MEDICAL HISTORY
HANOVER COLLEGE SPORTS MEDICINE

Name____ Date___________________________

Sport (s)______________________________ Participation Year: ☐ Fr ☐ SO ☐ JR ☐SR

Birthdate: __________________ Sex: _____F _____M Soc. Sec. #_________________

In order to provide quality care it is important that all questions be answered completely.
This information will be kept confidential.

Do you have now or have you had in the past problems with the following:

	YES	NO		YES	NO
Scarlet Fever	☐	☐	Insomnia	☐	☐
Measles	☐	☐	Thyroid disorder	☐	☐
German Measles	☐	☐	Gallbladder Trouble	☐	☐
Mumps	☐	☐	Stomach or Intestinal Trouble	☐	☐
Chicken Pox	☐	☐	Tooth/Gum Trouble	☐	☐
Malaria	☐	☐	Ear Trouble	☐	☐
Rheumatic Fever	☐	☐	Nose Trouble	☐	☐
Tuberculosis	☐	☐	Throat Trouble	☐	☐
Mononucleosis	☐	☐	Hepatitis	☐	☐
Jaundice	☐	☐	Recurrent Headache	☐	☐
Epilepsy	☐	☐	Recurrent Colds	☐	☐
Diabetes	☐	☐	Recurrent Diarrhea	☐	☐
Hay Fever	☐	☐	Recent Gain/Loss Weight	☐	☐
Asthma	☐	☐	Chronic Fatigue	☐	☐
Heart Murmur	☐	☐	Night Sweats	☐	☐
Convulsions	☐	☐	Shortness of Breath	☐	☐
Tumor	☐	☐	Pain/Pressure in Chest	☐	☐
Cyst	☐	☐	Heart Palpitations	☐	☐
Cancer	☐	☐	High/Low Blood Pressure	☐	☐
Kidney Disease	☐	☐	Chronic Cough	☐	☐
Arthritis	☐	☐	Heat Illness	☐	☐

Staff Use Only:

Height__________ Weight__________ B/P__________ Pulse__________

Wearing Contacts: Yes_____ No_____ Vision: Right_______ Left__________

R L

Ham P/F Ham P/F
Quad P/F Quad P/F

Do you have allergies to:	**YES**	**NO**	**Have you had surgery for:**	**YES**	**NO**
Penicillin	☐	☐	Appendix	☐	☐
Sulfamides	☐	☐	Tonsils	☐	☐
Serum	☐	☐	Hernia	☐	☐
Aspirin	☐	☐	Other (List Below)	☐	☐

Females: Do you have…			**Are you taking any medication:**		
Irregular Periods	☐	☐	i.e. aleve	☐	☐
Severe Cramps	☐	☐	Birth Control	☐	☐
Excessive Flow	☐	☐			
Endometriosis	☐	☐			
Amenorrhea	☐	☐			

Has any person in your family died before the age of 40? ☐ ☐

What relationship were they and list the cause of death:

*Mother*__________________________ *Father*__________________________

*Brother*__________________________ *Sister*___________________________

*Grandparents*____

List any medication(s) you are currently taking, including the birth control pill:

IF YOU ANSWERED **YES** IN ANY OF THE ABOVE AREAS PLEASE GIVE DETAILS BELOW. INCLUDE APPROXIMATE DATE OF PROBLEM.

Answer all of the following questions concerning your medical history. Please include the name of the doctor (if known), the date of the injury, the specifics of the injury, and any other pertinent information (surgery, restrictions, braces, etc.).

	YES	NO
Have you ever had a head injury? (Bell rung, concussion, etc.)	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a neck injury? (Fractures, burners, etc.)	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe shoulder injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe elbow or wrist injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe hand or finger injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe low back or trunk injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe thigh or hip injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe knee injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

Have you ever had a moderate or severe foot or ankle injury?	☐	☐

What_______________________________________
When______________________________________
Doctor_____________________________________
Comments____

	YES	NO
Have you ever had an injury that has caused you to be hospitalized or have surgery? If YES, please explain.	☐	☐

____
____
____

Have you ever worn any type of braces or specialized equipment to protect or prevent an injury? If YES, please explain.	☐	☐

____
____
____

Have you ever had shin splints?	☐	☐
Do you wear orthotics?	☐	☐
Do you have any foot condition we should be aware of?	☐	☐

Explain____
____

List any fractures/brakes. Include right or left side.

____

Do you have a pin, screw, staple, button or plate somewhere in your body as a result of surgery? If YES, please explain.	☐	☐

____

List any other information concerning your medical history that the Sports Medicine staff should be aware of?

____
____
____

I verify by my signature below, that the information given is complete and accurate to the best of my knowledge. If the above information changes I am responsible for updating my medical file by contacting the Head Athletic Trainer or Team Physician.

______________________________ ______________________

Student Signature Date

INSURANCE QUESTIONNAIRE

The Acknowledgement of Insurance Requirements must be read and understood and this form completed **PRIOR** to the student-athlete participating in practice and/or competition.

Student's Name____ Soc.Sec. #_______________________
Sport(s)_________________ Year in School: FR SO JR SR Date of Birth_____________ Gender M F
Street Address ____ Phone #______________________
City, State and Zip __________________________________ Cell # _______________________

FATHER

Name_________________________________
Soc.Sec.#_______________________________
Employed: ____Yes ____No
Employer______________________________
Work Phone ___________________________

MOTHER

Name____
Soc.Sec.#____
Employed: ____Yes ____No
Employer____
Work Phone____

Insurance Information

Policy Holder Name ____
Relationship to Student Athlete ____
Insurance Company Name____
Insurance Company Address ____
____
Policy or ID # ____________________ Group # __________________________
Insurance Company Phone # ______________________ Benefit phone # ____________________
Primary Physician Name __________________________Office number _____________________
Is pre-authorization required for non emergency procedures? _________yes _________ no
Does the policy cover athletically-related injuries? _________yes _________ no

I, ____, attest that I have insurance coverage under a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics. If there is a change in coverage or expiration of coverage, I agree to notify Hanover College of this development and update the insurance information I have on file with Hanover College Sports Medicine.

I/WE further agree that all information provided in this document is accurate and complete.

I/WE UNDERSTAND THAT I/WE are responsible for filing all claims associated with athletic injuries within 3 months of incurring the first bill. I/WE also understand that I am financially responsible for all uncovered claims.

Student/Athlete ____ Date___________________

Parent/Guardian ____ Date___________________
(Required if student is under the age 18)

CONSENT FOR TREATMENT

In the event of a medical or surgical need for the undersigned student while he or she is a student-athlete at Hanover College, I/we hereby authorize the performance upon said student-athlete of such medical or surgical procedures as may be prescribed by a physician licensed to practice medicine and surgery.

STUDENT SIGNATURE ____ Date ____________________

PARENT/GUARDIAN SIGNATURE______________________________ Date ___________________
(Required if student is under the age 18)

Acknowledgement of Receipt

I acknowledge receiving a copy of Hanover College's Athletic Injury and Medical Policy Guidelines. I understand the College's responsibility to a student who becomes injured as result of participation in intercollegiate sport. **I also understand that the Team Physician or his delegate has the final say as to participation status.**

STUDENT/ATHLETE
SIGNATURE____ Date____________

PARENT/GUARDIAN SIGNATURE_____________________________________ Date____________
(Required if student is under the age 18)

YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD AND THE COMPLETED EMERGENCY CONTACT AND INSURANCE INFORMATION FORM.

Permission to Release Information

Because of the Health Information Portability and Accountability Act (HIPAA) privacy rule which went into effect April, 14, 2003, we (Hanover College Sportsmedicine) are now required to obtain your permission to release information regarding your care and playing status.

In an effort to provide you with the best possible medical coverage, there may be times when your medical information will need to be shared with other designated medical providers such as: the team physicians, team dentist, team optometrist, staff physical therapist, staff certified athletic trainers and college nurse practitioner. **NOTE:** ***Release of information to providers outside the Hanover College network of providers, will require a separate release form.***

In addition to the medical providers, your head coach will need to know your capacity to participate in practices and competitions. Since your personal medical information is and will always be considered confidential only the most basic information will be shared with your head coach. However, once this information is release to your coach, it may no longer be protected under HIPAA.

I, ___________________________ understand the conditions
(Print Full Legal Name)
in which my personal medical information will be released and give permission to the Hanover College Sportsmedicine department to release this information to the designated parties involved in my medical care.

This authorization is good for the remainder of your Hanover College athletic career.

In addition, I understand that at anytime I can withdraw this blanket release so long as it is done in writing. My refusal to sign or withdrawal of permission will not be grounds for denial of treatment by the Hanover College Sportsmedicine staff.

____ ___________
(Signature) (Date)

____ ___________
(Parents signature if minor) (Date)

____ ___________
(Witness Signature) (Date)

6/27/2007