

**Student-Athlete Name:** \_\_\_\_\_ **Sport:** \_\_\_\_\_

**Returning Athlete?**  **Freshman/Transfer?**

- This form must be completed in its entirety prior to the first practice or you will not be allowed to participate.
- The information contained in this form is protected under medical confidentiality guidelines and will be used as an aid to providing appropriate health care while you are a student-athlete at Johnson State College.
- Your knowledge and consent are required for release of any information contained in this medical record.

**Completed forms must be returned to:** Renee Breault, Head Athletic Trainer **or – FAX: 802-635-1497**  
 Department of Athletics **ATTN: Renee Breault**  
 Johnson State College  
 337 College Hill  
 Johnson, VT 05656

**Personal Contact Information**

**Date of Birth:** \_\_\_\_\_ **Telephone (home):** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

(optional) – Do you or your family have any religious beliefs that would affect or restrict the medical assistance we provide for you if you become injured or ill while participating in athletics at Johnson State College?

Yes  No

Please explain if possible

**Father’s Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **same as above**

**Address:** \_\_\_\_\_ **same as above**

**Mother’s Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **same as above**

**Address:** \_\_\_\_\_ **same as above**

**Family Health History**

Please indicate if any of your family has had any of the following:

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Allergies				Fainting			
Anemia				Heart Disease			
Arthritis				High Blood Pressure			
Asthma				Migraine Headache			
Cancer				Kidney Disease			
High Cholesterol				Intestinal Problems			
Depression				TB/Lung Disease			
Diabetes				Stomach Disease			
Epilepsy				Stroke			
Convulsions				Heart Attack < age 50			

Anything not listed above: Yes  No

Please Explain any positive answers.

**Personal Health History**

Have you ever had or do you currently have:

	Yes	No		Yes	No		Yes	No
Anemia			Eating Problems			Sickle Cell Disease		
Arthritis			Fainting/Blackouts			Skin Trouble		
Asthma			Headaches (frequent)			Strep-throat (frequent)		
Chest Pain w/exercise			Headaches (migraine)			Tendency to bleed		
Colitis			Heart murmur			Tendency to bruise		
Convulsions			Hepatitis/Juandice			Tuberculosis		
Dental Bridges/Plates			Hernia			Tumor		
Depression			High Blood Pressure			Ulcer/Stomach or other		
Diabetes			Low Blood Pressure			Urinary Tract infection		
Dizziness w/exercise			Mononucleosis			Varicose Veins		
Ear trouble/hearing loss			Heart Palpitations			Vision Difficulties		
Gastrointestinal issues			Sinus infection (frequent)					

Others not listed? \_\_\_\_\_

Please explain any positive answers given above: \_\_\_\_\_

Do you wear contact lenses? Yes  No  Do you wear glasses? Yes  No

**Surgical History:**

Please list, giving dates and explanations, any surgeries you have had: \_\_\_\_\_

**Hospitalization History:**

Please list, giving dates and explanations, any hospitalizations you have had: \_\_\_\_\_

**Current Medications:**

Are you currently taking any medications? Yes  No

Please provide names and dosages for any medications you are taking: \_\_\_\_\_

**Allergies:** Please indicate if you have any of the following allergies:

- |                   |                          |                          |
|-------------------|--------------------------|--------------------------|
|                   | Yes                      | No                       |
| Environmental     | <input type="checkbox"/> | <input type="checkbox"/> |
| Ice (Cold)        | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex             | <input type="checkbox"/> | <input type="checkbox"/> |
| Bees/Wasps        | <input type="checkbox"/> | <input type="checkbox"/> |
| Food              | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs/Medications | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, do you have/use a bee sting kit? Yes  No

Please explain: \_\_\_\_\_

Please explain: \_\_\_\_\_

\*\*\*\*\* **Women Only: Please indicate if you have any of the following** \*\*\*\*\*

- |                   |            |           |   |
|-------------------|------------|-----------|---|
| Irregular Periods | <b>Yes</b> | <b>No</b> | What was your age at menstrual onset? _____ |
| Severe Cramps     | <b>Yes</b> | <b>No</b> |   |
| Breast Lumps      | <b>Yes</b> | <b>No</b> |   |

Excessive menstrual flow **Yes** **No**

In the past year, what was the longest time between periods? \_\_\_\_\_

Do you know, or is there any possibility that you may be pregnant? \_\_\_\_\_

Do you currently have, or have you ever had, any of the following injuries that caused you to miss at least 1 game or practice, or required X-rays or other diagnostic imaging? This information will help us better care for your injuries (present and future). Please be honest and complete to the best of your ability.

**A. Concussion (s) & / or Skull Fracture (s).** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**B. Neck Injuries (inc. burners/stingers).** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**C. Shoulder Injuries** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**D. Elbow Injuries** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**E. Wrist/Hand Injuries** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**F. Rib/Chest Injuries** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**G. Back/Spine Injuries** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**H. Hip/Thigh Injuries.** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**I. Knee/Lower Leg Injuries.** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

**J. Foot/Ankle Injuries.** Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_

Explain \_\_\_\_\_

Any special equipment/padding/braces/devises needed to participate in intercollegiate athletics at JSC?

Explain \_\_\_\_\_

**The undersigned, here with:**

- 1) Understands that if I am removed from a practice or a game or willingly leave a practice or game due to an injury or illness, that I must have appropriate medical clearance before I can return to participation;
- 2) Grants permission to JSC athletic trainers, personnel, or physicians to secure necessary and appropriate emergency and non-emergency medical care;
- 3) Understands that having passed a physical examination does not necessarily mean that s/he is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him/her at the time of said physical examination;
- 4) Certifies that the answers to the above questions are true.

<b>Emergency Contact Information</b>
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Student-Athlete's Parent/Guardian Signature if under 18 years of age: \_\_\_\_\_

Student-Athlete Name: \_\_\_\_\_ Sport: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Academic Year: FR  So  Jr  Sr 

Local (JSC) Address: \_\_\_\_\_

Residence Hall/Room #: \_\_\_\_\_

Local (JSC) Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent Name(s): \_\_\_\_\_

Parent Address: \_\_\_\_\_

Parent Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

<b>Insurance Policy Information</b>
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Policy Holder's Name: \_\_\_\_\_ Relationship to Student-Athlete: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile/Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group/Plan Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_ Expiration Date of Policy: \_\_\_\_\_

Does this insurance policy cover athletically related injuries? Yes No

Please Check One: HMO  PPO  other 

DOES THIS POLICY REQUIRE A REFERRAL FROM A PRIMARY CARE PHYSICIAN (PCP) TO SEE A SPECIALIST?

Yes  No 

Primary Care Physician (PCP): \_\_\_\_\_ Phone Number: \_\_\_\_\_

A COPY (FRONT &amp; BACK) OF CURRENT INSURANCE CARD MUST BE INCLUDED WITH THIS FORM

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if student is under 18 years): \_\_\_\_\_

Student-Athlete Name: \_\_\_\_\_ Sport: \_\_\_\_\_

**Assumption of Risk for Intercollegiate Athletic Participation**

By its nature, participation in intercollegiate athletics includes the risk of injury which may range in severity from minor to long term catastrophic, including but not limited to, permanent paralysis from the neck down and/or death. Although serious injuries are not common in supervised intercollegiate athletic activities, it is possible only to minimize, not eliminate risk. Participants can and have the responsibility to help reduce the chance of injury. Student-athletes must obey all safety rules, report all athletic injuries to the certified athletic trainers, follow a proper conditioning program and inspect all protective equipment daily. By signing this form I acknowledge that I have read and understand this warning.

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if athlete is &lt;18): \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Medical Treatment**

I hereby grant permission to the Johnson State College Athletic Training staff and team physicians to provide me with medical care in the event that I become injured while participating in intercollegiate athletics. I understand that any treatment, medical or surgical care that is provided to me will be given only when considered medically necessary for my health and well being. By signing this form, I acknowledge that I have read and understand this consent.

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if athlete is &lt;18): \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Release Information**

I hereby authorize and request JSC athletic trainers and / or their consulting physician (s) to furnish any and all requested information to their physicians, or athletic trainers, which directly pertains to my participation in athletics at JSC. Said authorization shall include, but is not limited to: information concerning my physical condition, illnesses, injuries, treatment, hospitalizations, examination, X-rays, or other forms of diagnostic testing. I hereby fully discharge all parties to whom this authorization extends from any and all penalties of breach of student-athlete confidentiality.

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if athlete is &lt;18): \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Referral and Primary Care Authorization**

Any appointment made with medical specialists (orthopedist, pedorthist, neurologist, etc.) may require a referral from the primary care physician. It is the student-athletes responsibility to acquire this referral prior to any appointment or office visit. **Johnson State College is not responsible for medical expenses incurred while participating in intercollegiate athletics.** Participation in athletics at Johnson State College is limited to student-athletes who are covered by a primary medical health insurance policy. Johnson State College Athletics does not offer medical insurance coverage to student-athletes. By signing this form, I hereby accept responsibility for obtaining all necessary referrals and understand that I am responsible for any and all charges incurred during medical treatment.

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if athlete is <18): \_\_\_\_\_ Date: \_\_\_\_\_

**For Parents**

I, \_\_\_\_\_, as parent/guardian or legal representative, attest that my son/daughter, \_\_\_\_\_, has insurance coverage under a current, in force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics.

**For Student-Athlete** (if he/she has a personal insurance policy not under a parent/guardian policy)

I, \_\_\_\_\_, attest that I have insurance coverage under a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics.

I agree to notify Johnson State College Athletic Training Department immediately if there is a material change in my insurance coverage or if there is an expiration of the coverage information that I have submitted.

**I understand and agree that Johnson State College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics.**

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if student is < 18 yrs old): \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* You must include a photocopy front/back of your current insurance card\*\***