

New Athlete Checklist

Welcome to Southeastern University Athletics. In an effort to make the process of completing physicals easier, please make sure to have all of your paperwork completed when you arrive for your first practice. It is very important that everything is completed in its entirety. If you are under the age of 18, a parent or legal guardian must sign all forms.

All students are required to complete a physical prior to participating in athletics at Southeastern University. Also, if you have any conditions that are currently being treated by a physician, please bring written documentation from the physician stating your ability to participate in athletics.

Below is a check list of the forms which are attached and will need to be completed prior to participation in Southeastern University Athletics.

- _____ Health Insurance Form: Must be completely filled out
- _____ A Copy of the front and back of your Insurance Card
- _____ Complete and Sign Health Appraisal Form
- _____ Sign Consent for Participation Form
- _____ Complete Medical History Form (include right/left to any questions answered yes)
- _____ Complete and Sign Personal Representative Appointment
- _____ Complete and Sign Authorization for Release of Health Information
- _____ Complete and Sign FERPA Release of Health Information
- _____ **Physician must sign physical form to clear you for participation** (last page of packet)

If you have any questions about any of the forms, please feel free to contact me.

Thank You,

Jem Serrine, MS, ATC
Certified Athletic Trainer
Southeastern University
Phone: (863) 667-5115
Fax: (863) 667-5200

**SOUTHEASTERN UNIVERSITY
HEALTH INSURANCE FORM**

Athlete Information

Name of Athlete: _____ Birth Date: _____ Sport: _____
Home Address: _____ City: _____ State: _____ Zip: _____
SEU Box#: _____ Cell Phone: _____ Social Security #: _____

Father's Information

Name: _____
Home Address: _____

Social Security #: _____
Birth Date: _____
Home Phone () _____
Work Phone () _____

Mother's Information

Name: _____
Home Address: _____

Social Security# #: _____
Birth Date: _____
Home Phone: () _____
Work Phone: () _____

Insurance Information

Insurance Company: _____
Policy ID#: _____ Group #: _____
Mailing Address for Claims _____
Claims Phone #: _____
Who is your policy through? Self Mother Father
What Type Policy do you have? HMO PPO

Emergency Contact Information (OTHER THAN PARENTS)

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____

Pertinent Medical Information (Office Use Only)

**SOUTHEASTERN UNIVERSITY
MEDICAL HISTORY FORM**

Athlete Information

Name of Athlete: _____ Birth Date: _____ Sport: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 SEU Box#: _____ Cell Phone: _____ Social Security #: _____

****PLEASE EXPLAIN WITH DATES FOR ANY "YES" ANSWERS****

HOSPITALIZATION	YES	NO	EXPLAIN WITH DATES
Have you ever been hospitalized? What for?			
Have you ever had surgery? What for?			
Have you ever been treated in an emergency room/urgent care?			

ALLERGIES/ASTHMA	YES	NO	EXPLAIN WITH DATES
Do you have any allergies? If yes, please list.			
Are you taking any medication for your allergies?			
Do you have asthma or exercise-induced asthma?			
Have you ever used an inhaler or had a nebulizer treatment?			
What inhaler(s) are you using?			
Do you have any skin problems? Itching, rash, hives, acne? Which one?			
Are you taking medication for the skin problem?			

CARDIAC HISTORY	YES	NO	EXPLAIN WITH DATES
Do you get frequent headaches?			
Have you ever felt dizzy or lightheaded during or after exercise?			
Have you ever had chest pain, tightness, pressure, or any discomfort during exercise?			
Have you ever had high blood pressure?			
Does your heart ever beat fast or skip beats?			
Has anyone in your family died suddenly before age 50?			
Has anyone in your family had a heart attack before age 50?			
Have you ever been told you have a heart murmur?			
Have you or any relative ever been diagnosed with Marfan's Syndrome?			
Have you or any relative ever been diagnosed as having hypertrophic cardiomyopathy or IHSS?			
Have you ever been told you have a "heart problem"?			
Have you ever passed out or fainted during exercise?			
Have you ever been seen by a cardiologist?			
Have you ever had an echocardiogram or EKG?			

RESPIRATORY HISTORY	YES	NO	EXPLAIN WITH DATES
Do you have shortness of breath or chest tightness?			
Have you ever been to an emergency room because of difficulty breathing?			
Do you wheeze or have to gasp to breathe?			
Are you bothered by coughing spells?			
Do you cough up a lot of phlegm (thick spit)?			
Have you ever coughed up blood?			

NEUROLOGICAL HISTORY	YES	NO	EXPLAIN WITH DATES
Have you ever had a head injury?			
Have you ever had a spinal cord injury?			
Have you ever had a concussion? How many?			
Have you ever been knocked out or unconscious?			
Have you ever had headaches, memory loss, mental confusion, disorientation, and/or double or blurry vision due to a head injury? Which one(s)?			
Have you ever had a pinched nerve or stinger?			
Have you ever had a seizure/convulsion?			
Have you or do you have any numbness or tingling? Where?			

INTERNAL HISTORY	YES	NO	EXPLAIN WITH DATES
Do you have any missing organs? (Kidney, eye, etc)			
Have you ever sustained an injury to any of your vital organs? Which one? (brain, lung, intestines, eye, stomach, kidneys, ears, liver, spleen, heart, genitalia)			
Do you have organs not functioning correctly?			
Have you ever had surgery to remove any body organs? Which ones? (gallbladder, tonsils, spleen, etc)			

DENTAL & VISION HISTORY	YES	NO	EXPLAIN WITH DATES
Have you ever had a tooth knocked out or fractured?			
Do you wear any dental appliance? Which (Permanent bridge, permanent crown or jacket, removable partial or full plate)			
Do you have any dead teeth? Where?			
Have you ever had an eye injury? What?			
Have you ever had problems with your eyes or vision? What?			
Do you wear contacts or glasses? Which one?			

HEAT/COLD & EXERCISE	YES	NO	EXPLAIN WITH DATES
Have you ever had heat or muscle cramps?			
Have you ever been dizzy or passed out in the heat?			
Have you ever had a heat illness (heat exhaustion/heat stroke)?			
Do you have trouble with dehydration?			

PLEASE CHECK YES OR NO FOR THE FOLLOWING CONDITIONS

	YES	NO		YES	NO
Abnormal bleeding/easy bruising			Kidney Disease/Problem		
Anemia			Malaria		
Appendectomy			Measles		
Blood Disease			Meningitis		
Blood in Urine			Mononucleosis		
Cancer			MRSA Infection		
Depression			Pneumonia		
Diabetes			Recent Weight Loss/Gain		
Frequent Ear Infections			Scarlet Fever		
Eating Disorder			Scoliosis		
Epilepsy			Sickle Cell Anemia/Carrier		
Frequent Urinary Infections			Thyroid Disease		
Hearing Loss			Trouble with Circulation		
Heart Disease			Tuberculosis		
Hepatitis			Tumor/Cyst		
Hernia			Tonsillectomy		
Insulin Dependent			Ulcer		

FAMILY HISTORY

PLEASE CHECK IF ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING

X	RELATION		X	RELATION	
		Alcohol or Drug Dependency			Hypertension (High Blood Pressure)
		Arthritis			Kidney Disease
		Asthma			Marfan's Syndrome
		Blood Disease (Hemophilia, Leukemia)			Stomach Disease (Ulcer, etc)
		Cancer			Stroke/Aneurysm
		Diabetes			Sudden Death before age 50
		Epilepsy/Seizures			Sudden Death While Exercising
		Heart Disease			Tuberculosis

ORTHOPEDIC HISTORY

HAVE YOU EVER EXPERIENCED ANY INJURY TO THE BELOW LISTED BODY PARTS? IF YES, PLEASE INDICATE DATES AND RIGHT/LEFT.

Location	YES	NO	Explain with dates and right/left
Head			
Neck			
Shoulder			
Back			
Chest/Ribs			
Abdomen			
Arm/Elbow			
Wrist			
Hand/Fingers			
Hip/Groin			
Thigh			
Knee			
Low Leg			
Ankle			
Foot/Toes			

MEDICATION & SUPPLEMENTS

PLEASE LIST ALL MEDICATION/SUPPLEMENTS YOU ARE CURRENTLY TAKING.

MEDICATION	DOSAGE	FREQUENCY	REASON FOR TAKING
SUPPLEMENT NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

FEMALES ONLY

When was your first menstrual period?	
When was your last menstrual period?	
How many periods have you had in the last 12 months?	
Any irregularities, cramps, or menstrual problems	

STUDENT ATHLETE CONSENT FOR PARTICIPATION

I, a Southeastern University Student-Athlete

- A. Understand that injuries are an inherent part of athletics and that participation in sports requires an acceptance of risk of injury, thus there is a risk that I may be injured while playing or practicing in an intercollegiate sport.
- B. Understand that these personal injuries include, but are not limited to, death, serious neck and spinal injuries, and further that such injury may result in complete or partial paralysis, brain damage and serious injury or impairment to virtually all internal organs, bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system and serious injury or impairment to other parts of the body, general health and well-being.
- C. Understand that the dangers and risks of playing or practicing to play or participate in any sports or athletic activity may result not only in serious injury, but in a serious impairment of my future capacities to earn a living, to engage in other business, social and recreational activities and generally, to enjoy life.
- D. Understand that I must refrain from practice or play while ill or injured, until cleared by appropriate clinical practitioners (Physicians) and/or their designated representative(s) (Certified Athletic Trainer) whether receiving medical treatment or not.
- E. Understand that having passed the physical examination does not necessarily mean that I am physically qualified to participate in athletics, but only that the evaluator did not find a medical reason for disqualification from participation.
- F. Understand that in an event of injury, I am to report to the Athletic Trainer and follow the protocol that is given to me until I am told to stop by the Athletic Trainer.
- G. Further acknowledge and understand that it is my responsibility to continue to notify the Southeastern University Athletic Trainer of any new limitations on my medical condition through my enrollment or participation in sports or athletic activities at Southeastern.
- H. Further acknowledge and understand that if I refuse or fail to treat and/or rehab my injury, I must get a clearance note from the team physician stating that I am cleared to participate in intercollegiate athletics, before I return to athletics at Southeastern University. Knowing that my insurance, the Southeastern University student medical insurance and/or the Southeastern University athletic insurance may refuse coverage due to my failure to treat my injury, I will be responsible to pay for the medical bill incurred for treatment of the injury by the team physician.
- I. Further agree for myself and on behalf of my heirs, personal representative(s) and assigns to defend, hold harmless, indemnify, and release, and forever discharge Southeastern University and anyone acting on its behalf from and against any and all claims, demands and actions, or causes of action, on account of damage to personal property, personal injury or death which may result from my participation, or from causes beyond the control of, and without the fault or negligence of Southeastern University, and anyone acting on its behalf, during the period of my enrollment or participation as aforesaid.
- J. Certify that the statements above are complete, correct and true.

Print Name _____

Date of Birth _____

Signature _____

Date _____

(Athlete if 18 years or older)

OR

Print Name _____

Date _____

Signature _____

(Parent/Guardian if under 18 years of age)

Personal Representative Appointment

I, _____
(Athlete's Name)

do hereby appoint Southeastern University Athletic Training Staff as my personal representative to act on my behalf in the matters of health insurance with Student Insurance.

I understand this is a voluntary designation and that this designation gives the personal representative the same rights to my health insurance information as myself. This appointment will expire at the end of the current academic/policy year.

Please complete the following information:

<u>Insured/Athlete Information</u>	<u>Personal Representative's Information</u>
<u>Insured/Athlete Name</u>	Personal Representative's Name: <u>Jem Serrine</u>
<u>Insured/Athlete's SS#</u>	Personal Representative's Address: <u>1000 Longfellow Blvd</u> <u>Lakeland, FL 33801</u>
<u>Athlete's Address</u>	
<u>Date</u>	
<u>Insured/Athlete's Signature</u>	

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Telephone Number _____

I authorize all educational agencies and institutions, physicians, athletic trainers, hospitals, clinics, and all other health care providers

To Release My Medical Information To:

Southeastern University
Athletic Training Staff
1000 Longfellow Blvd
Lakeland, FL 33801
(863) 667-5115

Expiration Date of this Authorization: Six years from the date this Authorization was signed by me or by my personal representative.

Purpose of Disclosure: To assist Southeastern University Athletic Department coaches, athletic trainers, and physicians in evaluating my fitness as it pertains to my ability to participate in my sport and in providing medical care to me.

Medical Information to be Disclosed: All records pertaining to my medical condition, whether past, present, or future, including all physicals, athletic trainers' records, physicians' records, diagnoses, treatment information, medical histories, and prognoses of any and all injuries and illnesses, from your personal knowledge and/or records.

Authorization and Direction: I hereby authorize and direct the entities listed above and their respective employees to release the designated information. I understand that a separate authorization is required for release of psychotherapy notes. I understand and acknowledge that this Authorization extends to any and all information designated above that may pertain to treatment for physical and mental illness.

Acknowledgement of Individual Rights: I have read and understood the following statements about my rights:

- I may revoke this Authorization at any time prior to its expiration date by notifying the disclosing entity in writing, but the revocation will not affect any actions the disclosing entity took before it received the revocation. In addition, I may revoke this Authorization at any time prior to its expiration date by notifying the Southeastern University Athletic Department, Head Athletic Trainer. However, such revocation will not affect any actions the disclosing entities took before they received the notice from the Southeastern University Department of Athletics.
- A disclosing entity (covered entity) may not condition my treatment or payment for health care upon whether I sign this Authorization.
- The information that is disclosed pursuant to this Authorization may no longer be protected by federal privacy rules such as HIPPA. The information disclosed may be redisclosed by the receiving entity. By signing below, I specifically authorize such redisclosure.

X _____
Signature of Patient/Student or Personal Representative

Date Signed

X _____
Relationship if not the patient/student

A copy of this Authorization shall be considered as effective and valid as the original

**SOUTHEASTERN UNIVERSITY
DEPARTMENT OF ATHLETICS
FERPA Authorization for Release of Health Information**

Name (Please Print)

Sport

Date of Birth

TO: THE SOUTHEASTERN UNIVERSITY ATHLETIC TRAINERS, PHYSICIANS, AND OTHER RELATED PERSONNEL:

You are hereby authorized and requested to disclose information and records pertaining to my physical health or condition, whether past, present or future, including all physicals, physicians' records, athletic trainers' records, diagnoses, treatment information, histories, and prognoses, and including information and records to any and all injuries or illnesses to (i) Southeastern University Department of Athletics and its personnel (including coaches of my sport) who the University, in good faith, determines have a legitimate "need to know"; (ii) Southeastern University's team physicians; (iii) all media organizations, including print, television, radio and internet, but only disclosing such information to the media as it relates to my ability to participate in my sport; and (iv) my parent(s), step-parent(s) or legal guardian(s) but only after I have informed such person(s) of my particular injury or illness.

The purpose of this authorization is (i) to assist coaches and other personnel within the Department of Athletics in evaluating my fitness as it pertains to my ability to participate in my sport; (ii) to allow personnel within the Department of Athletics knowledge with respect to my academic progress; (iii) to assist Southeastern University team physicians in providing medical care to me; (iv) to meet the requirements of insurers or health plans when such insurers require such information before paying for your health care services; (v) to allow athletic training students and student physicians in training to participate in my medical care or to contribute to their educational training; (vi) to provide to the media, for redisclosure to their respective audiences, information regarding my fitness as it pertains to my ability to participate in my sport; and (vii) to inform my parent(s), step-parent(s), or legal guardian(s) of my injury or illness.

I hereby agree that the information that is used or disclosed pursuant to this Authorization may be redisclosed by the receiving entity. By signing below, I specifically authorize and consent to all such redisclosures.

I understand that the information to be disclosed is protected either as "education records" by the Family Educational Rights and Privacy ACT of 1974 or as "medical record" under Florida law and, with certain exceptions, may not be disclosed without my consent. By signing this form, I certify that I agree to the disclosure of the records referenced above.

A copy of this authorization shall be considered as effective and valid as the original.

Student-Athlete Signature

Parent or Guardian if under 18 years

Date

Date

PHYSICAL EXAMINATION

Name _____ Birth Date _____ SS# _____

Height _____ Weight _____ Blood Pressure _____ Heart Rate _____

GENERAL EXAM	NORMAL	ABNORMAL FINDINGS
HEAD/SCALP		
NECK		
EYES/EARS		
NOSE/MOUTH/THROAT		
HEART		
LUNGS		
ABDOMEN		
SKIN		
GENITALIA		
HERNIA		
ORTHOPEDIC EXAM	NORMAL	ABNORMAL FINDINGS
NECK		
SHOULDER		
ARM		
ELBOW		
FOREARM		
WRIST		
HAND/FINGERS		
BACK/SCOLIOSIS		
HIP		
LEG		
KNEES		
CALF		
ANKLES		
FEET/TOES		
ARCH		
FUNCTIONAL EXAM	NORMAL	ABNORMAL FINDINGS
SPINE ROM		
JUMP		
HOP		
SQUAT		
DUCK WALK		

Physician's Comments

CLEARANCE STATUS		
	NO CLEARANCE	Diagnosis: Recommendations:
	CLEARED WITH RESTRICTIONS	Diagnosis: Recommendations:
	CLEARED WITHOUT RESTRICTIONS	

Examined By	I have examined the above student-athlete and my recommendations are as above	
	Physician's Signature	DATE
	Please Print Physician's Name	
	Address	Phone #