

# Stevens Athletics Preparticipation Physical

Academic Year: <b>Fr. So. Jr. Sr.</b>					
Last Name:		First :		Sex:	Age: Date of Birth:
Sport(s):		SS#:		Cell:	Email:
Home Address:		City:		State:	Zip: (H) Ph:
Personal Physician's Name & phone:					
In case of an emergency contact (name):			Relationship:		
Ph. (H):		Ph. (W):		Cell (Ph):	

Explain "YES" answers on back.			
		Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?	Y	N
2a	Have you ever been hospitalized overnight?	Y	N
2b	Have you ever had surgery?	Y	N
3a	Are you currently taking any prescription or non-prescription (over-the-counter) medications, pills or using an inhaler?	Y	N
3b	Do you have any allergies to medicines, pollens, foods or stinging insects?	Y	N
4a	Have you ever had discomfort, pain or pressure in your chest during or after exercise?	Y	N
4b	Have you ever passed out during or after exercise?	Y	N
4c	Have you ever been dizzy during or after exercise?	Y	N
5a	Does your heart race or skip beats during exercise?	Y	N
5b	Has a doctor ever told you that you have (check all that apply) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart infection	Y	N
5c	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	Y	N
6a	Has anyone in your family died for no apparent reason?	Y	N
6b	Does anyone in your family have a heart problem?	Y	N
6c	Has any family member or relative died of heart problems or of sudden death before age 50?	Y	N
6c	Does anyone in your family have Marfan syndrome?	Y	N
7	Do you have an ongoing medical condition (diabetes or asthma)?	Y	N
8a	Has a doctor ever told you that you have asthma or allergies?	Y	N
8b	Do you cough, wheeze, or have difficulty breathing during or after exercise?	Y	N
8c	Is there anyone in your family who has asthma?	Y	N
8d	Have you ever used an inhaler or taken asthma medicine?	Y	N
9	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	Y	N
10	Have you had mononucleosis (mono) within the last month?	Y	N
11a	Do you have any rashes, pressure sores, or other skin problems?	Y	N
11b	Have you ever had a herpes skin infection?	Y	N
12a	Have you ever had a head injury or concussion?	Y	N
12b	Have you been hit in the head, confused or lost your memory?	Y	N
12c	Have you ever had a seizure?	Y	N
12d	Do you have headaches with exercise?	Y	N
12e	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	Y	N
12f	Have you ever been unable to move your arms or legs after being hit or falling?	Y	N
13	When exercising in the heat, do you have severe muscle cramps or become ill?	Y	N

Explain "YES" answers on back			
		Yes	No
14	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	Y	N
15a	Have you had any problems with your eyes or vision?	Y	N
15b	Do you wear glasses, contacts or protective eyewear such as goggles or a face shield?	Y	N
16a	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	Y	N
16b	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	Y	N
16c	Have you ever had a sprain, strain, or swelling after injury?	Y	N
16d	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: (If yes, circle body part and explain on back)	Y	N
	Head Neck Chest Shoulder Upper Arm Elbow Forearm Wrist Hand Finger Back Hip Thigh Knee Shin/Calf Ankle Foot		
16e	Have you ever had a stress fracture?	Y	N
16f	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	Y	N
16g	Do you regularly use a brace or assistive device?	Y	N
17a	Are you unhappy with your weight?	Y	N
17b	Are you trying to gain or lose weight?	Y	N
17c	Has anyone recommended you change your weight or eating habits?	Y	N
17d	Do you limit or carefully control what you eat?	Y	N
18a	Do you feel stressed out or under a lot of pressure?	Y	N
18b	Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	Y	N
19a	Have you ever tried cigarette smoking, even 1 or 2 puffs?	Y	N
19b	Do you currently smoke?	Y	N
19c	In the past 30 days, did you chew tobacco, snuff, or dip?	Y	N
20	In the past 30 days, have you had a drink of alcohol?	Y	N
21a	Have you ever taken steroid pills or shots without a doctor's prescription?	Y	N
21b	Have you ever taken any supplements to help you gain or lose weight or improve your performance?	Y	N
22	Do you have any concerns that you would like to discuss with a doctor?	Y	N
<b>FEMALES ONLY</b>			
23	When was your first menstrual period? _____		
24	How many periods have you had in the last 12 months? _____		

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Date:    /    /

**Signature of athlete:**

## PHYSICAL EXAM

FR. PPE / JR. PPE / FOLLOW-UP/ TRANSFERS: \_\_\_\_\_

Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BF%: \_\_\_\_\_ cal/imp Vision: R 20/\_\_\_\_ L20/\_\_\_\_ cor/un

BP: \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_ P: \_\_\_\_\_

<b>MEDICAL</b>	<b>NL</b>	<b>ABNORMAL</b>
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Appearance		
HEENT		
Nodes		
Cardio		
Lungs		
Abdomen		
Skin		
G/U		
Pulses		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder		
Elbow/Hand		
Hip/Thigh		
Knee		
Leg/Ankle/Ft		
Other		



**STEVENS INSTITUTE OF TECHNOLOGY  
OFFICE OF SPORTS MEDICINE  
TREATMENT CONSENT FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sport(s) \_\_\_\_\_

**CONSENT:**

By signing below, I hereby give my consent for routine health examinations, diagnostic procedures, treatment of illnesses and/or injuries, or emergency medical treatment by the team physician, referred physicians, Office of Sports Medicine Staff, and other emergency facilities as indicated. In addition, permission is granted for the Team Physician or other specialized physicians to perform warranted surgical procedures at designated emergency facilities in the event I suffer an injury and/or illness and I am unable to make such a decision myself as a result of the injury and/or illness.

\_\_\_\_\_  
Signature of student-athlete

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of parent/guardian (minors)

Date \_\_\_\_\_

The following information outlines Stevens Institute of Technology's policy regarding medical claims for injuries sustained during supervised athletic practices, contests, or strength and conditioning sessions. **Please read carefully and sign at the bottom verifying that you have read and fully understand this information.**

- It is mandatory for all students to have medical insurance coverage before enrolling in classes at Stevens. All students will be billed on their tuition statement for a medical insurance plan. Students who do not wish to purchase this plan must show proof of coverage through another plan. **Student-athletes are strongly encouraged to purchase the Stevens plan as secondary coverage.** An outline of this coverage is available on-line at [www.universityhealthplans.com](http://www.universityhealthplans.com). \_\_\_\_\_(initial)
- The NCAA does not permit any college or university, to provide insurance coverage or pay bills for injuries or illnesses that are not a direct result of supervised athletic practices, contests, or strength and conditioning sessions. \_\_\_\_\_(initial)
- Primary coverage for injuries or illnesses is through the student-athlete's family insurance plan, or through the plan that may be purchased through Stevens. \_\_\_\_\_(initial)
- The Stevens Department of Athletics provides secondary athletic accident coverage for student athletes who are injured during participation in their particular sport. The athletic accident policy has a \$2,000 deductible which must be met before the policy will cover any outstanding charges not covered by the student-athlete's primary insurance plan. Any charges not covered by the student athlete's primary insurance policy will be the responsibility of the student-athlete, up to \$2,000. \_\_\_\_\_(initial)
- If a balance remains after the primary insurance coverage or you receive a letter of denial with no payment made from your primary insurance, mail or fax the explanation of benefits (EOB) from the insurance company and a copy of the itemized bill (HCFA-1500 or UB92 form) to:

Alison Bewalder, Head Athletic Trainer  
Stevens Institute of Technology Athletics  
1 Castle Point on Hudson  
Hoboken, NJ 07030  
Fax: 201-216-8532

It is the responsibility of the parent and student-athlete to submit all required paperwork as soon as possible. All forms must be received within 12 months of the original date of service. If you have any further questions please do not hesitate to contact the Office of Sports Medicine at (201) 216-5695. It is also the responsibility of the student-athlete and parents/guardians to inform the Office of Sports Medicine of any changes in your insurance coverage during the course of the school year. Failure to do so will result in your financial responsibility for any unpaid balances.

I have read the above information and understand completely the Stevens Athletic Insurance Policy. Signature \_\_\_\_\_ Date \_\_\_\_\_

**STEVENS INSTITUTE OF TECHNOLOGY  
OFFICE OF SPORTS MEDICINE  
INSURANCE QUESTIONNAIRE**

Name \_\_\_\_\_ Sport(s) \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Campus Address \_\_\_\_\_  
Campus Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Campus Email Address \_\_\_\_\_

**Person to Contact in Case of Emergency**

Name \_\_\_\_\_ Relationship to student \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_

Parents Contact Information

Father's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS # \_\_\_\_\_  
Home Phone(\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_  
Home Address \_\_\_\_\_  
Mother's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS # \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_  
Home Address \_\_\_\_\_

**PLEASE PROVIDE FRONT AND BACK COPIES OF MEDICAL INSURANCE CARD,  
DENTAL INSURANCE CARD, AND PRESCRIPTION CARDS**

**Primary Insurance Company Information**

Circle Type:      REGULAR      HMO      PPO      POS      OTHER \_\_\_\_\_

*Does your insurance require a referral to see a specialist, for testing, etc.?*       Yes    No

Primary Insurance Company Name \_\_\_\_\_  
Insurance Company Phone (\_\_\_\_) \_\_\_\_\_ Expiration Date \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Subscriber's Name \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_  
Insurance Subscriber's Date of Birth \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**Are you enrolled in the Consolidated Health Insurance Plan offered by Stevens?**       Yes  
   No

**If Yes, Please provide ID #** \_\_\_\_\_

**Stevens Institute of Technology**  
**Department of Physical Education, Athletics, and Recreation**  
**Student-Athlete Authorization/Consent for Disclosure of**  
**Protected Health Information**

\_\_\_\_\_ I hereby authorize the physicians, athletic trainers, sports medicine staff and other healthcare professionals representing Stevens Institute of Technology and the Stevens Institute of Technology Department of Physical Education, Athletics, and Recreation to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. I understand that if my record contains information containing treatment for abuse physical and/or mental or drug/alcohol treatment, such information will be released pursuant to this consent. This protected health information may be released pursuant to this consent. This protected health information may be released to other health care providers, parents/guardians, hospital and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

If the requested portion of the record contains information pertaining to the treatment for abuse, physical and/or mental illness, drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing the following:

\_\_\_\_\_ I understand that if my record contains **information concerning treatment for abuse, physical and/or mental or drug/alcohol treatment**, such information will be released pursuant to this consent.

\_\_\_\_\_ I understand that if my record contains **confidential HIV related information**, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate student athlete for Stevens Institute of Technology. I understand that my protected health information is protected by federal regulations under either the Health Insurance Portability and Accountability Act(HIPAA) or the Family Educational Rights and Privacy Act of 1974(Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once this information is disclosed per my authorization/consent, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Head Athletic Trainer, but if I do, it will not have any effect on the actions Stevens Institute of Technology and the Department of Athletics took in reliance on this authorization/consent prior to receiving this revocation. I also understood that revocation of this authorization/consent may affect my athletic eligibility. This authorization/consent expires six (6) years from the date it is signed.

\_\_\_\_\_  
Name of Student Athlete

\_\_\_\_\_  
Signature of Student Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Parent/Legal Guardian(if under 18)

\_\_\_\_\_  
Date