Illinois Wesleyan University Athletics
Medical History Addendum

ATHLETE INFORMATION

(please print)

Name: Date: Sport:

(last) (first) (middle)

Age: Birthdate: Cell Phone #: Class: Fr. Soph. Jun. Sen.

Please provide information for any changes that have occurred over the past year regarding the following information. If no changes have occurred please do not fill in any information.

Parents Address: Parents Phone #:

Emergency Contact Person: Emergency Phone #:

Insurance: (if you have a change in your insurance please fill out a new insurance information form)

MEDICAL INFORMATION

(please print)

Please list below if you have had any changes in your medical information within the last year other than injuries that have occurred in your sport.

Have you had any new disease or illness in the past year? (please explain):

____

____

Have you had any new head or neck injury in the past year? (please explain):

____

____

Have you had any change in vision, eye wear, or dental appliances in the past year? (please explain):

____

____

Have you had any new injuries to your bones, muscles, or joints in the past year? (please explain):

____

____

Have you had any other changes in your medical condition in the past year that the certified athletic trainers' or team physicians should know about before you begin your athletic season? (please explain):

____

____

Illinois Wesleyan University
Sports Medicine
Physical Exam and Medical Authorization Statement

Pre-Participation Physical Examination

I have had a complete physical examination on ____________________. I have completed a medical history questionnaire to the best of my knowledge and have discussed with the IWU team physicians, athletic trainers and/or consultants my prior medical history as well as all existing complaints, injuries, ailments, and symptoms. All of my questions concerning this medical history and my condition have been answered to my satisfaction. I also affirm that I do not suffer from any disability, injury, condition, complaint, or problem that I have NOT DISCLOSED on any such forms and/or have not discussed with the team physicians, athletic trainers and/or consultants. Also, I recognize the importance of fully and accurately disclosing my physical condition, past and present with the Illinois Wesleyan University medical staff and/or Athletic Training Staff.

Signature:____________________________________ Date:_________________________

Catastrophic Injury Statement

The possibility of sustaining a catastrophic injury is inherent in any athletic activity. I, _________________________________ understand that by participating in athletics at Illinois Wesleyan University the potential of a catastrophic injury does exist. With this fact in mind, I understand the importance of rules and procedures as well as the necessity of using proper athletic techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist though the above are followed to the fullest.

Signature: ___________________________________ Date:__________________________

Authorization to Treat and Care

I give authorization to the athletic training staff and/or medical staff to evaluate and treat my injuries that occur during my participation in athletics at Illinois Wesleyan University. I understand the medical staff members have the authority to eliminate me from further participation because of an injury, illness, medical condition, and/or because of an undue liability risk to Illinois Wesleyan University.

Signature: ___________________________________ Date:__________________________

Student Athlete Authorization/Consent For Disclosure of Protected Health Information to Illinois Wesleyan University Sports Medicine Practitioners and Athletic Department Personnel

I, ______________________________, hereby authorize Illinois Wesleyan University 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 and participation in intercollegiate athletics to coaches, administrative personnel, CCIW conference personnel, professional scouting organizations, and media.

I understand that my protected health information will be used by the Physicians and Athletic Trainers of Illinois Wesleyan University to ensure proper health care while I am an athlete at Illinois Wesleyan University.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution 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 Illinois Wesleyan University Athletic Department is not a covered entity under the Buckley Amendment or HIPAA and that these regulations will not apply to Illinois Wesleyan University'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 my institution. 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 of Student Athlete **Date**

Illinois Wesleyan University
Sports Medicine

INSURANCE AND EMERGENCY INFORMATION FORM

This form MUST be resubmitted every year – Leave No blanks – "N/A" is not acceptable

Student Name: ____
Birth date: ____
Social Security: ____
Family Physician Name: ___________________________________
Physician Office Phone #: _________________________________

IN CASE OF EMERGENCY:
Contact Person: ____________________________________
Relationship to you: ________________________________
Contact Person's Home #: ____________________________
Contact Person's Work #: _____________________________

Student Health Problems (allergies, etc.): ____
Student Medication: ____

FATHER

Father's Name: ____________________________________
Social Security Number: _____________________________
Employer: ____
Employer Phone #: __________________________________
Insurance CO.: _____________________________________
Address: ______________________________________
City: ____
State: __________ Zip: ____________________
Policy ID #: ___________________________________
Insurance CO Phone #: _______________________________
Is student covered by this policy? Yes ___ No ___
Is this policy: _____ Primary or ______ Secondary
Is this policy a: ____ Health Maintenance (HMO)
____ Preferred Provider (PPO)
____ Standard Policy
Is a pre-authorization or a referral needed for a
Doctor's appointment ____Yes ____No
Is a second opinion required before surgery:
_____Yes _____No

MOTHER

Mother's Name: ____________________________________
Social Security Number: _____________________________
Employer: ____
Employer Phone #: __________________________________
Insurance CO.: _____________________________________
Address: ______________________________________
City: ____
State: __________ Zip: ____________________
Policy ID #: ___________________________________
Insurance CO Phone #: _______________________________
Is student covered by this policy? Yes ___ No ___
Is this policy: _____ Primary or ______ Secondary
Is this policy a: ____ Health Maintenance (HMO)
____ Preferred Provider (PPO)
____ Standard Policy
Is a pre-authorization or a referral needed for a
Doctor's appointment ____Yes ____No
Is a second opinion required before surgery:
_____Yes ____ N

Does the student have individual personal insurance: _____ Yes _____ No
If Yes: Insurance CO: ____________________________________ Phone #: ____
Address: _______________________________________ Policy #: ____
City: ____________________ Zip: __________________

Will you play inter-collegiate Sports: _____ Yes _____ No

ATHLETES ONLY: **I give authorization to the athletic training staff, Arnold Health Service and/or medical consultants to evaluate and treat any injuries that occur during my participation in athletics at Illinois Wesleyan University. I understand that Team Physician has the authority to eliminate me from further participation because of an injury and/or because of undue liability to risk Illinois Wesleyan University.**

____ ______________________________
Student's Signature Date

____ ______________________________
(If student is under 18 yrs.) Parent or Guardian's Signature Date