation of your immunization record. As a returning student-athlete, the records provided to the Student Health Center upon your enrollment will satisfy the requirement for your immunization record and general physical. In order to help provide student-athletes with more thorough medical care, we are providing an Interim History Form for Returning Varsity Athletes.

Upon arrival, the Athletic Training staff and team physicians will perform a specialized orthopedic screening evaluation of all student-athletes prior to the start of their participation. Following are the dates and times of when the orthopedic screenings will be performed by our Athletic Training staff in the Athletic Training Room.

Sunday, August 19, 2007

| | |
|----------------------------|---------------------------|
| 11:00 AM – 12:30 PM | Field Hockey |
| 12:30 PM – 2:00 PM | Men's Soccer |
| 2:00 PM – 3:30 PM | Women's Soccer |
| 3:30 PM – 4:30 PM | Women's Volleyball |
| 5:15 PM – 6:15 PM | Women's Tennis |

All student-athletes must have insurance **before** participating in intercollegiate athletics. Most are covered by their parents' insurance or have their own personal health insurance. If you do not have insurance, it may be purchased through the school.

The following is a checklist of what we need before you can participate. In order to ensure a full review, we need to receive this information before **August 1, 2007**. If the information is not received by the date, then most likely you will not be able to start training with your team on time.

- Athletic Screening Questionnaire
- Athletic Participation Statement
- Release of Medical Information Form
- Insurance/Emergency Questionnaire
(With front/back copy of insurance card)

○ Interim History Form for Returning Varsity Athletes

All documents above can be accessed on-line at www.newpaltz.edu. Just click on the Athletics tab and go to the Athletic Training section and click on the Physical Information tab. Please fax to (845) 257-3921 or mail the completed forms to:

Mark deCastro
Head Athletic Trainer
SUNY New Paltz-Elting Gymnasium
1 Hawk Drive
New Paltz, NY 12561

As stated previously, in order to try out or participate in a varsity sport at SUNY New Paltz, every student must complete the required athletic training forms that are available online. Please refer to the scenarios below to clarify what is needed for each individual. Please note: Any student-athlete who arrives for pre-season without paperwork completed and submitted **will not be allowed to try out or practice**.

Returning student-athletes

Scenario 1

Returning student-athlete with no significant injury or illness requiring medical treatment during the summer.

- Go online and read the SUNY New Paltz athletic training links associated with the medical clearance of a returning student-athlete.
- Submit an Athletic Screening Questionnaire completed and signed by the student-athlete and parent/guardian if student-athlete is a minor.
- Submit an Athletic Participation Statement completed and signed by the student-athlete and parent/guardian if student-athlete is a minor.
- Submit an Insurance/Emergency Questionnaire completed and signed by the student-athlete and parent/guardian if student-athlete is a minor. Additionally, a legible photocopy of the front and back sides of your insurance card is needed.
- Submit an Authorization for the Release of Medical Information Form completed and signed by the student-athlete and parent/guardian if student-athlete is a minor.
- Submit an Interim History Form for Returning Student-Athletes completed and signed by the student-athlete and parent/guardian if student-athlete is a minor.
- Upon arrival, the Athletic Training staff will let you know when you will receive a specialized orthopedic screening evaluation performed by the Athletic Training Staff and team physicians.

Scenario 2

Returning student-athlete with an injury or illness occurring over the summer requiring medical treatment.

- Complete and submit all forms as described in Scenario #1.

- Submit all documentation for injuries, surgeries, etc. that required medical care. Documentation includes the following: doctor's office notes, copies of x-rays, MRI's, bone scans, operative notes, and radiology reports.
- Submit a note of release for full, unrestricted participation in the specific sport(s) that the student-athlete is trying out for at SUNY New Paltz. The treating physician or surgeon must write this note.

Submit all required paperwork by August 1st to:

Mark deCastro
Head Athletic Trainer
SUNY New Paltz- Elting Gymnasium
1 Hawk Drive
New Paltz, New York 12561

If you have any questions, feel free to call the Athletic Training Room at (845) 257-3913. The Head Athletic Trainer is off for the summer between June 1st and July 31st. He will check his voicemail periodically and will return any calls that may require a response.

SUNY New Paltz Athletic Screening Questionnaire

Instructions: (Please read carefully) This form is to review your health history. If you need to further explain any condition, please use the explanation lines following the question to explain the situation more clearly. Please circle each question yes or no.

Name: _____ SS#: _____ Date: _____

DOB: _____ Sex: M F Year of Eligibility: 1 2 3 4 Sport: _____

- | | | |
|---|-------------------------|---------------------------------|
| 1) Have you ever had a head injury? If yes, how many? _____ | Yes | No |
| Seen a doctor/hospital due to a head injury? | Yes | No |
| Frequent Headaches? | Yes | No |
| 2) Have you ever been diagnosed with a heart murmur or any other heart abnormalities? If yes, what and when? _____ | Yes | No |
| 3) Have you experienced any chest pain, irregular heartbeat, shortness of breath, dizziness, or fainting as a result of exercising? If yes, please explain: _____ | Yes | No |
| 4) Do you have a history of heart disease, sudden cardiac death, or Marfan syndrome in your family? If yes, please explain. _____ | Yes | No |
| 5) Do you have any family history of diabetes, epilepsy, asthma, hepatitis, or stroke? If yes, please explain. _____ | Yes | No |
| 6) Are you presently taking any medication(s)? If yes, please list and explain. _____ | Yes | No |
| 7) Are you presently taking any nutritional supplement(s)? If yes, please list: _____ | Yes | No |
| 8) Do you have any allergies (food, medications, other)? If yes, please explain. _____ | Yes | No |
| 9) Do you wear eyeglasses or contact lenses during competition? If Yes, which?: _____ | Yes | No |
| 10) Have you/are you being treated for an eating disorder? Explain _____ | Yes | No |
| 11) Have you/are you being treated for any mental/emotional disorders? Explain: _____ | Yes | No |
| 12) Have you/are you receiving professional care or counseling for a substance abuse? _____ | Yes | No |
| 13) Do you have medical problems such as: (please circle) | | |
| Seizure/convulsions | High blood pressure | High Cholesterol |
| Hair/skin changes | Fatigue | Amenorrhea |
| Hepatitis | Diabetes/Hypoglycemia | Asthma |
| Dizziness/fainting | Unexplained weight loss | Abdominal pain/chronic diarrhea |
| Wounds that do not heal | Excessive urination | Loss of a paired organ |
| Visual changes/injury to an eye | Heat-related problems | |
| If yes, please explain. _____ | | |
| _____ | | |
| _____ | | |

14) Have you ever had an injury or surgery, missed a game or practice, or seen a physician or physical therapist for any of the following: (please circle)

| | | | | | |
|---------------|------------|------------|-------|-----------|-----------|
| Neck | Back | Hip/Pelvis | Ankle | Shoulder | Upper Arm |
| Elbow/Forearm | Hand/Wrist | Upper Leg | Knee | Lower Leg | Foot |

15) Have you been immunized for tetanus in the last 10 years? List year: _____ Yes No

FEMALES ONLY

16) Missed any menstrual periods in the past 12 months? If yes, how many? _____ Yes No
Average cycle length _____ Last Menstrual Period _____

I verify that all the above information is accurate and complete. I understand that failure to disclose previous medical conditions may result in removal from the team. Upon, your signature, this form will give consent for the Sports Medicine staff to evaluate and treat all injuries that occur while you are attending SUNY New Paltz.

Athlete's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if student is under 18 years old)

Athletic Trainers Use Only:

Athlete: _____

Case #1 _____

Case #2 _____

Case #3 _____

Case #4 _____

Height- _____ Blood Pressure- ____ / ____ Pulse- _____

Weight- _____ SAC Form/Score- _____

| | | | |
|---|---------|---------------------------|-------------|
| Athletic Trainer Clearance: | Cleared | Cleared with restrictions | Not cleared |
| Athletic Trainer Rehabilitation Needed: | | Yes No | |
| Strength Conditioning Coach Needed: | | Yes No | |
| Athletic Trainer Signature _____ | | Date _____ | |

ATHLETICS PARTICIPATION STATEMENT

A. Participation Agreement, Assumption of Risk and Release

I, _____ (print name), verify that I have been informed that I may be injured while participating in intercollegiate athletic practice or competition which include but are not limited to training, try-outs, practicing, playing, and traveling. I understand that it is possible that I may sustain an injury, which may result in permanent disability, paralysis, or death. I freely acknowledge that I am aware of and accept the risks associated with such participation. _____
Initials

I fully realize the dangers in participating in such activities and fully assume the risks associated with such participation, which may include but are not limited to the possibility of serious physical injury and/or mental trauma, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment. These injuries may be caused in whole or in part by numerous factors including my medical or physical condition, the actions or inaction of athletes, the conditions of premises, and the negligence of the entity or individuals released hereby. I waive, release and discharge of myself, heirs, executors, administrators, legal representatives, and assignees any and all rights or claims for injuries or losses of any description that I may have or which may hereafter result to me against SUNY New Paltz, its trustees, employees or agents, in connection with my participation in activities associated with a SUNY New Paltz intercollegiate athletic team. _____
Initials

I understand that it is the recommendation of the SUNY New Paltz medical staff that all jewelry be removed for practice and competition. If I do not remove all jewelry, including, but not limited to earrings, rings, necklaces, belly button rings or bars, and tongue rings, I understand I will be solely responsible for any medical or dental costs resulting from any injury consequential to jewelry being worn. _____
Initials

B. Medical Consent to Treatment

I grant permission to physicians, athletic trainers, and/or other medical professionals or practitioners associated, assisting, or employed in connection with SUNY New Paltz athletic programs or student athletes, to render any preventative, emergency, surgical, or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being in circumstances connected with my participation in activities associated with a SUNY New Paltz athletic team. I understand that all injuries are to be reported to the certified athletic trainer and that I am responsible for the follow-up care and treatment of my injuries under the supervision of the certified athletic trainer.

This Consent is not intended to, and does not, create a duty on the part of physicians, athletic trainers, and/or other medical professionals or practitioners associated, assisting, or employed in connection with SUNY New Paltz athletic programs or student athletes, to render or arrange for such treatment or care.

Initials

C. Signature Approval

I have read, understand, and approve Parts A and B of this Participation Statement. A photocopy of this Participation Statement will be deemed to have the same force and effect as the original.

Student's Signature

Age

Date

Parent or Guardian (if under 18 years old)

Authorization for the Release of Medical Information

I, _____, hereby authorize SUNY New Paltz and its physicians, athletic trainers, and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participating in intercollegiate athletics to the SUNY New Paltz Athletic Training staff and its employees or agents.

I understand that my protected health information will be used by the SUNY New Paltz Athletic Training staff for the purpose of managing athletic illness or injury.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health care plan or receipt of any benefits if applicable on whether I provide the authorization requested for this disclosure. I also understand that I am not required to sign this authorization in order to be eligible for participation in NCAA or conference athletics.

I also understand that the SUNY New Paltz Athletic Training Staff is not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the SUNY New Paltz Athletic Training Staff's use or disclosure of my injury/illness information. This authorization expires three hundred and eighty days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the Athletic Training Staff.

PRINT NAME _____

SPORT _____

SIGNATURE _____

DATE _____

SUNY New Paltz Intercollegiate Athletic Insurance Questionnaire

Accident / injury benefits for student athletes are provided on an excess basis. This means the student athlete's **OWN PERSONAL INSURANCE or that of the ATHLETE'S SPOUSE OR PARENTS MUST BE BILLED FIRST.** Benefits are available from the secondary policy only when the student athlete's are exhausted. Our secondary insurance has a zero dollar deductible. The following information is essential to assure that expenses are adequately and completely covered by the proper insurance. Inadequate or incomplete answers will delay the payment of medical bills. No medical expenses will be paid by the secondary policy without a signed, accurate questionnaire on file, which will be updated yearly. It is the student athlete's responsibility to keep this information up to date.

Section 1 – Student Athlete Information

Name _____ Single ___ Married ___ Eligibility Year 1 2 3 4
SS# _____ DOB _____ Sex: M ___ F ___
Permanent Address _____
School (local) Address _____
Home Phone _____ Cell Phone _____ Local Phone _____

Section 2 – Parent/Guardian Information

| | |
|------------------------|------------------------|
| Father | Mother |
| Name _____ | Name _____ |
| Address _____ | Address _____ |
| Home phone _____ | Home phone _____ |
| Cell Phone _____ | Cell Phone _____ |
| Employer _____ | Employer _____ |
| Employer Address _____ | Employer Address _____ |
| Work Phone _____ | Work Phone _____ |
| DOB _____ | DOB _____ |

Primary Medical Insurance

Primary Holder's Name _____
Insurance Co. Name _____
Address _____

Member Services Phone # _____
Policy # _____
Group # _____
ID or SS# _____

Secondary Medical Insurance

Secondary Holder's Name _____
Insurance Co. Name _____
Address _____

Member Services Phone # _____
Policy # _____
Group # _____
ID or SS# _____

Circle one: HMO PPO

Circle one: HMO PPO

I hereby certify that the foregoing answers are true, complete, and correct to the best of my knowledge. I also hereby authorize any insurance company, organization, employer, hospital, MD, or other health care provider to release any information with respect to injury, treatment, or insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

ATHLETE SIGNATURE _____ DATE _____ SPORT _____

Parent or Guardian Signature if under 18 _____ Date _____

STATE UNIVERSITY OF NEW YORK – NEW PALTZ
STUDENT HEALTH CENTER

INTERIM HISTORY FOR RETURNING VARSITY ATHLETES

Name: _____ Phone: (Local) _____

The following information is vital to adequately screen and medically clear athletes for continued participation in their sport. The purpose of this form is to update each athlete's chart with significant information regarding injuries, medical conditions, symptoms of concern, and use of medication since the athlete's entrance physical exam.

Has anyone in your family developed heart problems or experienced sudden death before age 50? Yes _____ No _____

If yes: Relationship to you: _____ Nature of Problem: _____

History: In the **PAST YEAR**, have any of the following happened to you? (Answer all questions)

| | Y/N | If yes, explain | Still a Problem, Y/N |
|--|-------|-----------------|----------------------|
| 1. Hospitalized for any reason? | _____ | _____ | _____ |
| 2. Surgery of any kind? | _____ | _____ | _____ |
| 3. Significant injury (fracture, dislocation, etc)? | _____ | _____ | _____ |
| 4. Overuse Injury (sprain, strain, etc)? | _____ | _____ | _____ |
| 5. Recurrent back pain? | _____ | _____ | _____ |
| 6. Use of medications for more than 10 days? | _____ | _____ | _____ |
| 7. Are you currently taking any prescription medicine including birth control or over the counter medication or pills or using an inhaler? | _____ | _____ | _____ |
| 8. Allergic reaction to food, medication, or stinging insects? | _____ | _____ | _____ |
| 9. Passed out during or after exercise? | _____ | _____ | _____ |
| 10. Chest pain or dizziness during or after exercise? | _____ | _____ | _____ |
| 11. High blood pressure and/or high cholesterol? | _____ | _____ | _____ |
| 12. Irregular heartbeats? | _____ | _____ | _____ |
| 13. Significant head injury/knocked? Unconscious? | _____ | _____ | _____ |
| 14. Seizures? | _____ | _____ | _____ |
| 15. Any shortness of breath with exercise? Wheezing? | _____ | _____ | _____ |
| 16. Chronic or recurrent cough with exercise? | _____ | _____ | _____ |
| 17. Loss or decreased function of any organ? | _____ | _____ | _____ |
| 18. Have you had any illness lasting a week or more such as mono or a chronic recurring illness or infection? | _____ | _____ | _____ |
| 19. Have you had any blood disorders, including Sick cell trait, anemia (low blood), blood clot, unusual bleeding, etc? | _____ | _____ | _____ |
| 20. Asthma/seasonal allergies that require medical treatment? | _____ | _____ | _____ |
| 21. Menstrual problems/irregularities? | _____ | _____ | _____ |
| 22. Recurrent heat exhaustion? | _____ | _____ | _____ |

- 23. New onset or unusual headaches? _____
- 24. Have you been treated or evaluated for an eating disorder? _____
- 25. Have you been treated, or encouraged to seek treatment for an alcohol or substance/drug abuse problem? _____
- 26. Any other significant illness or problems? _____
- 27. Are you taking any supplements, vitamins, or herbal remedies? _____
- 28. Caffeine Use
Chewing tobacco _____
Smoking tobacco _____
- 29. PREGNANCIES
Number of pregnancies? _____
Have you used steroids? _____
- 30. Have you used marijuana, ecstasy, narcotics Cocaine/crack or other drugs for non-medical reasons? _____

PLEASE READ AND SIGN BELOW:

- (A) I certify that the above information is accurate and complete to the best of my knowledge. I realize that falsification of the provider information is a violation of the honor code that could result in sanctioning by a hearing panel.
- (B) I give permission for the Certified Athletic Trainers (within the Athletic Department), Student Health Center Staff, and all consulting physicians, permission to exchange, written or orally, any information concerning any injuries or illness which effects my ability to participate in physical activities throughout the time in which I am an official student athlete at the State University of New York New Paltz College. Any change in this status must be made in writing by the student athlete and rendered to all parties concerned.

Student Signature

Social Security #

Printed Name

Sport

Date

FR ___ SO ___ JR ___ SR ___