

Student's Name: \_\_\_\_\_

## Marian University Past Medical Health History Form:

Please list current or past medical illness:.....  
.....

Circle any of the following that apply:

- |                    |           |                         |               |
|--------------------|-----------|-------------------------|---------------|
| Anemia             | Asthma    | Hypertension            | Mononucleosis |
| Bruising/ bleeding | Hay Fever | Urinary Tract Infection | Diabetes      |
| Concussion         | Headache  | Chronic Fatigue         |               |

**Allergies** (drugs, insects, foods, hay fever, etc.):

**\*\*Please note: if you are an athlete and you require the use of an EpiPen or Inhaler, please bring an additional one to campus with you that can be left with the athletic trainers or coach for ease access during an emergency\*\***

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.....

**Medications:** please list all prescription and over-the-counter medications/supplements

.....  
.....

**Surgeries:** please include dates

.....  
.....

### For Female Menstrual History

When was your last menstrual period? .....  
What was the longest time between periods in the last year?.....  
Are your periods regular? Yes No

### Family History: Please indicate relationship of family members for any yes answers

Yes No Has anyone in your family died of heart disease or sudden death before the age of 50?  
Yes No Has anyone in your family had Marfan's Syndrome?  
Yes No Has anyone in your family had sickle cell disease?

.....  
.....

### Social History: Please provide average amount per day/week

Please list any countries that you have traveled to in the past 2 years: .....  
Yes No Do you smoke? .....  
Yes No Do you use smokeless tobacco? .....  
Yes No Do you drink alcohol? .....  
Yes No Do you use any recreational drugs? .....

### Review of Systems: Explain yes answers in the space provided next to each question

Yes No Have you passed out during exercise? .....  
Yes No Have you experienced dizziness during or after exercise? .....  
Yes No Have you had chest pain during or after exercise? .....

**Student's Name:** \_\_\_\_\_

- Yes No Have you ever been told that you have a heart murmur? .....
- Yes No Have you ever had racing of your heart or skipped beats?.....
- Yes No Have you ever had an echocardiogram? .....
- Yes No Do you have trouble breathing or do you cough during or after activity?.....
- Yes No Have you had high blood pressure? .....
- Yes No Have you ever had a seizure or epilepsy?.....
- Yes No Have you ever had heat cramps, heat illness, or muscle cramps?.....
- Yes No Have you ever had a head injury?.....
- Yes No Have you ever been knocked unconscious? .....
- Yes No Have you ever had a "burner" or "stinger"?.....
- Yes No Do you use any special equipment (pads, braces, neck rolls, eye guards).....
- Yes No Do you have problems with your eyes or vision?.....
- Yes No Have you had vision correction surgery?.....
- Yes No Are you missing an eye or kidney?.....
- Yes No Have you had any bone, joint, or muscle injuries in the past year?.. .....

Please provide a month/year for any of the following structures that you have injured. This includes sprains, strains, fractures/breaks (including stress fractures), and dislocations.

.....Head	.....Shoulder	.....Elbow	.....Wrist
.....Neck	.....Hand	.....Knee	.....Ankle
.....Back	.....Hip	.....Thigh	.....Shin/Calf

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**Proof of immunization:** One of the following (a copy- not the original) must be attached to this form.

- \* Personal record (i.e. vaccination booklet)
- \* A physician or clinic report
- \* School immunization

**Required Immunizations:**

**Hepatitis B**

Requires 3 vaccinations

#1 Date: \_\_\_\_\_

#2 Date: \_\_\_\_\_

#3 Date: \_\_\_\_\_

**Varicella (Chickenpox)**

Yes, I had chickenpox. Date: \_\_\_\_\_

No. If you have not had the Varicella disease you will need 2 vaccinations. #1 Date: \_\_\_\_\_ and #2 Date: \_\_\_\_\_

**Tetanus-Diphtheria or Tdap**

TD in the last 10 years. Date: \_\_\_\_\_

Tdap. Date: \_\_\_\_\_

**MMR**

*All entering college students born after 1956 should have two doses of live measles vaccine.*

Requires 2 vaccinations

#1 Date: \_\_\_\_\_

#2 Date: \_\_\_\_\_

**Polio**

Requires 3 Vaccinations

#1 Date: \_\_\_\_\_

#2 Date: \_\_\_\_\_

#3 Date: \_\_\_\_\_

**Tuberculin PPD (within the last 12 months)**

Mantoux Skin Test (PPD Test)

Date read: \_\_\_\_\_

Result: \_\_\_\_\_

**If you have had a positive PPD Test, a chest X-ray is required within the last 12 months. Attach a copy of the X-ray report to the health form.**

**Recommended Immunizations:**

**Hepatitis A**

Requires 2 vaccinations

#1 Date: \_\_\_\_\_

#2 Date: \_\_\_\_\_

**Meningococcal Vaccine**

I understand that the Meningococcal Vaccine offers protection against certain strains of Neisseria Meningitis. This vaccine is available at Marian’s Student Health Center for a fee. The vaccine may also be available through family physician offices or clinics. If vaccine has been given enter name of vaccine/ month given/year given: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**All Student’s required to sign:**

\_\_\_\_\_  
Student Signature (If student is 18 years or older)

\_\_\_\_\_  
Date

**Student Athlete’s required to sign:**

I know of and acknowledge the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation and choose to accept any and all responsibility for my safety and welfare while participating in athletics.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

**This form must be completed by a physician, other than a pediatrician, for all student athletes.**

## Physical Examination Form:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Pulse \_\_\_\_\_ Regular /Irregular BP \_\_\_\_\_/\_\_\_\_\_, (\_\_\_\_/\_\_\_\_)  
Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Yes No Pupils Equal \_\_\_ Unequal \_\_\_ R>L L>R

**This portion is to be completed and signed by a Medical Doctor:**

Medical		Specific Findings
Yes No	Marfan's syndrome	_____
Yes No	Irregular Heartbeat	_____
Yes No	Murmur supine	_____
Yes No	Murmur standing	_____

	Normal (please check)	Specific findings
<b>HEENT</b>	_____	_____
Neck	_____	_____
Chest/Lungs	_____	_____
Abdomen	_____	_____
Genitalia/Hernia	_____	_____
Femoral Pulses	_____	_____
Neurological	_____	_____
<b>Musculoskeletal</b>		
Neck	_____	_____
Shoulders	_____	_____
Elbows	_____	_____
Wrists	_____	_____
Hands	_____	_____
Cervical spine	_____	_____
Thoracic spine	_____	_____
Lumbar spine	_____	_____
Hips	_____	_____
Thigh	_____	_____
Knees	_____	_____
Shin/Calf	_____	_____
Ankles	_____	_____
Feet	_____	_____

Additional Tests	Comments
___ CBC with diff, plts	_____
___ Ferritin	_____
___ EKG	_____
___ Peak Flow	_____
___ ImPACT neuropsych testing	_____
___ ETT	_____
___ PFT's	_____
___ Other	_____

Medical Clearance:

- A. Cleared. I hereby certify that this athlete was examined by me. At that time, no physical condition was detected which would reasonably be anticipated to render this athlete physically unfit to engage in athletic activities.
- B. Cleared after completing evaluation/rehabilitation for : \_\_\_\_\_
- C. Not cleared due to: \_\_\_\_\_

Recommendations: Mouthguard Polycarbonate protective eyewear Nutrition Education

Signature of physician \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*Please have MD stamp form or staple business card if this is completed off campus\*\*\***

# MARIAN UNIVERSITY

Indianapolis

## STUDENT ATHLETE HIPAA AUTHORIZATION FORM

I understand my rights under the federal regulations mandated by the Health Insurance Portability and Accounting Act (HIPAA) and I authorize Marian University's athletic training staff to provide to my parents or guardians, coaches, insurance company representatives, university personnel, and medical personnel, all information concerning my healthcare, injury, rehabilitation, treatment, and health status. This information is to be used for the following purposes: advising persons of my health or injury status for further medical treatment; accessing the insurance coverage under the policy that covers medical treatment and costs for me; and advising the coaching staff of my health status and restrictions on my ability to participate in athletics.

I do hereby consent to receiving athletic training services from St. Vincent Sports Performance. I understand that during the course of these services certain health information related to the student's athletic training services may be used and/or disclosed for treatment, payment or healthcare operations purposes, or as otherwise required by law. I further consent to certain health information being disclosed to school personnel, including but not limited to, coaches, school administration, and/or staff, as necessary.

I understand this consent is subject to my revocation at any time, except to the extent that action has been taken in reliance on this consent. Otherwise, this consent shall expire at the end of the school year or the student's current athletic season, whichever is later.

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Student-Athlete Signature

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Date



*St. Vincent  
Sports Performance*



**STUDENT ATHLETE ASSUMPTION OF RISK AND  
CONSENT FOR TREATMENT FORM**

Assumption of Risk

I understand the risk of injury or losses that can occur as a result of my participation in Intercollegiate Athletics and assume all such risks. In consideration of my being permitted to participate in the Marian University Intercollegiate Athletic Program, I release and agree to indemnify and hold harmless Marian University, its board of trustees, president, officers, students and employees from all claims, actions, damages and liabilities for personal injury or damage I might experience relating to or arising out of any Intercollegiate Athletics activity.

Consent for Treatment

I hereby further consent to Marian University obtaining whatever medical treatment and/or care as is deemed necessary by university staff for my health and well being as a Student Athlete and I hereby consent to have administered any emergency medical or surgical treatment recommended by a licensed professional.

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Date



*St. Vincent  
Sports Performance*

PARENTS/GUARDIANS TO COMPLETE AND RETURN TO:

ATTN: ATHLETIC DEPARTMENT  
MARIAN UNIVERSITY  
3200 COLD SPRING ROAD  
INDIANAPOLIS, IN 46222

**FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not, i.e., deceased, divorced, unknown.**

Name of Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

College Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Medical Insurance Co.: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your insurance or plan require a second opinion before surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

I hereby authorize **Marian University** and Student Athletic Protection, Inc. of Kalamazoo, MI to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and /or previous confinements and/or disabilities. **A photo static copy of this authorization shall be deemed as effective and valid as the original and valid up to two years from the date of signature.**

We authorize **Marian University** or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

**Student's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent's Signature** \_\_\_\_\_