



Athletic and Activities Pre-Participation Forms

Dear Parent and Student-Athlete,

According to NCAA Guideline 1B, "A pre-participation medical evaluation should be required upon a student-athlete's entrance into the institution's intercollegiate athletics program."

In addition to following these guidelines, St. Edward's University is committed to providing the most appropriate healthcare to each student-athlete. The following paperwork must be completed before a student may participate in an Athletics program:

1. Athletic and Student Activities Information Form
2. Insurance Information Form (attach current health insurance identification card)
3. Pre-Participation Physical Evaluation: Medical History Form
4. Pre-Participation Physical Evaluation: Physical Examination Form (to be completed by team physician upon arrival at St. Edward's University)
5. Athletics-Sponsored Insurance and Medical Referral Guidelines
6. Athletics Medical Treatment and Information Authorization Form

After the first year, each student-athlete will need to complete the following paperwork on an annual basis:

1. Athletic and Student Activities Information Form
2. Insurance Information Form with a current health insurance card attached
3. Pre-Participation Physical Evaluation: Medical History Form
4. Pre-Participation Physical Evaluation: Physical Examination Form*
5. Athletics-Sponsored Insurance and Medical Referral Guidelines
6. Athletics Medical Treatment and Information Authorization Form

**Another physical evaluation by the team physician will only need to be completed if the student-athlete has sustained a significant injury or illness during the season to re-establish medical clearance before resuming participation.*

PLEASE RETURN PAPERWORK TO:

Lisa Lowe
Head Athletic Trainer
St. Edward's University
3001 South Congress Avenue
Austin, Texas 78704

Athletic and Student Activities Information Form

Name: _____

Student ID Number: _____ Classification: Fr. So. Jr. Sr. 5th Yr. Sr. Grad Student

Date of Birth: _____ Age: _____

E-mail: _____

Emergency Contact: _____ Relationship: _____

Address: _____

City & State: _____ Zip: _____

Phone: _____

Parent(s)/Guardian(s): _____

Address (if different from above): _____

Phone Numbers: Work _____ Home _____ Cell _____

E-mail: _____

Student's Local Address: _____

City & State: _____ Zip: _____

Local Phone: _____ Cell Phone: _____

Residence Hall: _____ Room: _____ Apt. #: _____

Please check all that apply:

Men's Sports

- ___ Baseball
- ___ Basketball
- ___ Golf
- ___ Soccer
- ___ Tennis

Women's Sports

- ___ Basketball
- ___ Golf
- ___ Soccer
- ___ Softball
- ___ Tennis
- ___ Volleyball

Co-Ed

- ___ Cheerleading

Insurance Information Form

Name: _____ Social Security Number: _____

Select One:

_____ I am enrolling and purchasing student insurance offered by St. Edward's University.

_____ I am enrolled in a parent's or guardian's individual insurance plan.

Insurance Policy Holder Information:

Policyholder: _____ Social Security Number: _____

Date of Birth: _____ Relationship to Student: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Insurance Information:

Policyholder's Employer: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Type: HMO _____ PPO _____ Other _____ If "other," describe: _____

HMO/PPO Physician: _____ Phone: _____ Effective Dates: _____

Group Number: _____ Insured's ID #: _____ Policy #: _____

Please attach a clean copy of the FRONT and BACK of the insurance card to this page:

I, _____, verify that all insurance information and copy of the insurance card provided is correct and current. If anything should change, I will inform the SEU Athletic Training Staff (512-448-8498) as soon as possible and provide a copy of the new insurance card.

Signature of policyholder

Date

Pre-Participation Physical Evaluation: Medical History Form

This form must be completed annually in order to participate in athletic activities. The questions are designed to determine if the student-athlete has any condition that would make it hazardous to participate in an athletic event.

Name: _____ Age: _____ Date of Birth: _____

Personal Physician: _____ Phone: _____

Explain "yes" answers on next page. Circle questions you do not understand.

| | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last check-up or sports physical? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized overnight in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently taking any prescriptions or non-prescription (over the counter) medications or pills, or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies (pollen, medicine, food or stinging insects)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you get tired more quickly than your friends do during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had high blood pressure or high cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been told you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative died of heart problems or of sudden unexpected death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has any family member been diagnosed with enlarged heart, hypertrophic cardiomyopathy, long QT syndrome, Marfan's syndrome or abnormal heart rhythm? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you had a severe viral infection (example: myocarditis or mononucleosis) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has a physician ever denied or restricted your participation in sports for any heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have any current skin problems (example: itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been knocked out, lost consciousness, or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how many times? _____ | | |
| When was your last concussion? _____ | | |
| How severe was each one? (Explain below) | | |
| Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |

| | Yes | No | | |
|---|--------------------------|--------------------------|--------|---------|
| 19. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 20. Have you ever gotten unexpectedly short of breath with exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Do you cough, wheeze, or have trouble breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Do you have seasonal allergies that require medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 21. Have you had any problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 22. Are you missing any paired organ? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 23. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 24. Have you ever had a sprain, strain or swelling after injury? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Have you broken or fractured any bones or dislocated any joints? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| If yes, circle appropriate area and explain below: | | | | |
| Head | Elbow | Hip | Neck | Forearm |
| Thigh | Back | Wrist | Knee | Chest |
| Hand | Shin/Calf | Shoulder | Finger | Ankle |
| Upper Arm | Foot | | | |
| 25. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Do you fear becoming fat? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Have you made repeated attempts to diet or restrict your eating? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Do you feel fat even though family and friends say you are not? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 26. Do you feel stressed out? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 27. Are you under a doctor's care? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Females only | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 28. 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? _____ | | | | |

Pre-Participation Physical Evaluation: Physical Examination Form

Name: _____ Age: _____ Date of Birth: _____

Physical Examination:

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

| Medical | Normal | Abnormal Findings | Initials* |
|---|--------|-------------------|-----------|
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart Auscultation in the supine position | | | |
| Heart Auscultation in the standing position | | | |
| Heart – Lower extremity pulse | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Skin | | | |
| Musculoskeletal | Normal | Abnormal Findings | Initials* |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

Physician’s Recommendation for Collegiate Physical Activity:

- ___ 1. There are no history or findings on exam that would prohibit this student from participating in athletics and/or club activities.
- ___ 2. This student should have the following health problems evaluated or treated prior to participation in athletics and/or club activities: _____
- ___ 3. The following health problems would prohibit this student from participation in athletics and/or club activities: _____

| |
|--|
| Physician’s Signature: _____ Date: _____ |
| Printed Name: _____ |
| Address: _____ |
| Physician’s Phone: _____ |

Athletics-Sponsored Insurance and Medical Referral Guidelines

Name: _____ Date of Birth: _____

St. Edward's University endeavors to conduct its athletic programs in a manner which is consistent with the highest standards of safety. However, intercollegiate sports by their very nature involve the risk of personal injury, which in some cases may be serious or even catastrophic. Therefore, as a willing participant in any college athletic program, there is a personal assumption of risk on your part.

Student-athletes participating in the intercollegiate athletics program at St. Edward's University are hereby advised to the following. The university provides secondary medical coverage for all student athletes with the following limitations and stipulations:

1. Coverage applies only to injuries sustained during participation in scheduled and supervised intercollegiate athletic events or travel related thereto. It provides **no coverage** for sickness or disease in any form.
2. The university requires all students to maintain and show proof of medical health insurance for the academic year. It is the responsibility of each student-athlete to have in force personal medical health insurance or to enroll in the university's student insurance plan. All international student-athletes **must purchase** the university's student insurance plan. The university will not cover any student-athlete who does not maintain a primary health care plan.
3. It is the responsibility of the student-athlete to confirm that chosen medical health insurance includes athletic injuries. Health Maintenance Organization (HMO) plans and certain health insurance policies exclude athletic injuries. Should this be the case, the student-athlete must enroll in the university offered health plan.
4. It is the responsibility of the student-athlete to abide by all rules and regulations that are stated in their policy. In the event that you are covered by an HMO that is located outside Austin, be advised that you must still abide by the policies of the HMO. This could necessitate travel outside the area for medical, surgical and rehabilitative services. If this is not feasible due to distance, the athlete must enroll in the university offered health plan, or become personally liable for all medical debts incurred. Be advised with some HMOs, you may be able to change the service area.
5. The university provides quality care for all athletic injuries through its network of sports medicine providers. It is the responsibility of the student-athlete to report all injuries to the athletic training staff as soon as they occur. Student-athletes will be evaluated and treated for the condition, as well as referred for specialty consultations. Student-athletes have 60 days to request a medical consultation.
6. All injuries needing medical attention must be referred by a university athletic trainer. Do not seek treatment for any injury without first consulting with one of the university's athletic trainers. Student-athletes will be evaluated and treated for the condition, as well as referred for specialty consultations. Seeking initial treatment for any athletic injury without first consulting one of the university's athletic trainers will void existing secondary excess coverage. In seeking treatment without a referral the student-athlete will assume the cost of any medical expenses incurred as a result of their injury.
7. It is the responsibility of the student-athlete to provide the university with any billing statements they may receive in error. The student-athlete must also provide the university with the Explanation of Benefits documents, or EOB, from their primary insurance company that coincide with the billing statements. Without this paperwork, the university's secondary insurance policy will be unable to take effect. Student-athletes have 120 days from the primary insurance company payment date to provide the university with a billing statement and EOB for payment. Student-athletes who fail to provide the necessary paperwork will assume the cost of any medical expenses incurred as a result of their injury. For personal credit purposes, please provide the billing statements and EOBs as soon as possible to the university.
8. Secondary coverage by the university provides coverage for office visits, diagnostic medicine, specialty consultations, physician-prescribed second opinions and other usual, customary, and reasonable options prescribed as a necessity by the physician. The university does not cover the following:
 - a. Contact lenses or glasses
 - b. Orthotics (unless dictated by initial injury)
 - c. Dental (unless dictated by injury)
 - d. Physical therapy (unless prescribed by a physician)
 - e. Unauthorized second opinions
 - f. Chronic injuries or re-injuries
9. Secondary coverage by the university provides payment for usual, customary and reasonable charges up to two years from date of onset of condition.

Student-Athlete's Signature

Date

Parent's Signature (If student-athlete is under 18.)

Date

Athletics Medical Treatment and Information Authorization Form

Name: _____ Date of Birth: _____

MEDICAL TREATMENT INFORMATION AUTHORIZATION

I hereby give my permission for any hospital and its agents or a licensed physician and his/her agents to administer any necessary medical treatment to the above named student-athlete in the event of illness and/or injury. Furthermore, I hereby authorize any insurance company, hospital, physician, other care provider or St. Edward's University to disclose or secure copies of all information and records with respect to any injury, medical history, consultation, prescription, treatment and insurance policy coverage of the named athlete. A photocopy of this authorization shall carry the same validity as the original.

I also understand and agree that St. Edward's University, Athletics and its employees will neither accept responsibility nor be held responsible for injuries and illness that occurred prior to commencement of athletic participation at St. Edward's University or injuries and illness not directly the result of an accident during my athletic participation at St. Edward's University.

I also understand that the secondary coverage is provided, but will not cover any conditions unrelated to athletic participation or an athletic sponsored/authorized event, and will pay a claim ONLY after the primary insurance listed above has been utilized. I also understand that seeking medical attention without following the referral procedures from Athletics will void my secondary coverage and makes all charges become the responsibility of the insured. I also understand that falsifying insurance information or failing to provide medical information may delay the claims process and result in all charges becoming the responsibility of the insured.

Student-Athlete's Signature

Date

Parent's Signature (If student-athlete is under 18.)

Date