

Instructions: We require you to complete this medical history form and return it to the Athletic Training Department prior to participation.
Please Print:

Name: *Last* *First* *M.I.* *Telephone Number*

Local address/Street *City* *State/Zip*

Month/Day/Year of Birth *Single/Married* *Social Security Number*

In an emergency notify: Name/Relationship *Address* *Telephone Number*

Personal Physician *Address* *Telephone Number*

Hospital Preference (If a local Student-Athlete)

Insurance Company Name: _____

Group Name: _____ **Group Number:** _____

Name of Insured: _____

Social Security # relationship

Personal Health History

Please check if you have had any of the following. Give date of illness, operation, or injury, and date of last treatment.

Alcohol Abuse	Ear trouble	Meningitis
Amnesia	Eating disorder	Menstrual problems
Appendicitis	Encephalitis	Migraine headaches
Asthma	Exercise Induced Asthma	Mumps
Birth Defects	Eye trouble	Nervous/Mental condition
Blood Clots	Fainting	Pneumonia
Bronchitis	Frequent headaches	Recurrent headaches
Cancer	Gall Bladder trouble	Rheumatic fever
Car or Air Sickness	Hearing defect/loss	Rubella
Chest Pain	Heart problem	Scarlet fever
Chicken Pox	Hemorrhoids	Seizure disorder
Chronic Cough	Hepatitis	Sexually transmitted disease
Concussion	Hernia	Sickle cell anemia
Convulsions	High Blood pressure	Sinus trouble
Diabetes	Hypoglycemia	Stomach/intestinal problems
Diphtheria	Kidney disease	Tuberculosis
Depression	Malaria	Ulcers
Drug abuse	Measles	

Head and Neck History: Check and write brief description

yes no

Have you ever been unconscious? (If yes, check which one) a. Knocked out _____ b. Blacked out after accident, _____		
Have you ever had a concussion? (If yes): How many times? _____ How long to make a complete recovery? _____ Date of last concussion? _____		
Have you ever had a skull/or spine fracture?		
Have you ever had a herniated disc?		
Have you ever had a "pinched nerve"?		

General Musculoskeletal

yes no

Have you ever fractured a bone (includes stress fractures)? Which bone(s)?		
Have you ever had a musculoskeletal surgery? Where?		
Have you ever had a pin, plate, or screw placed in joint? Where?		
Have you had a sprain or strain to a muscle or ligament within the last 2 yr.?		

Allergies (are you allergic to?)

Anti-Inflammatory	Hay Fever	Tetanus Antitoxin/serum
Aspirin	Insect Bites/Stings	Any food
Codeine	Penicillin	Any other drug
Cortisone	Sulfa	Other

Heat (have you ever experienced any of the following, list when and how long it took to recover)

Frequent dehydration/Heat syncope (fainting)	Heat Cramps
Heat Stroke	Heat Exhaustion

List any medications taken regularly:

Family History: (Have any of your relatives ever had any of the following?)

	Age	State of health	Age of Death	Cause of Death		yes	Relationship	Explain
Father					Tuberculosis			
Mother					Diabetes			
Brothers					High Blood Press			
					Heart Disease			
					Arthritis			
Sisters					Hay Fever			
					Asthma			
					Cancer			

Immunization Record: (List the date last completed)

Tetanus/Diphtheria		Measles, Mumps, and Rubella	
Influenza		Hepatitis B Vaccine (Have you completed the series?)	

Foreign Travel Vaccines, Other

Tuberculin Skin Test

Immunization	Date	Date	Results
		<i>Chest</i>	<i>X-ray (if skin test positive)</i>
		<i>Date</i>	<i>Results</i>

List any other physical or mental concerns not already noted above:

Signature and Consent (if student is under 18, both parent/guardian and student must sign)

I certify that the medical facts stated above are true to the best of my knowledge.

I agree to pay any charge for service not covered by university fees or by insurance.

I hereby consent to the release of medical information to the appropriate university representatives.

Signature of student

Date

Signature of parent or guardian

Date

Wright State University
PHYSICAL EXAMINATION

Name _____

Date _____

Date last examined _____

Sport _____

Year in sport (*circle one*):

Freshman

Sophomore

Junior

Senior

5th year

	Normal	Comments
1. Height & Weight	_____	_____
2. Urine Analysis	_____	_____
3. Blood Pressure	_____	_____
4. Pulse	_____	_____
5. Eyes	_____	_____
6. Skin	_____	_____
7. Head	_____	_____
8. Ears	_____	_____
9. Nose	_____	_____
10. Throat & Mouth	_____	_____
11. Neck	_____	_____
12. Lymph Nodes	_____	_____
13. Lungs	_____	_____
14. Heart	_____	_____
15. Abdomen	_____	_____
16. Genitalia	_____	_____
17. Extremities	_____	_____
18. Neurological	_____	_____
19. Musculoskeletal	_____	_____

Regular Medications (*please list*): _____

Accepted _____

Rejected _____

Hold for further testing _____

Physician's Signature: _____

Wright State University

Personal Information

Name: _____

Sport: _____

Sex: _____

Date of Birth: _____

Social Security: _____

Permanent Address: _____
Street

_____ City State Zip Code

School Address: _____
Street

_____ City State Zip Code

Home Phone: _____

School Phone: _____

Cell Phone: _____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Wright State University

Parent Information

Father/Guardian: _____

Date of Birth: _____

Social Security: _____

Address: _____
Street

_____ City State Zip Code Country

Phone Number: _____

Mother/Guardian: _____

Date of Birth: _____

Social Security: _____

Address: _____
Street

_____ City State Zip Code Country

Phone Number: _____

Release of Medical Information

I, _____, hereby authorize the following healthcare provider, _____, to release any and all information regarding the injury stated below. This includes but is not limited to all dictations and test results from the date of initial treatment forward.

Injury

Signature

Please forward all information to:

Jason Franklin ATC
Wright State University
3640 Colonel Glenn Hwy #356
Dayton, OH 45435

Work (937)775-2776
Fax (937)775-2841

For the 2005-2006 school year, Wright State University has contracted with the Baker Agency, Inc. of Ostego, Michigan to provide this coverage for intercollegiate athletes. The staff of The Baker Agency, Inc. will provide quality services and benefits to those athletes who suffer injuries as a result of participation in our athletics program. Listed below is a description of our program:

1. The athletes should first submit charges for medical treatment due to an athletic injury to any Group Insurance Company or plan that provides coverage of the athlete. Such a group insurance carrier is often the group health insurance plan at the place of employment of the athlete's parents.
2. The group insurance plan will pay benefits based on its contract of coverage. It is important to note that claims filed under a group medical insurance plan will not directly increase the premiums the parents of the athlete pay for the plan.
3. Any balance due for treatment of an athlete after payment by the group insurance plan will be considered for a benefit payment by our athletic insurance coverage, **provided that bills are received within 52 weeks from the date of injury.**
4. If another insurance or medical plan does not cover the athlete, all expenses incurred **due to an athletic injury** are considered for a benefit.
5. The first \$15,000 of covered expenses incurred within one year of an athletic injury is eligible for 100% benefit payment under the University's basic athletics insurance coverage.
6. Benefits for covered charges exceeding \$15,000 during the first four years from the date of the accident are eligible for a 100% benefit payment up to a maximum additional benefit of \$35,000. To be eligible for this second level of benefits, covered charges must exceed \$15,000 in the first year after the date of the accident.
7. Should medical expenses exceeding \$50,000 within two years from the date of a covered injury, additional benefits may be paid for the remainder of the athlete's life under the NCAA Lifetime Catastrophic Insurance Program.
8. **Our athletic accident insurance coverage does not cover personal illnesses.** We recommend that athletes purchase the university's student health insurance plan if they are not otherwise covered. The cost of the student insurance plan is \$178 per quarter or \$696 for the year. Benefits are payable for hospital charges, surgery charges, and for other covered medical expenses. A Certified Family Nurse Practitioner and Physician are available for primary health care in Student Health Services located on the first floor of the F. A. White Health Center for a fee. Should you have any questions regarding this coverage, please call Marsha Jones at (937) 775-2553. **THE STUDENT HEALTH INSURANCE COVERAGE DOES NOT COVER ATHLETIC INJURIES OR TRAMAS.**

9. No benefits will be paid under this insurance plan for services, surgeries and/or physical therapy performed by other than the Wright State University designated team physicians group and therapy center unless prior approval for treatment is obtained through the athletic training office.
10. NO BENEFITS WILL BE PAID UNDER OUR INSURANCE PLAN FOR EXPENSES INCURRED AS A RESULT OF A PRE-EXISTING CONDITION OR AN AGGRAVATION OF A PRE-EXISTING CONDITION.
11. All injuries/illnesses (whether they are emergencies or not) must be reported to the athletic training room. All necessary care will be arranged through the athletic training room. Failure to follow this procedure will result in forfeiture of your athletic accident insurance benefits.
12. It is important for those athletes covered through Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's) to realize that they must be treated by HMO or PPO physicians approved by the HMO or PPO before the university's coverage will pay any benefit. We will be glad to work with you in contacting your HMO or PPO for their approval to forestall any problems during the competitive season.
13. Enclosed is a form to be completed and returned to the Athletics Department with a *copy of your insurance* card providing is with the necessary information to process insurance claims for our athletes. **ALL INCOMPLETE FORMS WILL BE RETURNED, AND PARTICIPATION WILL BE PROHIBITED.**
14. All physicals must be arranged through Jason Franklin, Coordinator of Athletic Training Services in the Athletic Training Room.
15. Any athlete missing the scheduled appointments for a physical examination must pay for the cost of a physical from a private physician. That physician must use the Wright State University Athletic Training Room Physical Forms.

Claims for medical expenses due to athletic injuries will be filed through the office of Jason Franklin, Coordinator of Athletic Training Services, in room 140 Nutter Center. It is then sent to the Student Health office who is in charge of all claims. If you should have any problems or questions concerning a claim, we request your cooperation in informing the Student Health office at (937) 775-2552.

Sincerely,

Paul Newman

I have read and understand the above insurance policies of Wright State University. I also agree to all policies mentioned above.

Student Athlete Signature

Parent/Guardian Signature

**Wright State University
Insurance Information**

Name of Primary Insurance: _____

Address: _____

Phone number: _____

Policy #: _____

Group #: _____

Name of Secondary Insurance: _____

Address: _____

Phone Number: _____

Policy #: _____

Group #: _____

The medical insurance companies listed above is/are:
 Health Maintenance Organizations (HMO)
 Preferred Provider Organizations (PPO)

Amount of deductible: \$ _____

Does your insurance plan require a second opinion and/or pre-admission certification before surgeries or hospitalizations?

- YES
- NO

Is a referral required prior to physician visit?

- YES
- NO

Do you as individuals carry accident or hospital insurance to cover this claimant?

- YES
- NO

I hereby authorize Wright State University and the Baker Agency, Inc. of Ostego, Michigan to inspect or secure copies of history records, laboratory reports, diagnosis, x-rays, and any other data covering this an/or previous confinements and/or disabilities. A photo-static copy of this authorization shall be deemed as effective and valid as the original.

Parent's Signature: _____ Student Signature: _____

Student Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
Horizon League

I, _____, hereby authorize Wright State University
Name of Student Athlete

and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for the participation in intercollegiate athletics to the Horizon League and its employees or agents.

I understand that my protected health information will be used by the Horizon League for the purposes of:

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under the HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that Wright State University will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics.

I also understand that the Horizon League is not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the Horizon League's use or disclosure of my injury/illness information.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at Wright State University. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Printed Name of Student Athlete

Signature

Date

Wright State University

Release of Information

I understand that the team physicians are representatives of Kettering Medical Center and that he/she may therefore disclose any and all medical information contained in this questionnaire or my medical files to the athletic training staff at Wright State University. It may also be necessary to discuss the above mentioned files with additional consulting physicians pertaining to related injuries or illnesses.

It is also understood that various physicians not associated with Kettering Medical Center may also act in the capacity as team physician for various ailments which may include but are not limited to optical, dental, and dermatological conditions. I authorize these attending physicians to disclose medical files to the athletic training staff at Wright State University and consulting physicians.

I further authorize Wright State University Athletic Training Room, to release information regarding injuries and illnesses that occur during my athletic career at Wright State University with attending physicians and coaches if necessary for return to play considerations. This may include but is not limited to personal and health related information.

Athlete Signature

Parent Signature (if minor)