

Dear Parents and Student-Athlete:

Welcome to Stevens Athletics. Please pay close attention to the pre participation physical protocol for **varsity athletes** because it has changed this year. All student athletes are required to fill out paperwork but beginning in the fall of 2007, **only incoming freshmen, transfers, and 3<sup>rd</sup> year student athletes** will need a physical from their primary care physician.

**If you are a freshmen, transfer, 3<sup>rd</sup> year student athlete, please follow these instructions:**

Please have your primary care physician fill out the Supplemental Medical History for Varsity Athletes. You are also required to sign the treatment consent form, insurance questionnaire, and HIPAA forms. These forms must be filled out **in their entirety** and returned to the Athletic Training Office no later than **August 1**. **Failure to return these forms by this date will delay your medical clearance to practice and/or compete.**

**If you are a 2<sup>nd</sup>, 4<sup>th</sup> or 5<sup>th</sup> year student athlete, please follow these instructions:**

Please fill out the medical history update, treatment consent form, insurance questionnaire and HIPAA forms. These forms must be filled out **in their entirety** and returned to the Athletic Training Office no later than **August 1**. **Failure to return these forms by this date will delay your medical clearance to practice and/or compete**

Please return completed forms to:

Nicole Castellano, Head Athletic Trainer  
Schaefer Athletic Center  
Stevens Institute of Technology  
1 Castle Point on Hudson  
Hoboken, NJ 07030

Thank you for your cooperation in this matter. Should you have any questions or concerns regarding any of these procedures, please feel free to contact the Athletic Training Office at (201)216-5695.

Sincerely,

Stevens Institute of Technology Athletic Training Staff

**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 from the insurance company and a copy of the itemized bill to:

Nicole Castellano, Head Athletic Trainer  
Stevens Institute of Technology  
1 Castle Point on the Hudson  
Hoboken, NJ 07030  
Fax: 201-216-8532

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

Academic Year as of Sept 2007

1 2 3 4 5

Please Print

Name: \_\_\_\_\_ Address \_\_\_\_\_

Sport(s): \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_\_

Cell Ph.: \_\_\_\_\_ Email: \_\_\_\_\_ I.D.: \_\_\_\_\_

INSTRUCTIONS (PLEASE READ CAREFULLY): The purpose of this form is to evaluate your health history since your last pre-participation exam. For example, we are interested in any injury or illness, whether it has resolved or not, especially if it is still an issue. A full explanation may prevent us from having to call you into the office and delay your participation. Please use the back of this form to explain your answer completely.

- 1. Have you ever had a pre-participation physical exam at the Sports Medicine Office. YES NO
2. Do you have any chronic illness or injury that requires ongoing or periodic medical supervision, medication, or other therapy (e.g. asthma, diabetes, or heart condition)? Please list condition and required supervision. (on the back) YES NO
3. Are you presently using any medications or pills (including non-prescription meds, vitamins, supplements, herbs, inhalers, contraceptives, or creams). Please list with name, dose, and how often you use them. (on the back) YES NO
4. Since your last medical exam, have you passed out during exercise or stopped because of dizziness? Please explain. (on the back) YES NO
5. Have you had any injuries during the last academic year which limited your ability to participate in athletics. If so, please circle the body part(s) and explain on the back of this form. Include whether the injury listed was evaluated by our staff at Stevens, and if you are recovered. YES NO

FOOT / ANKLE / LEG / KNEE / HIP / BACK / NECK / SHOULDER / HEAD / ARMS / HANDS

- 6. Have you suffered any other illnesses or significant symptoms since your last exam? Please explain. (on the back) YES NO
7. Do you have any concerns or questions about your health? Please explain (on the back) YES NO
8. FEMALES ONLY: Have you missed more than 3 menstrual periods in the past 12 months? Please explain. (on the back) YES NO
9. Has your Health Insurance Coverage changed during this past year? If yes please submit copies of the front and back of each card changed. YES NO

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

(Signature of Athlete): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Trainer Use Only:

Requires a physical exam prior to participation: YES NO Reviewed by: \_\_\_\_\_ (initials) Date \_\_\_/\_\_\_/\_\_\_

OFFICE USE ONLY:

Requires a physical exam prior to participation: YES NO Reviewed by: \_\_\_\_\_ (initials) Date \_\_\_/\_\_\_/\_\_\_

STEVENS PRE-PARTICIPATION PHYSICAL QUESTIONNAIRE										Date of Exam: _____							
Last		First															
Name:				Sex:		Age:		Date of Birth:									
Sport(s):				SS#:		Campus Ph:		Cell Phone:									
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 Phone:									
				Yes		No						Yes		No			
<b>Explain "YES" answers on back.</b>																	
Circle questions you don't know the answers to.																	
<b>1</b>		Have you had a medical illness or injury since your last check up or sports physical?				<input type="checkbox"/>		<input type="checkbox"/>		<b>11</b>				<input type="checkbox"/>		<input type="checkbox"/>	
<b>2</b>		Have you ever been hospitalized overnight?				<input type="checkbox"/>		<input type="checkbox"/>		Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?							
<b>3</b>		Have you ever had surgery?				<input type="checkbox"/>		<input type="checkbox"/>		<b>12</b>				<input type="checkbox"/>		<input type="checkbox"/>	
		Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?				<input type="checkbox"/>		<input type="checkbox"/>		Do you wear glasses, contacts or protective eyewear?				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?				<input type="checkbox"/>		<input type="checkbox"/>		<b>13</b>				<input type="checkbox"/>		<input type="checkbox"/>	
<b>4</b>		Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?				<input type="checkbox"/>		<input type="checkbox"/>		Have you ever had a sprain, strain, or swelling after injury?				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had a rash or hives develop during or after exercise?				<input type="checkbox"/>		<input type="checkbox"/>		Have you broken or fractured any bones or dislocated any joints?				<input type="checkbox"/>		<input type="checkbox"/>	
<b>5</b>		Have you ever passed out during or after exercise?				<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"/>	
		Have you ever been dizzy during or after exercise?				<input type="checkbox"/>		<input type="checkbox"/>		If yes, check appropriate box and explain on back.				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had chest pain during or after exercise?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Head				<input type="checkbox"/>		<input type="checkbox"/>	
		Do you get tired more quickly than your friends do during exercise?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Neck				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had racing of your heart or skipped heartbeats?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Elbow				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you had high blood pressure or high cholesterol?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Forearm				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever been told you have a heart murmur?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Hip				<input type="checkbox"/>		<input type="checkbox"/>	
		Has any family member or relative died of heart problems or of sudden death before age 60?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Thigh				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Back				<input type="checkbox"/>		<input type="checkbox"/>	
<b>6</b>		Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Wrist				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had a head injury or concussion?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Knee				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever been knocked out, become unconscious, or lost your memory?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Chest				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had a seizure?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Hand				<input type="checkbox"/>		<input type="checkbox"/>	
		Do you have frequent or severe headaches?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Shoulder				<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"/>		<input type="checkbox"/> Finger				<input type="checkbox"/>		<input type="checkbox"/>	
		Have you ever had a stinger, burner, or pinched nerve?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Ankle				<input type="checkbox"/>		<input type="checkbox"/>	
<b>8</b>		Have you ever become ill from exercising in the heat?				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Foot				<input type="checkbox"/>		<input type="checkbox"/>	
<b>9</b>		Do you cough, wheeze, or have trouble breathing during or after activity?				<input type="checkbox"/>		<input type="checkbox"/>		<b>14</b>				<input type="checkbox"/>		<input type="checkbox"/>	
		Do you have asthma? REGULAR or EXERCISED INDUCED				<input type="checkbox"/>		<input type="checkbox"/>		Do you want to weigh more or less than you do now?				<input type="checkbox"/>		<input type="checkbox"/>	
		Do you have seasonal allergies that require medical treatment?				<input type="checkbox"/>		<input type="checkbox"/>		Do you lose weight regularly to meet weight requirements for your sport?				<input type="checkbox"/>		<input type="checkbox"/>	
<b>10</b>		Do you have any chronic illness or injury that requires ongoing or periodic medical supervision, medication, or other therapy (eg. Asthma, diabetes, or heart condition)?				<input type="checkbox"/>		<input type="checkbox"/>		<b>15</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Do you feel stressed out?				<input type="checkbox"/>		<input type="checkbox"/>	
										<b>16</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Record the dates of your most recent immunizations (shots) for:							
										Tetanus: _____ MMR 1: _____ MMR 2: _____							
										Hepatitis B 1st: _____ 2nd: _____ 3rd: _____ Chickenpox: _____							
										<b>17</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										When driving or riding in a car, what % of the time do you wear a seatbelt? _____							
										<b>18</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										If sexually active, what method of contraception do you use? _____							
										<b>19</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Do you perform regular testicular self exams (males)? _____							
										<b>20</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Do you use any: Tobacco/Chew/Snuff? _____							
										Alcohol? _____							
										Medicines not prescribed by a doctor? _____							
										<b>21</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Are there any firearms where you live? _____							
										<b>22</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Do you have any questions about your health? _____							
<b>FEMALES ONLY</b>																	
										<b>23</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										When was your first menstrual period? _____							
										<b>24</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										When was your most recent menstrual period? _____							
										<b>25</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										How much time do you usually have from the start of one period to the start of another? _____							
										<b>26</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										How many periods have you had in the last 12 mos? _____							
										<b>27</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										What was the longest time between periods in the last 12 mos? _____							
										<b>28</b>				<input type="checkbox"/>		<input type="checkbox"/>	
										Do you perform regular breast self exams? _____							
<b>Explain "YES" answers on back</b>																	
<b>I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.</b>																	
Signature of athlete:										Date: / /							
Signature of parent/guardian (if under 18)										Date: / /							

## PHYSICAL EXAM

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

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

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

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

MEDICAL	NL	ABNORMAL
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		