



Date: May 5, 2010

TO: Student-Athlete and Parents

FROM: Doug Frye, ATC, LAT

RE: Important Information about Insurance, Sickle Cell Testing, Physical Forms, and Other Forms

In this packet of material, you should find forms to be completed on-line and returned:

Athletes Personal/Insurance Information

- Due to the number of problems filing health insurance claims and changes with University policy, I think a brief note to you is in order. University policy requires **all students** to maintain personal health insurance coverage. Both the University and the athletic department require proof of insurance.
- Please complete the entire form, sign, date, and attach an enlarged photocopy of the front and back of your personal health insurance card. By checking the box provided on the form, you certify that you have personal health insurance and do not wish to purchase the Blanket Accident and Health Insurance plan designed for the students of JU. This does not mean that the University will not provide you with a secondary accident policy for injuries that occur during countable athletically related activities (See Form-Medical Bill Payment Policy). If you change health insurances or any information listed on the form changes, please report the changes immediately to the University, athletic department and current medical providers.
- Since many injuries and most illnesses are not athletically related, please have a personal copy of your health insurance card with you while at the University.
- Many health insurance plans have limited or no benefit outside of your home area except for emergency room visits. They may not cover doctor visits, follow-up care, diagnostic evaluation, surgery, and physical therapy. Contact your health insurance company to ensure you have medical coverage away from your hometown area. Many companies will provide away from home coverage with pre-planning and some advanced paperwork. Some companies require you to arrange away from home coverage each year. Prepare now. It may save you from reduced or denied benefits in the future and/or a delay in non-emergency medical services.
- Some athletes change their primary care physician to a local Medical Doctor. This may ease gaining medical care and/or obtaining referrals. Here is a list of local MD's that the Athletic Department have used in the past.

Preferred (Works Directly with our Student-Athletes on a Daily Basis)

- Dr. Richard Valenzuela, Baptist Primary Care, 5566 Ft. Caroline Road, Suite 20, (904) 744-5244

Other Suggestions

- Dr. William L. Carrierre at The Family Care Center of Arlington, 6484 Ft. Caroline Road, (904) 744-7300
- Dr. Michael L. Waters, Baptist Primary Care, 13001-2 Atlantic Blvd., (904) 221-0262.
 - There are other very good MD's in the area. Contact me for other recommendations/suggestions.

- If your son/daughter is covered under a Dental and/or Vision Insurance Plan, please fill out the Dental Insurance form and/or Vision Insurance Form. These additional forms can be accessed on the JU Sports Medicine Website.

Initial Health Questionnaire Form

- Explain, in detail, any yes answers. For any conditions/injuries that required diagnostic testing or physician evaluation please include copies of testing reports as well as physician office and/or surgery notes.
- If your son/daughter is ADHD, there is additional paperwork that must be filled out. This can be accessed on the JU Sports Medicine website.

Pre-Participation Physical Form

- A United States licensed M.D./D.O. physician must complete the Pre-participation Athletic Physical Evaluation form. Physicals performed by a Chiropractor will not be accepted. Physicals performed by a Nurse or Physician's Assistant must be accompanied by a Physician's signature.

Sickle Cell Informed Consent Form

- In Division I, legislation has been adopted that requires institutions, as part of the medical examination required before athletics participation, to include: **1) a sickle cell solubility test 2) documented results of a prior test are provided to the institution or 3) the student-athlete declines the test and signs a written release.** This legislation is effective as of August 1, 2010 and is applicable to student-athletes who are beginning their initial year of eligibility, including transfers, and student-athletes trying out for a team. Returning student-athletes are not required to be given the test. According to NCAA rules, **Student-athletes who choose to have the test done will not be allowed to participate until the sports medicine staff has a copy of the test results on file.**
- **Testing is to be completed PRIOR to your arrival on campus.** All newborns are screened at birth for sickle cell trait. Contact your family physician, pediatrician, or Health Department to obtain copies of these results. If you have never had a lab screening for sickle cell trait, or are unable to obtain prior results, then you should schedule one immediately. Typically, the blood test can take 48-72 hours to be finalized and documented results provided. If you wait until you arrive at JU to have the test completed, there could be a delay in your clearance for participation. Jacksonville University is not responsible for any fees that may be incurred for testing.

Orthopedic History Form

- Explain, in detail, any yes answers. For any conditions/injuries that required diagnostic testing or physician evaluation please include copies of testing reports as well as physician office notes and/or surgery notes.

Consent to Treat/Assumption of Risk Form

- Read and sign in the appropriate box.

Release of Information/ Gain Information Form

- Read and sign in the appropriate box.

Injury Reporting/Bill Payment

- Read and sign in the appropriate box

Please complete and mail all forms back to Jacksonville University Sports Medicine Department, **do not fax**.

****Do not include University required admission paperwork (immunization /health questionnaire) with the Athletic Department required paperwork.****

If you have any questions, please feel free to contact myself or the JU Sports Medicine Department (904) 256-7714.

Doug Frye, ATC, LAT
Head Athletic Trainer
Jacksonville University
2800 University Blvd N
Jacksonville, FL 32211
dfrye@ju.edu

**Jacksonville University Sports Medicine
Athlete Personal / Insurance Information 2010-2011**

Student-Athlete Information

Last Name: _____ First Name: _____ Middle Initial: _____ Sport(s): _____
Sex: _____ SS# _____ JU Student ID# _____ Date of Birth: _____
Cell Phone # (____) _____ Home Phone # (____) _____ E-Mail: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Allergies: NONE YES List: _____
Medications Taken Regularly: NONE YES List: _____
Medical Alerts/Conditions: NONE YES List: _____

Emergency Contact Information

Name: _____ Relationship: _____
Home # (____) _____ Cell # (____) _____
Work # (____) _____ E-Mail: _____
Address: _____
City: _____ State: _____ Zip: _____

Primary Care Physician Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (____) _____
 I do not have a Primary Care Physician

Primary Insurance Information

Policy Holder's Name: _____ Date of Birth: _____ SS# _____
Address: _____ City: _____ State: _____ Zip: _____
Home # (____) _____ Cell # (____) _____ Work # (____) _____ E-Mail: _____
Policy Holders Employer: _____
Insurance Company: _____ Phone (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Policy # _____ Group # _____ ID # _____
Please circle what type of insurance your son/daughter has: HMO PPO POS Other _____
If you have an HMO, do you have Out-of-Network Benefits? YES NO Does your son/daughter have Dental Insurance? YES NO
Is a referral required from the athlete's Primary Care Physician? YES NO Does your son/daughter have Vision Insurance? YES NO
Is pre-authorization required for (circle all that apply): Specialist Care Surgery Diagnostic Services Emergency Dept. Hospitalization

PLEASE ATTACH AN **ENLARGED, CLEAN, COPY OF THE FRONT AND BACK** OF THE INSURANCE CARD

By checking the box, I certify that I have local coverage under an existing personal health insurance plan and do not require the school-endorsed Student Health Insurance.

I certify that the above information is true and correct to the best of my knowledge. I understand that I must notify Jacksonville University in a timely manner if any changes in insurance should occur. I understand that failure to notify Jacksonville University of any insurance changes may result in Jacksonville University not being financially responsible for athletic related injuries.

Athlete Signature

Date

**Jacksonville University Sports Medicine
Athlete Insurance Card Copy 2010-2011**

Athlete Name: _____ Sport(s): _____

HEALTH INSURANCE CARD

PLEASE ATTACH AN ENLARGED, CLEAN, COPY OF THE FRONT AND BACK OF THE HEALTH INSURANCE CARD BELOW

FRONT	BACK
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If Applicable, PRESCRIPTION CARD

PLEASE ATTACH AN ENLARGED, CLEAN, COPY OF THE FRONT AND BACK OF THE PRESCRIPTION CARD BELOW

FRONT	BACK
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I certify that the above information is true and correct to the best of my knowledge. I understand that I must notify Jacksonville University in a timely manner if any changes in insurance should occur. I understand that failure to notify Jacksonville University of any insurance changes may result in Jacksonville University not being financially responsible for athletic related injuries.

Athlete Signature

Date

**Jacksonville University Sports Medicine
Initial Health History Form 2010-2011**

Athlete Name: _____

Sport(s): _____

HEAD INJURIES/CONCUSSION HISTORY	Y	N	Explain Yes Answers
1. Do you experience frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you experience frequent or severe migraines?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever experience dizzy spells, fainting, black out, and/or loss of memory?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever had convulsions, seizures, fits, or told you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever had a head injury/ concussion? <i>(if concussion, how many and give dates)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you ever had any diagnostic tests for a head related injury: <i>(if yes, please circle and give dates)</i> MRI CT, X-RAY, Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you ever been hospitalized for a head injury and /or concussion? <i>(if yes, give dates)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has a physician ever denied or restricted your participation in sports due to any head related conditions?	<input type="checkbox"/>	<input type="checkbox"/>	
** If you were seen by a physician or had any diagnostic testing done due to a head injury, please include copies of physician office notes and diagnostic testing reports.			
VISION HISTORY	Y	N	Explain Yes Answers
1. Have you ever suffered an injury to your eye(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Were any diagnostic tests performed?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever been hospitalized or seen an Ophthalmologist for an eye injury?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever been advised not to participate in sports activities due to an eye injury?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you routinely wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you routinely wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL HISTORY	Y	N	Explain Yes Answers
1. Have you ever suffered an injury to your mouth, jaw, and/or teeth?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever been hospitalized for a mouth, jaw, and/or tooth injury?	<input type="checkbox"/>	<input type="checkbox"/>	
EAR, NOSE, AND THROAT HISTORY	Y	N	Explain Yes Answers
1. Have you ever suffered an injury to your ear(s), nose, and/or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Were any diagnostic tests performed? <i>(if yes, please circle and give dates)</i> MRI, CT, X-RAY, Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever been hospitalized for a ear, nose, and/or throat injury?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever been advised not to participate in sports due to a ear, nose, and/or throat injury?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you experience hearing loss or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you have sinus trouble or serious sinus infections?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you have frequent nose bleeds?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you have frequent or severe sore throat and/or infections?	<input type="checkbox"/>	<input type="checkbox"/>	

CARDIOVASCULAR HISTORY	Y N	Explain Yes Answers
1. Have you ever been dizzy during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	
2. Have you ever passed out during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	
3. Do you have shortness of breath with exertion or lying down?	<input type="checkbox"/> <input type="checkbox"/>	
4. Do you have chest pain or tightness during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	
5. Do you tire more quickly than your friends during exercise?	<input type="checkbox"/> <input type="checkbox"/>	
6. Have you ever had the feeling of your heart racing or skipping beats?	<input type="checkbox"/> <input type="checkbox"/>	
7. Do you have or have you ever been told you have high blood pressure?	<input type="checkbox"/> <input type="checkbox"/>	
8. Do you have or have you ever been told you have high cholesterol?	<input type="checkbox"/> <input type="checkbox"/>	
9. Do you have or have you ever been told you have heart disease?	<input type="checkbox"/> <input type="checkbox"/>	
10. Has any member of your immediate family died of a heart problem or sudden death before the age of 50?	<input type="checkbox"/> <input type="checkbox"/>	
11. Do you have or have you ever been told you have a heart murmur?	<input type="checkbox"/> <input type="checkbox"/>	
12. Do you have or have you ever been told you have a heart murmur with Valsalva Maneuver?	<input type="checkbox"/> <input type="checkbox"/>	
13. Have you ever had a heart attack or experienced Angina?	<input type="checkbox"/> <input type="checkbox"/>	
14. Have you ever had a stroke or CVA?	<input type="checkbox"/> <input type="checkbox"/>	
15. Do you have or ever been told you have Mitral Valve Prolapse?	<input type="checkbox"/> <input type="checkbox"/>	
16. Do you have or ever been told you have an arrhythmia? (i.e. Wolff-Parkinson White, Long QT)	<input type="checkbox"/> <input type="checkbox"/>	
17. Do you have or ever been told you have an irregular heartbeat?	<input type="checkbox"/> <input type="checkbox"/>	
18. Have you ever had: <i>(if yes, please circle and give dates)</i> EKG, Echocardiogram (ECHO), Exercise Stress Test	<input type="checkbox"/> <input type="checkbox"/>	
19. Do you have or have you ever been told you have: <i>(if yes, please circle)</i> Pericarditis Myocarditis Endocarditis	<input type="checkbox"/> <input type="checkbox"/>	
20. Do you have or have you ever been told you have Marfan's Syndrome?	<input type="checkbox"/> <input type="checkbox"/>	
21. Has a physician ever denied or restricted your participation in sports due to any heart/cardiovascular related conditions?	<input type="checkbox"/> <input type="checkbox"/>	

**** If you have had any diagnostic testing done on your heart or seen a physician for any cardiovascular problems, please include copies of diagnostic test reports and physician office notes.**

ASTHMA/RESPIRATORY HISTORY	Y N	Explain Yes Answers
1. Do you have difficulty breathing during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	
2. Do you cough or wheeze during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	
3. Do you have a persistent cough or have you ever coughed up blood?	<input type="checkbox"/> <input type="checkbox"/>	
4. Do you have or have you ever been told you have Asthma and/or Exercise Induced Asthma?	<input type="checkbox"/> <input type="checkbox"/>	
5. Have you used or are you currently using an inhaler? (If yes, give dates and how many times you use it in an average week)	<input type="checkbox"/> <input type="checkbox"/>	
6. Have you had an Asthma attack within the last 12 months?	<input type="checkbox"/> <input type="checkbox"/>	
7. Do you have or ever been told you have Emphysema and/or lung disease?	<input type="checkbox"/> <input type="checkbox"/>	
8. Do you have or have you ever been told you have Tuberculosis?	<input type="checkbox"/> <input type="checkbox"/>	
9. Has a physician ever denied or restricted your participation in sports due to a respiratory condition?	<input type="checkbox"/> <input type="checkbox"/>	

ABDOMINAL/GASTROINTESTINAL HISTORY		Y N	Explain Yes Answers	
1. Do you have or have you been told you have stomach and/or intestinal problems? (i.e. Colitis, Crohns, etc)	<input type="checkbox"/>	<input type="checkbox"/>		
2. Do you suffer from severe or recurrent abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Do you have or have you ever been told you have a stomach ulcer?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Do you have or have you had any change in bowel habits?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Do you have or have you had frequent constipation and/or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Do you have or have you had any rectal problems? (i.e. hemorrhoids, rectal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>		
7. Do you have or have you had bloody, clay colored stool?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Do you have or have you been told you have Liver Disease? (i.e. Hepatitis, Cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>		
9. Do you have or have you been told you have a kidney or bladder problem?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Do you have or have you had difficulty passing urine or do you find yourself urinating more often?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Do you have or ever been told you have blood or protein in your urine?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Do you have or have you ever had an injury to your spleen?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Do you have or have you ever been told you have gall bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>		
14. Do you have or ever been told you have a Hernia and/or Sports Hernia?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Has a physician ever denied or restricted your participation in sports due to an abdominal/gastrointestinal condition?	<input type="checkbox"/>	<input type="checkbox"/>		
FEMALE MEDICAL HISTORY (Males Please Skip)		Y N	Explain Yes Answers	
1. At what age was your first period?				
2. How much time do you usually have from the start of one period to the start of another?				
3. How many periods have you had in the last year?				
4. What was the longest time between periods last year?				
5. Number of pregnancies with dates:				
		Y N		
6. Do you have or have you had painful or heavy menstruation?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Do you take any medications for your menstrual periods? (if yes, please list)	<input type="checkbox"/>	<input type="checkbox"/>		
8. Do you have or have you had absence of menstruation?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Are you taking or have you taken any female hormones (estrogen, progesterone, birth control) for the purpose of regulating your periods? (if yes, please list)	<input type="checkbox"/>	<input type="checkbox"/>		
10. Have you have had a pelvic exam within the last year?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Do you have or have you had any medical problems with your breasts?	<input type="checkbox"/>	<input type="checkbox"/>		
MALE MEDICAL HISTORY (Females Please Skip)		Y N	Explain Yes Answers	
1. Do you have or have you had any medical problems with your testicles or penis?		<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you have or have you ever had any problems with your prostate?		<input type="checkbox"/>	<input type="checkbox"/>	
3. Were you born with two normal testicles?		<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever had surgery to remove or repair testicles?		<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever had a severe testicular injury?		<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have or have you ever been told you have a hernia?		<input type="checkbox"/>	<input type="checkbox"/>	

HEAT ILLNESS HISTORY	Y N	Explain Yes Answers
1. Have you ever had heat cramps?	<input type="checkbox"/> <input type="checkbox"/>	
2. Have you ever had heat exhaustion?	<input type="checkbox"/> <input type="checkbox"/>	
3. Have you ever had heat syncope (fainting)?	<input type="checkbox"/> <input type="checkbox"/>	
4. Have you ever had heat stroke?	<input type="checkbox"/> <input type="checkbox"/>	
5. A) Do you have or have you had excessive weight loss after exercise? B) If yes, Are you able to gain your weight back after weight loss from exercise?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
6. Have you ever been given I.V. fluids for a heat related illness?	<input type="checkbox"/> <input type="checkbox"/>	
7. Have you ever been hospitalized for a heat related illness?	<input type="checkbox"/> <input type="checkbox"/>	
8. Has a physician ever denied or restricted your participation in sports due to a heat related condition?	<input type="checkbox"/> <input type="checkbox"/>	

ALLERGY HISTORY	Y N	Explain Yes Answers
1. Do you have or have you been told you have seasonal allergies?	<input type="checkbox"/> <input type="checkbox"/>	
2. Do you take or have you taken any medications for allergies?	<input type="checkbox"/> <input type="checkbox"/>	
3. Are you allergic to and/or had an allergic/ unfavorable reaction to any medications?	<input type="checkbox"/> <input type="checkbox"/>	
4. Are you allergic to and/or had an allergic/ unfavorable reaction to any food item?	<input type="checkbox"/> <input type="checkbox"/>	
5. Are you allergic to and/or had an allergic/ unfavorable reaction to any insect bites?	<input type="checkbox"/> <input type="checkbox"/>	

DIABETIC HISTORY	Y N	Explain Yes Answers
1. Have you ever been diagnosed with diabetes?	<input type="checkbox"/> <input type="checkbox"/>	
2. Are you presently taking or have you taken Diabetic medication? (If yes, list medication(s) and dosage)	<input type="checkbox"/> <input type="checkbox"/>	
3. Do you monitor your blood sugar daily? (if yes, fill out below) How many times? What is your average level?	<input type="checkbox"/> <input type="checkbox"/>	
4. Have you had any hypoglycemic episodes (low blood sugar) in the last 12 months?	<input type="checkbox"/> <input type="checkbox"/>	
5. Have you ever been told not to participate in sports due to your diabetes?	<input type="checkbox"/> <input type="checkbox"/>	
6. Please list any precautions you take and/or any information not listed above:		

MEDICATION HISTORY			
Please list ALL Prescription Medications and Over-The-Counter you have taken or are CURRENTLY taking or HAVE TAKEN in the last 2 years and for what purpose			
Medication	Purpose	Dosage	Dates

MENTAL HEALTH HISTORY		Y N	Explain Yes Answers
1. Have you ever been diagnosed with a mental health disorder and/or treated (if yes, specify)		<input type="checkbox"/> <input type="checkbox"/>	
2. While participating in your sport, how often do you feel the following? Using the scale 1-None to 5-often, write the appropriate number in the space: Euphoria _____ Depression _____ Anxiety _____ Sleeplessness _____ Anger or short temper _____ Feelings of isolation _____ Fatigue _____ Low self-esteem _____			
3. Do you have any other mental health issues, which require the services of a mental health provider? (if yes, specify)		<input type="checkbox"/> <input type="checkbox"/>	

ADHD/ADD HISTORY		Y N	Explain Yes Answers
1. Do you have or ever been told you have ADHD/ADD?		<input type="checkbox"/> <input type="checkbox"/>	
2. Have you been or are you currently under the care of a Physician for ADHD/ADD?		<input type="checkbox"/> <input type="checkbox"/>	
3. Have you or are you currently taking any medications for ADHD/ADD? ** SEE BELOW		<input type="checkbox"/> <input type="checkbox"/>	

****If you are currently taking medications for ADHD/ADD, there is additional paperwork you will need to complete as per the NCAA. This paperwork can be found at www.judolphins.com/sportsmedicine/ , click on the ADHD Medical Exceptions link. Contact JU Sports Medicine, (904) 256-7714 if further info is needed or if you have any questions.**

FAMILY HISTORY							
For each full-blooded relative listed below, please indicate if they have a history of the following. Circle all that apply. Circle (No Hx) for no history in family, or if family history is unknown.							
High Blood Pressure	No Hx	Mother	Father	Brother	Sister	Grandparent	
Heart Attack (under Age 50)	No Hx	Mother	Father	Brother	Sister	Grandparent	
High Cholesterol	No Hx	Mother	Father	Brother	Sister	Grandparent	
Other Heart Problems	No Hx	Mother	Father	Brother	Sister	Grandparent	
Marfan's Syndrome	No Hx	Mother	Father	Brother	Sister	Grandparent	
Anemia	No Hx	Mother	Father	Brother	Sister	Grandparent	
Sickle Cell Disease/Trait	No Hx	Mother	Father	Brother	Sister	Grandparent	
Blood clotting disorder	No Hx	Mother	Father	Brother	Sister	Grandparent	
Leukemia	No Hx	Mother	Father	Brother	Sister	Grandparent	
Cancer	No Hx	Mother	Father	Brother	Sister	Grandparent	
Diabetes	No Hx	Mother	Father	Brother	Sister	Grandparent	
Seizures or Epilepsy	No Hx	Mother	Father	Brother	Sister	Grandparent	
Cancer	No Hx	Mother	Father	Brother	Sister	Grandparent	
Asthma	No Hx	Mother	Father	Brother	Sister	Grandparent	
Kidney Disease	No Hx	Mother	Father	Brother	Sister	Grandparent	
Tuberculosis	No Hx	Mother	Father	Brother	Sister	Grandparent	
Eating Disorders	No Hx	Mother	Father	Brother	Sister	Grandparent	
Depression	No Hx	Mother	Father	Brother	Sister	Grandparent	
Mental Illness	No Hx	Mother	Father	Brother	Sister	Grandparent	
Other Family Medical History problems not listed that want the Jacksonville University Sports Medicine staff should be aware of:							

GENERAL MEDICAL HISTORY (Do you have, have you ever had, or been told you have)	Y N	Explain Yes Answers
1. Anemia	<input type="checkbox"/> <input type="checkbox"/>	
2. Sickle Cell Disease or Sickle Cell Trait	<input type="checkbox"/> <input type="checkbox"/>	
3. Been tested for Sickle Cell Disease or Sickle Cell Trait	<input type="checkbox"/> <input type="checkbox"/>	
4. Blood clots or Embolisms	<input type="checkbox"/> <input type="checkbox"/>	
5. Leukemia	<input type="checkbox"/> <input type="checkbox"/>	
6. Cancer	<input type="checkbox"/> <input type="checkbox"/>	
7. Excessive thirst	<input type="checkbox"/> <input type="checkbox"/>	
8. Bruise easy	<input type="checkbox"/> <input type="checkbox"/>	
9. Bleed easy	<input type="checkbox"/> <input type="checkbox"/>	
10. Motion Sickness	<input type="checkbox"/> <input type="checkbox"/>	
11. Have only one of two paired organs (kidneys, ovaries, testicles, etc)	<input type="checkbox"/> <input type="checkbox"/>	
12. Meningitis (if yes, bacterial or viral)	<input type="checkbox"/> <input type="checkbox"/>	
13. Mononucleosis	<input type="checkbox"/> <input type="checkbox"/>	
14. Rubella (German Measeles)	<input type="checkbox"/> <input type="checkbox"/>	
15. Chicken Pox	<input type="checkbox"/> <input type="checkbox"/>	
16. Arthritis	<input type="checkbox"/> <input type="checkbox"/>	
17. Gout	<input type="checkbox"/> <input type="checkbox"/>	
18. Rheumatism	<input type="checkbox"/> <input type="checkbox"/>	
19. Rheumatic or Scarlet fever	<input type="checkbox"/> <input type="checkbox"/>	
20. Tumor, cyst, or growth	<input type="checkbox"/> <input type="checkbox"/>	
21. Any gland or hormone problem	<input type="checkbox"/> <input type="checkbox"/>	
22. Ongoing or chronic illness	<input type="checkbox"/> <input type="checkbox"/>	
23. Any decline in general health	<input type="checkbox"/> <input type="checkbox"/>	
24. Ever had a tetanus booster (if yes, date _____)	<input type="checkbox"/> <input type="checkbox"/>	
25. General Medical Surgical History (if yes, circle all that apply) *Orthopedic surgeries and history will be asked for on a later form* Eyes Ears, Nose, Throat Heart Lungs Stomach/Bowels Appendix Kidneys Liver/Spleen/Gall Bladder Other _____	<input type="checkbox"/> <input type="checkbox"/>	
26. Been hospitalized overnight?	<input type="checkbox"/> <input type="checkbox"/>	
27. Are you currently under a physician's care for any medical conditions?	<input type="checkbox"/> <input type="checkbox"/>	
28. Any severe illness, mental condition, and/or physical condition not mentioned?	<input type="checkbox"/> <input type="checkbox"/>	
29. Has a physician ever denied or restricted your participation in sports due to any medical condition?	<input type="checkbox"/> <input type="checkbox"/>	
30. Are you aware of any medical reason why you should not participate in intercollegiate athletics?	<input type="checkbox"/> <input type="checkbox"/>	

I certify that I have listed all medical conditions and injuries and they are true and correct to the best of my knowledge. I understand that other questions may be asked by the Jacksonville University Sports Medicine Department to determine if the injury/condition needs additional evaluation.

Athlete Signature

Date

JU Sports Medicine Staff Only

Reviewed By:

Staff Initials

Date

Jacksonville University
Sickle Cell Testing/ Informed Consent Form 2010-2011

Purpose of Testing

In Division I, legislation has been adopted that requires institutions, as part of the medical examination required before athletics participation, to include: **1) a sickle cell solubility test 2) documented results of a prior test are provided to the institution or 3) the student-athlete declines the test and signs a written release.** This legislation is effective as of August 1, 2010 and is applicable to student-athletes who are beginning their initial year of eligibility, including transfers, and student-athletes trying out for a team. Returning student-athletes are not required to be given the test. According to NCAA rules, **Student-athletes who choose to have the test done will not be allowed to participate until the sports medicine staff has a copy of the test results on file.**

Definition of Terms

Definition of Sickle Cell Disease: Sickle Cell Disease is an inherited blood disorder that affects red blood cells. Red blood cells are cells that carry oxygen to through our bodies. Persons with Sickle Cell Disease produce sickle-shaped blood cells, instead of normal round shaped cells. This process is called Sickling. Sickling prevents blood and oxygen from flowing to all parts of our bodies, which can lead to serious medical problems or even death. Sickling can occur within the first 2-3 minutes of exercise. Certain conditions can make the sickling worse. Some of these conditions include: *infection, overexertion, dehydration, stress, heat, asthma, and high altitude.*

Definition of Sickle Cell Trait: Carrying the Sickle Cell Trait means that you carry enough genetic material to pass on the trait to your children. If you have children with someone else who has the Sickle Cell Trait, the child could develop Sickle Cell Disease. People with Sickle Cell Trait usually do not get the disease, but under certain extreme conditions (especially dehydration and high altitudes), some Sickling may occur.

Pre-Cautions for the Sickle Cell Athlete

In the event you test positive for the trait or the disease, you will be provided additional information on how to minimize the risks associated with participation in athletics. Some of the precautions include:

- 1) Build up slowly in training with paced progressions, allow for longer periods of rest and recovery between repetitions.
- 2) Participation in preseason strength and conditioning programs.
- 3) Discontinue activity with onset of symptoms: I.e. muscle 'cramping', pain, swelling, weakness, tenderness; inability to "catch your breath", and fatigue.

Testing is to be completed PRIOR to your arrival on campus. All newborns are screened at birth for sickle cell trait. Contact your family physician, pediatrician, or Health Department to obtain copies of these results. If you have never had a lab screening for sickle cell trait, or are unable to obtain prior results, then you should schedule one immediately. Typically, the blood test can take 48-72 hours to be finalized and documented results provided. If you wait until you arrive at JU to have the test completed, there could be a delay in your clearance for participation. Jacksonville University is not responsible for any fees that may be incurred for testing.

Jacksonville University
Sickle Cell Testing/ Informed Consent Form 2010-2011

Athlete Name: _____ Sport(s): _____

Date of Birth: _____ JU Student ID # _____

The NCAA has mandated that all college athletes beginning their initial year of eligibility, including transfers and student-athletes trying out for a team, be given the option of being tested for the sickle cell trait, While Jacksonville University strongly encourages all student athletes to be tested for the trait, your participation is strictly voluntary. Testing is to be completed PRIOR to your arrival on campus.

Authorization for Sickle Cell Testing

Please initial next to the option that you are choosing and sign and date at the bottom

_____ I agree to submit to a Sickle Cell solubility test prior to my participation in intercollegiate athletics at Jacksonville University. I understand that I will not be allowed to participate until a copy of the test results have been turned into the JU Sports Medicine Department. I also understand that JU is not responsible for any fees associated with testing.

_____ I certify that I have already been tested for Sickle Cell Trait and will provide documentation to Jacksonville University of results of this test for my medical file. I understand that I will not be allowed to participate until a copy of the test results have been turned into the JU Sports Medicine Department.

_____ I do not wish to be tested for Sickle Cell Trait. By refusing this test, I certify that I have read and understand all risks involved with refusing this test. I voluntarily assume(s) all risks of having Sickle Cell Trait or Disease associated with participation with athletics and agree to exonerate, save harmless and release Jacksonville University, its agents, servants and employees from any and all liability, including claims of negligence, on the part of Jacksonville University, related to my participation in athletics.

Student Athlete Signature

Date

Parent/Guardian Signature (If under 18yrs)

Date

Jacksonville University Sports Medicine Staff Only

_____ Form Received by Sports Medicine Staff

_____ Waived Testing

_____ Test Results Provided

Reviewed by:

Staff Signature

Date

**Jacksonville University Sports Medicine
Pre-Participation Physical Evaluation 2010-2011**

Athlete Name: _____

Sport(s): _____

HEIGHT: _____ in. **WEIGHT:** _____ lbs. **B.P.:** _____ / _____ **PULSE:** _____ **PUPILS:** Equal _____ Unequal _____
VISION: Right 20/ _____ Left 20/ _____ **CORRECTED:** Yes No Glasses _____ Contacts _____

PHYSICAL EVALUATION MUST BE COMPLETED BY A LICENSED U.S. MD or DO

	WNL	ABNORMAL	<u>REMARKS</u>
APPEARANCE			
EARS/ EYES/ NOSE/ THROAT			
LYMPH NODES			
HEART			
LUNGS			
ABDOMEN			
GENITALIA/HERNIA (MALES)			
SKIN			

PARTICIPATION STATUS AFTER EVALUATION

_____ **CLEARED** to participate in intercollegiate athletics with no limitations.

_____ **CONDITIONALLY CLEARED** to participate in intercollegiate athletics, further evaluation(s) required.
 _____ **MAY** participate prior to further evaluation(s)
 _____ Without limitations _____ With limitations: _____

- Areas to be Re-evaluated: _____

_____ **MAY NOT** participate in intercollegiate athletics prior to further evaluation(s).

- Areas to be Re-evaluated: _____

_____ **NOT CLEARED** for participation in intercollegiate athletics.

PHYSICIAN INFORMATION

Physician's Signature _____
 Physician's Name (Print) _____ Date _____
 Physician's Address _____ Phone (_____) _____
 City _____ State _____ Zip _____

JU Sports Medicine Staff Only

Reviewed By:

Staff Initials *Date*

JU Sports Medicine Staff Comments

**Jacksonville University Sports Medicine
Initial Orthopedic History Form 2010-2011**

Athlete Name: _____

Sport(s): _____

CERVICAL SPINE / NECK (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Pinched Nerve	<input type="checkbox"/> <input type="checkbox"/>	
5. Burner/ Stinger (if yes, How many and often do they occur)	<input type="checkbox"/> <input type="checkbox"/>	
6. Bulging/Herniated Disc	<input type="checkbox"/> <input type="checkbox"/>	
7. Stenosis	<input type="checkbox"/> <input type="checkbox"/>	
8. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
9. Other	<input type="checkbox"/> <input type="checkbox"/>	
10. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
11. Do you wear a cowboy collar, neck roll?	<input type="checkbox"/> <input type="checkbox"/>	
SPINE / BACK (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Pinched Nerve	<input type="checkbox"/> <input type="checkbox"/>	
5. Disc Disease	<input type="checkbox"/> <input type="checkbox"/>	
6. Bulging/Herniated Disc	<input type="checkbox"/> <input type="checkbox"/>	
7. Scoliosis	<input type="checkbox"/> <input type="checkbox"/>	
8. Spondylosthesis	<input type="checkbox"/> <input type="checkbox"/>	
9. Sciatica	<input type="checkbox"/> <input type="checkbox"/>	
10. Facet Disorder	<input type="checkbox"/> <input type="checkbox"/>	
11. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
12. Other	<input type="checkbox"/> <input type="checkbox"/>	
13. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
CHEST / RIBS / THORAX (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Rib Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Rib Contusion	<input type="checkbox"/> <input type="checkbox"/>	
4. Sternum Fracture	<input type="checkbox"/> <input type="checkbox"/>	
5. Costochondral Injury	<input type="checkbox"/> <input type="checkbox"/>	
6. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
7. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
8. Other	<input type="checkbox"/> <input type="checkbox"/>	
9. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
SHOULDER / UPPER ARM (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
5. Tendonitis/Bursitis	<input type="checkbox"/> <input type="checkbox"/>	
6. Rotator Cuff Injury	<input type="checkbox"/> <input type="checkbox"/>	
7. Labral Tear	<input type="checkbox"/> <input type="checkbox"/>	
8. AC Joint Separation	<input type="checkbox"/> <input type="checkbox"/>	
9. Injections	<input type="checkbox"/> <input type="checkbox"/>	
10. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
11. Other	<input type="checkbox"/> <input type="checkbox"/>	
12. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
13. Do you wear a shoulder harness or brace?	<input type="checkbox"/> <input type="checkbox"/>	

ELBOW / FOREARM (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
5. Tendonitis/Bursitis	<input type="checkbox"/> <input type="checkbox"/>	
6. Injections	<input type="checkbox"/> <input type="checkbox"/>	
7. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
8. Other	<input type="checkbox"/> <input type="checkbox"/>	
9. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
10. Do you wear a brace or other protective equipment?	<input type="checkbox"/> <input type="checkbox"/>	
WRIST / HAND / FINGERS (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
5. Tendonitis/Bursitis	<input type="checkbox"/> <input type="checkbox"/>	
6. Injections	<input type="checkbox"/> <input type="checkbox"/>	
7. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
8. Other	<input type="checkbox"/> <input type="checkbox"/>	
9. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
10. Do you wear a brace or other protective equipment?	<input type="checkbox"/> <input type="checkbox"/>	
HIP / PELVIS (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
5. Tendonitis/Bursitis	<input type="checkbox"/> <input type="checkbox"/>	
6. Sacroiliac Dysfunction	<input type="checkbox"/> <input type="checkbox"/>	
7. Injections	<input type="checkbox"/> <input type="checkbox"/>	
8. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
9. Other	<input type="checkbox"/> <input type="checkbox"/>	
10. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
THIGH (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Contusion	<input type="checkbox"/> <input type="checkbox"/>	
5. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
6. Other	<input type="checkbox"/> <input type="checkbox"/>	
7. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
KNEE / PATELLA (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Grinding	<input type="checkbox"/> <input type="checkbox"/>	
3. Locking, Popping, or Giving way	<input type="checkbox"/> <input type="checkbox"/>	
4. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
5. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
6. Tendonitis/Buristis	<input type="checkbox"/> <input type="checkbox"/>	
7. Osgood-Schlatter	<input type="checkbox"/> <input type="checkbox"/>	
8. ACL injury	<input type="checkbox"/> <input type="checkbox"/>	
9. MCL injury	<input type="checkbox"/> <input type="checkbox"/>	
10. LCL injury	<input type="checkbox"/> <input type="checkbox"/>	
11. PCL injury	<input type="checkbox"/> <input type="checkbox"/>	
12. Meniscus tear	<input type="checkbox"/> <input type="checkbox"/>	
13. IT Band Syndrome	<input type="checkbox"/> <input type="checkbox"/>	
14. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
15. Other	<input type="checkbox"/> <input type="checkbox"/>	
16. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
17. Do you wear any braces or protective equipment?	<input type="checkbox"/> <input type="checkbox"/>	

SHIN / LOWER LEG (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Stress Fractures	<input type="checkbox"/> <input type="checkbox"/>	
4. Shin Splints	<input type="checkbox"/> <input type="checkbox"/>	
5. Compartment Syndrome	<input type="checkbox"/> <input type="checkbox"/>	
6. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
7. Achilles Tendonitis	<input type="checkbox"/> <input type="checkbox"/>	
8. Heel Spurs	<input type="checkbox"/> <input type="checkbox"/>	
9. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
10. Other	<input type="checkbox"/> <input type="checkbox"/>	
11. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
ANKLE (Have you had or do you have)	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
4. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
5. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
6. Other	<input type="checkbox"/> <input type="checkbox"/>	
7. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
8. Do you wear ankle braces or tape your ankles?	<input type="checkbox"/> <input type="checkbox"/>	
FOOT / TOES	Y N	Explain Yes Answers and Give Dates
1. Pain	<input type="checkbox"/> <input type="checkbox"/>	
2. Fracture	<input type="checkbox"/> <input type="checkbox"/>	
3. Stress Fractures	<input type="checkbox"/> <input type="checkbox"/>	
4. Sprain/Strain	<input type="checkbox"/> <input type="checkbox"/>	
5. Subluxation/Dislocation	<input type="checkbox"/> <input type="checkbox"/>	
6. Turf Toe	<input type="checkbox"/> <input type="checkbox"/>	
7. Sesamoiditis	<input type="checkbox"/> <input type="checkbox"/>	
8. Plantar Fasciitis	<input type="checkbox"/> <input type="checkbox"/>	
9. Injections	<input type="checkbox"/> <input type="checkbox"/>	
10. Surgery	<input type="checkbox"/> <input type="checkbox"/>	
11. Any diagnostic tests? (MRI, CT, X-Ray, Bone Scan)	<input type="checkbox"/> <input type="checkbox"/>	
GENERAL ORTHOPEDIC HISTORY	Y N	Explain Yes Answers and Give Dates
1. Any severe orthopedic injury, surgery, or condition not mentioned above?	<input type="checkbox"/> <input type="checkbox"/>	
2. Has a physician ever denied or restricted your participation in sports due to an orthopedic condition?	<input type="checkbox"/> <input type="checkbox"/>	
3. Are you aware of any medical reason why you should not participate in intercollegiate athletics?	<input type="checkbox"/> <input type="checkbox"/>	

*Jacksonville University Sports Medicine requires copies of all physician office notes, diagnostic test reports, and/or surgical notes for all injuries that required such during the last 5 years.

I certify that I have listed all medical conditions and injuries and they are true and correct to the best of my knowledge. I understand that other questions may be asked by the Jacksonville University Sports Medicine Department to determine if the injury/condition needs additional evaluation.

Athlete Signature

Date

JU Sports Medicine Staff Only

Reviewed By:

Staff Initials

Date

**Jacksonville University Sports Medicine
Consent to Treat and Assumption of Risk Form 2010-2011**

Athlete Name: _____

Sport(s): _____

*(The Jacksonville University athlete must sign each subsection if he or she is at least 18 years old.
If under 18, a parent or legal guardian **MUST** sign)*

CONSENT TO TREAT

I, _____, hereby grant permission to the Jacksonville University Team Physician and/or consulting specialist to render to myself (my son or daughter, if under 18 years of age) any treatment, medical or surgical care that they deem reasonably necessary for my (son's or daughter's) health and well being.

I also hereby authorize the Athletic Training Staff at Jacksonville University, who is under the direction and guidance of the University's Team Physicians, to render to myself (son or daughter), any preventive, first-aid, rehabilitative, or treatment that they deem reasonably necessary for my (son's or daughter's) health and well being.

If an injury/illness occurs off campus, I authorize the Athletic Training Staff or Coach to seek and render treatment or medical care that they deem reasonably necessary, including hospitalization, for my (son's or daughter's) health and well being.

Signature

Date

If this form was signed by someone other than the athlete, please circle authority to act on behalf of the athlete:

Parent Legal Guardian Other _____

ASSUMPTION OF RISK/RELEASE OF LIABILITY

I, _____, hereby acknowledge that I (my son or daughter) have/has been properly advised, cautioned and warned by the proper administrative and/or coaching staff at Jacksonville University, that by participating in the sport(s) _____, I (he or she) am (is) exposing myself (himself/herself) to the risk of serious injury, including but not to, the risk of sprains, strains, fractures and/or cartilage damage which could result in a temporary or permanent, partial or complete impairment in the use of my (his or her) limb, brain damage, paralysis, or even death. I (he /she) also understand that there are risks involved with traveling in connection with intercollegiate athletics. Having been so cautioned and warned, it is still my (his or her) desire to participate in the above sport(s). As consideration for participation in the sports program, I (he/she) hereby voluntarily assume(s) all risks associated with participation and agree to exonerate, save harmless and release Jacksonville University, its agents, servants and employees from any and all liability, any medical expenses not covered by the University's secondary sports accident policy, and all claims, causes of action or demand of any kind and nature including claims of negligence which may arise by or in connection with my (his/her) participation in any activities related to intercollegiate athletics.

Signature

Date

If this form was signed by someone other than the athlete, please circle authority to act on behalf of the athlete:

Parent Legal Guardian Other _____

**Jacksonville University Sports Medicine
Authorization to Release/Gain Information Form 2010-2011**

Athlete Name: _____

Sport(s): _____

*(The Jacksonville University student/ athlete must sign each subsection if he or she is at least 18 years old.
If under 18, a parent or legal guardian **MUST** sign.)*

AUTHORIZATION FOR JACKSONVILLE UNIVERSITY TO RELEASE INFORMATION

I, _____, hereby allow the Jacksonville University Athletic Training Staff and/or Team Physicians to release any medical information regarding the athlete named above. This information can be given to coaches, the Athletic Training Staff, the Jacksonville University Sports Information Department, the Jacksonville University Athletic Administration, the Atlantic Sun Conference, media outlets, representative scouts of professional athletic teams, insurance companies, health plans, athlete's parent/guardian or other third party payers. This can include any information concerning injury or medical condition related to my past, present, or future participation in athletics at Jacksonville University. These disclosures may be made for purposes related to athletic training, public relations, media coverage, recruitment, payment and reimbursement, or health care operations. The authorization expires twelve months after the athlete is no longer enrolled at Jacksonville University.

I understand that I do not have to sign this form. My choice about whether to sign this form will not change the way health care providers treat the athlete. I know that I can see or copy any paper records that have been given out. I also understand that if information is given to others as allowed in this form, it may no longer be protected by federal privacy laws. This form can be revoked at any time in writing. Written revocations should be signed and given to the Athletic Training Staff or Team Physicians. Revocation letters will not affect any actions taken before the Athletic Training Staff or Team Physicians received the revocation.

Signature

Date

If this form was signed by someone other than the athlete, please indicate authority to act on behalf of the athlete:

Parent

Legal Guardian

Other _____

RELEASE OF INFORMATION TO JACKSONVILLE UNIVERISTY ATHLETIC TRAINING STAFF

I, _____, hereby allow Jacksonville University Team Physicians, other physicians and rehabilitation and diagnostic centers, or consulting medical specialists to release any and all medical information concerning the athlete named above to the Athletic Training Staff at Jacksonville University. This information includes anything relating to or affecting participation in athletics at Jacksonville University. This information may include, but is not limited to, all information within their knowledge, or contained in any records under their control or supervision concerning the student's physical condition, illness, and/or injuries. This includes, but is not limited to: X-rays, MRIs, results of tests, and dictations.

I also hereby authorize the Jacksonville University Athletic Training Staff to receive from insurance companies, medical providers, and employer health plans payment information pertaining to the athlete's injury or illness. This includes, but is not limited to, benefits information, explanation of benefits forms and itemized statements. These disclosures may be made for evaluation and treatment purposes, payment purposes, health care operations purposes, or any other purpose as required by Jacksonville University. This authorization expires twelve months after the athlete is no longer enrolled at Jacksonville University.

I understand that I do not have to sign this form. My choice about whether to sign this form will not change the way health care providers treat the athlete. I know I can see or copy any paper records that have been given out. I also understand that if information is given to others as allowed in this form, it may no longer be protected by federal privacy laws. This form can be revoked at any time in writing. Written revocations should be signed and given to the Athletic Training Staff or Team Physicians. Revocation letters will not affect any actions taken before the Athletic Training Staff or Team Physicians received the revocation.

Signature

Date

If this form was signed by someone other than the athlete, please indicate authority to act on behalf of the athlete:

Parent

Legal Guardian

Other _____

Photocopies of this form are as binding as the original and shall remain in effect until revoked in writing

Jacksonville University Sports Medicine
Athletic Injuries/Illness Reporting and Medical Bill Payment Policy 2010-2011

Athlete Name: _____

Sport(s): _____

1. All athletic injuries/illness must be reported to the Athletic Training Staff immediately. If an athletic trainer is not available, contact your coaching staff, then report to the Athletic Training Staff as soon as possible. Failure to report an injury in a timely manner may reduce or terminate Jacksonville University's involvement. It is the student-athletes responsibility to report all injuries to the athletic training staff in a timely manner.
2. The reporting of injuries also includes reporting signs and symptoms of concussions, heat illness, or sickle cell.
3. Except in cases of extreme emergencies, if an injury occurs during a countable athletically related activity requires a physician's care other than that of the University's Infirmary; **only the Athletic Training Staff** can authorize the arrangements.
4. Jacksonville University **is not** financially responsible for: a) pre-existing conditions or the exacerbation of a pre-existing condition; b) general medical conditions/illness; c) injuries/conditions that occur during non-countable athletically related activities. This includes, but not limited to: voluntary workouts/training/play/ captain practices; d) injuries/conditions related to body piercing; e) medical bills resulting from a countable athletically related injury/conditions when proper procedure (i.e., injury reporting, insurance filing) is not followed or processed in a timely manner; f) medical expenses if you fail to maintain personal health insurance as required by the University; g) unauthorized medical expenses including expenses incurred from physician consultations for the purpose of a second opinion unless referred by the team physician or authorized attending physician and authorized by a JU staff athletic trainer.
5. Jacksonville University's policy on paying medical bills is as follows:
 - Primary insurance coverage is the athlete's personal health insurance. It is the athlete's and/or parent's responsibility to ensure that all medical providers have correct insurance information and all claims are properly processed with their insurance company. This includes, but not limited to, primary care physician and insurance notification and gaining referrals, proof of student status and completion of any insurance claim forms.
 - Jacksonville University has secondary insurance coverage. If proper procedure is followed with the athlete's personal health insurance and the primary insurance denies the claim or does not cover the entire balance, the J.U. and/or insurance carrier will be responsible for the balance.
6. Jacksonville University and/or the University's insurance carrier will make final payment when the Athletic Training Staff or our secondary insurance carrier receives the following. Untimely filing penalties are not the responsibility of the University or secondary insurance carrier.
 - All available itemized bills (HCFA 1500 or UB92) for medical service. "Balance Due" bills are not acceptable.
 - Explanation of Benefits (EOB) from insurance plan. There should be an EOB for each itemized bill submitted for payment.

Secondary Insurance Information:

Group Name – Jacksonville University. Policy # - JU – (Athlete's S.S. #). Send Claims to: Trustway T.E.A.M., Claims Department. P.O. Box 674168, Marietta, GA 30006. Phone – (678) 803-1317. Fax – (678) 803-1811.

Every effort will be made by me to make this process easy for you. If you have any questions that the insurance company or medical provider can not answer, please feel free to contact me at the University. I may be reached at: Phone - (904) 256-7421, E-Mail - bmcDoug@ju.edu, Fax - (904) 256-7116, Mail - Bo McDougal, Jacksonville University, 2800 University Blvd. North, Jacksonville, FL 32211.

Signature

Date

(Please retain copy for future reference)