2019 – 2010

RETURNING PLAYER’S PACKET

INFORMATION AND INSTRUCTIONS
FOR ALL
RETURNING STUDENT-ATHLETES
WHO DID NOT ATTEND ATHLETIC PHYSICALS

GENERAL INFORMATION:
• Please read these instructions carefully. Failure to follow them will prevent you from participating with your team.
• All forms must be printed and submitted single-sided only.
• The purpose of this Athletic Physical is to: perform the required annual health update; ensure that any current health conditions you have are being managed appropriately and in compliance with NCAA regulations; and to discuss any health-related questions you may have.
• These forms are completely confidential. The information on these forms cannot and will not be used for purposes beyond treating you and processing insurance claims for individual injuries without express permission from you.
• All of these forms must be COMPLETE, VALID, SIGNED AND SUBMITTED TO LISA KOMNIK, HEAD CERTIFIED ATHLETIC TRAINER BEFORE YOU CAN BEGIN PRACTICE!

QUESTIONS:
Any questions can be directed to the Danzi Center Athletic Training Room. Our telephone number is 631.687.1454, the fax number is 631.687.1453.
THE FORMS AND INSTRUCTIONS:

1. **Athletic Physical Form**
   There are six sections on this form. You must complete the Athlete Information (both pages), Emergency Information and Insurance Information sections. Your physician will complete the Physical Exam and Overall Physical Exam Results sections. Please make sure that you sign the bottom of the second page.

   The Orthopedic Exam section only needs to be completed if you are currently undergoing treatment or recovering from an injury. It should be completed by the treating orthopedist.

   Only when all sections are complete and the form is signed dated and stamped will the Athletic Physical Form be considered complete and valid. **Please note that all sections MUST be completed. Blanks and “n/a” are not acceptable.**

   All physicals must be completed after **July 1, 2019**.

2. **Copy of Insurance Card(s)**
   St. Joseph’s College requires all students to have primary health insurance. You must provide a copy of the front and back of your insurance card(s). If you have coverage through more than one person, copies of each card must be provided. You are required to update this form with any changes throughout the year. Please contact the Office of the Vice President of Student Life at 631.687.4595 for additional information regarding health insurance coverage requirements.

3. **Medication Declaration Form**
   This form is where you should list ALL medications you use (over-the-counter and prescription, including birth control, inhalers and/or Epi-pens) as well as any supplements you are taking. A certified athletic trainer will be present to answer any specific questions you may have. This form meets the NCAA requirements for medication documentation and will be used if you have a positive drug test.

   You must read and sign the NCAA Nutritional/Dietary supplements warning at the top of this page. You are required to update this form with any changes throughout the year.

   Please provide the Sports Medicine Department with an extra device when you submit your Player Packet.

4. **Acknowledge/Waiver/Release Form**
   By signing this form you are acknowledging the inherent risk of sport and voluntarily assuming that risk; you are agreeing to participate in your healthcare; you understand the limitations of the secondary insurance accident policy; and you are allowing the Sports Medicine Department at St. Joseph’s College to treat you.

5. **Health Insurance Portability and Accountability Act (HIPAA) Form**
   This form allows the Sports Medicine Department to access and share medical information about you with treating and billing entities for the purpose of your care and bill payment only. This form also ensures the confidentiality of all of your medical records at St. Joseph’s College.
ATHLETE INFORMATION: The student-athlete should complete this section before the exam.
Name: ____________________________  M  F  DOB: __________________
Street Address: _____________________  City, State, Zip: __________________
Home phone: (____) _______  Cell phone: (____) _______  Email: ________________________
Sport(s): ___________________________  Position(s): ___________________________
Year in school: 1  2  3  4  5
Medications: _________________________  Allergies: _________________________  Glasses / Contacts?

MEDICAL HISTORY UPDATE:
Have you sustained any injury/illness since last exam, including a head injury, infection, etc? Yes ___  No ___
If yes, please explain: __________________________________________________________
Are you currently being treated (ex MD, PT, chiropractor, etc.)? Yes ___  No ___  Reason _______________________________________________________
Is there anything you would like to discuss at this visit? ____________________________

PHYSICAL EXAM: **FORM WILL NOT BE ACCEPTED WITH ANY BLANKS!**
ORTHOPEDIC EXAM
PMHX: __________________________  Reason for exam: __________________________
Findings: __________________________  Recommendations: ________________________

Signature of Physician: ___________________________________  Date of exam: __________
GENERAL MEDICAL EXAM
PMHX: __________________________
Ht: _______ in  Brachial pulse/min: __________  R) eye 20/____ corrected?  BP: __________
Wt: _______ lbs  Femoral pulse/min: __________  L) eye 20/____ corrected?  BP Arm: __________

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<th>MUSCULOSKELETAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<td>Neck</td>
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<td>Back/Spine/Scoliosis</td>
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<td>Shoulder/Upper arm</td>
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<td>Elbow/Forearm</td>
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<td>Wrist/Hand/Fingers</td>
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<td>Hip/Thigh</td>
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<td>Knee/Lower leg</td>
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<td>Ankle</td>
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<td>Foot/Toes</td>
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<td>Neurological</td>
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<tr>
<td>Appearance</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<td>Hearing</td>
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<td>Neck/Teeth</td>
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<td>Lymph Nodes</td>
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<td>Heart</td>
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<td>Lungs/Respiratory</td>
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<td>Abdomen/Hernia</td>
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<td>Skin/Scalp</td>
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OVERALL PHYSICAL EXAM RESULTS: Based on all available information, please check A, B, or C:
A. Individual is cleared for (choose one): _______ all sports OR _______ non-contact sports only
B. Advised to consult physician for: ______________________________________________________
C. Deferred due to: _____________________________________________________________________

Signature of Physician: _______________________________  Date of exam: _______
Office stamp with telephone number:
The student-athlete should complete this page before the exam.

ATHLETE INFORMATION:
Name: ________________________________ M F DOB: ________________
Street address: _________________________ City, State, Zip: ________________
Home phone: (____) ___________________ Cell phone: (___) __________ Email: _______________________
Sport(s): ____________________________ Position(s): ____________________ Year in school: 1 2 3 4 5
Medications: ____________________________ Allergies: ____________________ Glasses / contacts?

EMERGENCY INFORMATION:
Notify in case of emergency: ____________________________________________________________
Relationship: ________________________________________________________________________
Contact number(s) with area code: _______________________________________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE – complete with the policy holder’s information
Policy Holder’s Name: __________________________ Relationship to athlete: __________ DOB: ______
Address: __________________________________ Telephone: _______________________
Employer: __________________________________ Telephone: _______________________
Insurance Company: __________________________ Policy/Group #: ________________________
Insurance Company Address: ___________________________________________________________

SECONDARY INSURANCE (if applicable) – complete with the policy holder’s information
Policy Holder’s Name: __________________________ Relationship to athlete: __________ DOB: ______
Address: __________________________________ Telephone: _______________________
Employer: __________________________________ Telephone: _______________________
Insurance Company: __________________________ Policy/Group #: ________________________
Insurance Company Address: ___________________________________________________________

You must provide a photocopy of the front and reverse sides of all insurance cards.

I hereby certify that the foregoing answers I have designated to the stated questions are true, complete and correct to the best of my knowledge.

Signature: _____________________________ Date: ________________
ST. JOSEPH’S COLLEGE – LONG ISLAND MEDICATION DECLARATION FORM

It is your responsibility to update this information as your medications and supplement use changes.

NCAA Nutritional/Dietary Supplements Warning:
Before consuming any nutritional/dietary supplement product, review the product with a certified athletic trainer!

- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken at your own risk.

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<th>Printed Name</th>
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PHYSICIAN NAME: ___________________________ TELEPHONE: ___________________________

MEDICATION NAME: ___________________________ DOSAGE: ___________________________

INSTRUCTIONS: ___________________________ DATE FILLED: ___________ REFILLS: ________

PHARMACY: ___________________________ TELEPHONE: ___________________________ RX NO.: ________

PHYSICIAN NAME: ___________________________ TELEPHONE: ___________________________

MEDICATION NAME: ___________________________ DOSAGE: ___________________________

INSTRUCTIONS: ___________________________ DATE FILLED: ___________ REFILLS: ________

PHARMACY: ___________________________ TELEPHONE: ___________________________ RX NO.: ________

PHYSICIAN NAME: ___________________________ TELEPHONE: ___________________________

MEDICATION NAME: ___________________________ DOSAGE: ___________________________

INSTRUCTIONS: ___________________________ DATE FILLED: ___________ REFILLS: ________

PHARMACY: ___________________________ TELEPHONE: ___________________________ RX NO.: ________

PHYSICIAN NAME: ___________________________ TELEPHONE: ___________________________

MEDICATION NAME: ___________________________ DOSAGE: ___________________________

INSTRUCTIONS: ___________________________ DATE FILLED: ___________ REFILLS: ________

PHARMACY: ___________________________ TELEPHONE: ___________________________ RX NO.: ________

SUPPLEMENT NAME(S): ___________________________

AMOUNT USED PER DAY: ___________ IF TAKEN WITH WATER, HOW MUCH? ___________

DURATION OF USE: ___________________________ WHERE PURCHASED? ___________________________
RISK ACKNOWLEDGEMENT
I am aware that playing or practicing in any sport, athletic event or activity can be a dangerous activity involving many risks or injuries. I understand that the dangers and risks of playing or practicing in the sport(s) listed below include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all internal organs, bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system and serious injury or impairment to other aspects of my body, general health and well-being.

This includes, but is not limited to illness; infection; adverse reactions to medications; or allergies; signs and symptoms of a head injury or concussion.

PARTICIPANT RESPONSIBILITY
I, _________________________ (print name), acknowledge that I have to be an active participant in my own healthcare. I have the direct responsibility for reporting all of my injuries and illnesses to a St. Joseph’s College Certified Athletic Trainer. I acknowledge and understand that it is essential for my general health and well-being that I not participate in the below sport(s) unless I am in good health and physical condition. I have advised a St. Joseph’s College Certified Athletic Trainer of any limitations on my participation for any medical reasons. I further acknowledge and understand that it is my responsibility to continue to notify a St. Joseph’s College Certified Athletic Trainer of any new injury or illness that affects my general condition regardless of how the injury was sustained, as well as any new limitations on my medical condition through my enrollment or participation in sports or athletic activities at St. Joseph’s College.

I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to a St. Joseph’s College Certified Athletic Trainer.

STATEMENT OF SECONDARY INSURANCE LIMITATIONS
I certify that I have health insurance which affords coverage for sickness and accident expenses. In the event of an athletically related injury that engages the college’s secondary coverage, I am responsible for all costs that exceed usual and customary charges and/or the duration of plan coverage.

WAIVER
In consideration of St. Joseph’s College permitting me to practice, play, or tryout for ______________________ (sport or sports), and to engage in all activities related to the team, including practicing, playing and travel, I hereby voluntarily assume all risks associated with the participation and agree to exonerate and save harmless St. Joseph’s College, their agents, servants, employees, the St. Joseph’s College athletic staff, the physicians, Certified Athletic Trainers, and other practitioners of the healing arts treating me, from any and all liability, claims, causes of action or demands of any kinds and nature whatsoever which may arise by or in connection with my participation in any activities related to the ___________________________ team(s).

The terms hereof shall serve as a release and assumption of risks for my heirs, executor, administrator, assignees and all members of my family.

CONSENT TO TREAT
I, _________________________ (print name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team/school/family physician, licensed physical therapists, certified athletic trainers and other practitioners of the healing arts. Under the direction of a certified athletic trainer, this also may include college/university student athletic trainers, and high school student athletic trainers.
I authorize St. Joseph’s College to provide information related to my care to the family/school/team physician, coaches, athletic directors, EMS personnel and other qualified medical personnel as needed for them to provide consultation, treatment, and establish a plan of care.

I give authorization to St. Joseph’s College to access medical or other information stored in various forms related to treatment or services provided to me in connection with my care, healthcare operations or payment for treatment and services. I also authorize information related to my care to be provided to my family/school/team physician and such persons as necessary for them to provide consultation, treatment and/or services to me. I understand that this authorization is in effect for one year from the date below.

I understand that health record(s) will not be released without my signature below. I understand that I have the right to revoke this authorization at any time by sending in a written request. My decision to revoke does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke authorization.

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<tr>
<th>Printed name</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>If student is under 18, printed name of parent</td>
<td>Signature of parent</td>
<td>Date</td>
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