Personal Information
Coastal Carolina Athletic Training

Date:_____

Last Name:_____**MI:**_____**First Name:**_____

SSN/ID:_____ **College Graduation Date**_____

DOB:_____**(m/d/yr)** **Sex: M**_____**or F**_____**Sport:**_____

Cell Phone: (_____**)**_____ Email:_____

Permanent Home Address:

_____

Street **City** **State** **Zip**

Home Phone:(_____**)**_____

School Address:

_____

Street **City** **State** **Zip**

Parent's Employer Information:

Father's Employer:_____ **Mother's Employer**:_____

Address:_____**Address**:_____

City, State, Zip:_____**City, State, Zip**:_____

Phone:_____ **Phone**: _____

Emergency Primary Contact (Typically your Parents):

Last Name:_____ **First Name:**_____

_____

Street **City** **State** **Zip**

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ Email:_____

Relationship_____

Emergency Secondary Contact:

Last Name:_____ **First Name:**_____

_____

Street **City** **State** **Zip**

Home Phone:_____**Work Phone:**_____

Cell Phone:_____ Email:_____

Relationship:_____

Coastal Carolina University Athletic Training
Insurance Information

Primary Medical Insurance: (please provide copy of **FRONT & BACK** of card)

Name of Company: _____

Claims Address: _____

City, State, & Zip: _____

Claims Phone Number: _____

Plan: _____ Policy Number: _____ Group #: _____

Name of Policy Holder (typically parent): _____

Policy Holder SSN (required): _____ Policy Holder DOB (required): _____

PLEASE CONTACT YOUR INSURANCE COMPANY REGARDING THE FOLLOWING INFORMATION:

Is this insurance a: ☐ PPO ☐ HMO ☐ PCP ☐ Other

Does your insurance cover intercollegiate athletics? ◯ YES ◯ NO

Do you have NETWORK coverage in the Conway/Myrtle Beach, SC area? ◯ YES ◯ NO

Do you have out of network benefits? ◯ YES ◯ NO

If HMO, are you able to establish a guest membership in the Conway/Myrtle Beach, SC area? YES ◯ NO ◯

Deductible amount $_____

Primary Care Provider Name: _____ Phone #: _____

****

Dental Coverage Information:

_☐_ Included in Primary Medical Insurance Coverage

_☐_ Do not carry/hold Dental Insurance coverage

_☐_ Separate Policy (please provide copy of insurance card)

Prescription Coverage:

_☐_ Included in Primary Medical Insurance Coverage

_☐_ Do not carry/hold Prescription Insurance coverage

_☐_ Separate Policy (please provide copy of card)

****

ACKNOWLEDGE OF INSURANCE REQUIREMENTS:

I attest that _____ has insurance coverage under a current insurance policy that covers injuries sustained while participating in intercollegiate athletics at Coastal Carolina University.

If there is a change in coverage or expiration of coverage, I agree to notify the Athletic Training Staff at Coastal Carolina University and update the insurance information I have on file.

I understand and agree that Coastal Carolina University will assume **NO** responsibility for the payment of, or authorization to pay, any medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Coastal Carolina University if the primary coverage specified above is not in place.

I also understand that ALL services rendered outside the established NETWORK of University approved physicians MUST be approved in writing by the Athletic Training staff prior to the date of service for charges to be considered for payment.

Student-Athlete Signature_____ Date _____

Parent or Guardian (required) _____ Date _____

Coastal Carolina University
Department of Athletics
Intercollegiate Participation Waiver

I, _____, recognize and accept the following statements regarding my participation in intercollegiate athletics at Coastal Carolina University. I understand and agree to abide by the statements listed below:

- I understand that participation in intercollegiate athletics is voluntary.
- I recognize and accept that risks are associated with participation in intercollegiate athletics including, but not limited to, practice, competition, strength and conditioning, and travel. I understand that injury is possible and there is potential for catastrophic accidents.
- I authorize the Sports Medicine Team (athletic trainers, team physicians, coaches, and/or athletic administrators) to secure any and all emergency medical treatment which may be deemed necessary.
- I authorize the Athletic Trainers to release, verbally and/or in writing, information pertaining to injuries that affect my athletic participation to coaches, media relations department, the media (via media relations department), and professional scouts as necessary upon request.
- I acknowledge that Team Physicians and the Athletic Training staff of Coastal Carolina University have the final decision in regards to my athletic participation level.
- I understand and accept the responsibility of reporting ALL injuries and illnesses to the Sports Medicine Team of Coastal Carolina University in a timely fashion.
- I understand and accept the responsibility of reporting ALL SIGNS and SYMPTOMS of concussions. I understand the risks associated with not disclosing necessary information.

By signing below I acknowledge that I have read and understand these statements. That I have been given an opportunity to discuss each one and have been provided educational material related to concussions.

_____ _____
STUDENT-ATHLETE DATE

_____ _____
PARENT/GUARDIAN (If under 18 yrs of age) DATE

_____ _____
WITNESS DATE

COASTAL CAROLINA UNIVERSITY ATHLETIC TRAINING DEPARTMENT
Student-Athlete Health History Questionnaire Form

The information contained in this medical history form will only be used by the Athletic Training Department of Coastal Carolina University for purposes of determining if you pose a health threat / risk to yourself on the athletic field. This information will remain **CONFIDENTIAL** at all times.

(please print clearly in *BLUE or BLACK INK ONLY!)*

Name _____ Date _____

Social Security # _____ Date of Birth _____ m/d/yr

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian/Pacific ☐ Alaskan/Indian ☐ Other _____

Sport(s) _____ Position(s) _____

Height _____ Weight _____ ☐ Right Handed ☐ Left Handed

PERMANENT ADDRESS:

_____
STREET

_____
CITY STATE ZIP CODE

_____
PHONE 1 PHONE 2 (CELLULAR)

Father's Name _____ Age _____

If Deceased, Cause of Death _____ Age @ Death _____

Father's Occupation _____

Address *(if different from permanent address):*

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE WORK PHONE

Mother's Name _____ Age _____

If Deceased, Cause of Death _____ Age @ Death _____

Mother's Occupation _____

Address *(if different from permanent address):*

_____
STREET

_____
CITY STATE ZIP CODE

_____
HOME PHONE WORK PHONE

I. Cardiovascular Risk Factors:

Have you ever had chest pain and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please Describe _____

Have you ever felt dizzy, lightheaded, and/or passed out during or after exercise / practice? ☐ YES ☐ NO

- Please Describe _____

Have you ever had the feeling of your heart racing or skipping beats during or after exercise / practice? ☐ YES ☐ NO

- Please Describe _____

Do you get tired more quickly than your teammates / friends do during exercise / practice? ☐ YES ☐ NO

- Please Describe _____

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please Describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please Describe _____

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please Describe _____

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / Please Describe _____

Does anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please Describe _____

Have you ever been told that you have / had high blood pressure? ☐ YES ☐ NO

- Please Describe _____

Does anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please Describe _____

Have you ever been told that you have / had high blood cholesterol? ☐ YES ☐ NO

- Please Describe _____

II. Allergies:

Have you ever been diagnosed with Seasonal Allergies? ☐ YES ☐ NO

- Please Describe _____

Are you presently taking/have you previously taken any allergy medications? ☐ YES ☐ NO

- Please Describe _____

Are you allergic to and/or ever had an unfavorable / allergic reaction to any medications? ☐ YES ☐ NO

- Please Describe _____

Are you allergic to and/or ever had an unfavorable / allergic reaction to any food items? ☐ YES ☐ NO

- Please Describe _____

Are you allergic to and/or ever had an unfavorable / allergic reaction to bee stings, insect bites, etc.? ☐ YES ☐ NO

- Please Describe _____

III. Asthma:

Have you ever been diagnosed with Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? _____
- Please Describe _____

Are you presently taking / have you previously taken any Asthma medications / use an Inhaler? ☐ YES ☐ NO

- Date(s)? _____
- Please Describe _____

How many times do you use your rescue inhaler (e.g. Albuterol, Proventil, etc.) during an average week? _____

How many acute asthma attacks have you had in the past 12 months? _____

- Date(s)? _____
- Please Describe _____

Have you ever been hospitalized as a result of Asthma and/or Exercised Induced Asthma? ☐ YES ☐ NO

- Date(s)? _____
- Please Describe _____

Have you ever been advised not to participate in athletic activities due to asthma or any related condition? ☐ YES ☐ NO

- Please Describe _____

IV. Head Injuries / Concussion:

Have you ever suffered a head injury/concussion (no matter how minor)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Have you ever been evaluated by a Doctor for a head injury/concussion? ☐ YES ☐ NO

- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Neuropsychological Testing ☐ Other _____

Have you ever been hospitalized, knocked out, become unconscious, and/or lost your memory due to a head injury / concussion? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to a head injury / concussion? ☐ YES ☐ NO

- Please Describe _____

Do you suffer from Headaches? ☐ YES ☐ NO

- When? ☐ Every Day ☐ 1-2 Times/Week ☐ 1-2 Times/Month
- Where are your Headaches located? ☐ Left Side of Head ☐ Right Side of Head ☐ Front of Head ☐ Back of Head ☐ All Over Your Head

Do you have a history of Migraine Headaches? ☐ YES ☐ NO

- How Often _____ Please Describe _____
- Medications Taken for Migraines? _____

Have you had Headaches for more than three (3) months? ☐ YES ☐ NO

- If yes, please explain _____

V. Eye:

When was your last Eye Exam? _____

- Findings? _____

Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other _____

Have you ever been hospitalized and/or seen an Ophthalmologist for an eye injury? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to an eye injury? ☐ YES ☐ NO

- Please Describe _____

Do you routinely suffer from blurred vision, double vision, tunnel vision, and/or any other abnormal sight? ☐ YES ☐ NO

- Please Describe _____

Do you routinely wear glasses? ☐ YES ☐ NO

Do you routinely wear contact lenses? ☐ YES ☐ NO Type _____

Do you require any special devices / equipment? ☐ YES ☐ NO Type _____

VI. Ear / Nose / Throat:

Have you ever suffered an injury to your ear(s), nose, and/or throat? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other _____

Have you ever been hospitalized for an ear, nose, and/or throat injury? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to an ear, nose and/or throat injury? ☐ YES ☐ NO

- Please Describe _____

VII. Dental:

When was your last dental exam? _____

- Findings? _____

Have you ever suffered an injury to your mouth, jaw, and/or teeth? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-ray ☐ MRI ☐ CT-Scan ☐ Other _____

Have you ever been hospitalized for a mouth, jaw, and/or tooth injury? ☐ YES ☐ NO

- Please Describe _____

Any permanent dental appliances (i.e. retainers)? ☐ YES ☐ NO

VIII. Cervical Spine / Neck:

Have you ever suffered an injury to your cervical spine and/or neck? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a cervical spine / neck injury? ☐ YES ☐ NO

- When? _____ Where? _____
- Please Describe _____

Have you ever had "Burners", "Stingers", or Brachial Plexus Injuries? ☐ YES ☐ NO

- How Many? _____ Date(s)/Time Missed? _____

Have you ever experienced numbness and/or tingling in your arms/fingers? ☐ YES ☐ NO

- Date(s)? _____
- Please Describe? _____

Have you ever had surgery of any kind on your cervical spine / neck? ☐ YES ☐ NO

- When? _____ Surgeon? _____
- Please Describe _____

Have you ever been advised not to participate in athletic activities due to a cervical spine / neck injury? ☐ YES ☐ NO

- Please Describe _____

Do you presently wear a Neck Roll / Collar, "Cowboy Collar" or Helmet Restrictor Plate? ☐ YES ☐ NO

Have you ever worn or been advised to wear a Neck Roll, Neck Collar, "Cowboy Collar", and/or Helmet Restrictor Plate?

If yes, please explain _____ ☐ YES ☐ NO

IX. Shoulder / Upper Arm:

Have you ever suffered an injury to your shoulder / upper arm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Have you ever suffered a dislocated shoulder? ☐ YES ☐ NO

If yes, did a physician put the shoulder back into place? ☐ YES ☐ NO

- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a shoulder / upper arm injury? ☐ YES ☐ NO

- When? _____ Where? _____
- Please Describe _____

Have you ever had surgery of any kind on your shoulder / upper arm? ☐ YES ☐ NO

- When? _____ Surgeon? _____
- Please Describe _____

Have you ever been advised not to participate in athletic activities due to a shoulder / upper arm injury? ☐ YES ☐ NO

- Please Describe _____

X. Elbow / Forearm:

Have you ever suffered an injury to your elbow / forearm? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for an elbow / forearm injury? ☐ YES ☐ NO

- When? _____ Where? _____
- Please Describe _____

Have you ever had surgery of any kind on your elbow / forearm? ☐ YES ☐ NO

- When? _____ Surgeon? _____
- Please Describe _____

Have you ever been advised not to participate in athletic activities due to an elbow / forearm injury? ☐ YES ☐ NO

- Please Describe _____

XI. Wrist, Hand, & Fingers:

Have you ever suffered an injury to your wrists(s), hand(s), and/or finger(s)? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a wrist, hand, and/or finger injury? ☐ YES ☐ NO

- When? _____ Where? _____
- Please Describe _____

Have you ever had surgery of any kind on your wrist, hand, and/or finger(s)? ☐ YES ☐ NO

- When? _____ Surgeon? _____
- Please Describe _____

Have you ever been advised not to participate in athletic activities due to a wrist, hand, and/or finger injury? ☐ YES ☐ NO

- Please Describe _____

XII. Spine / Low Back / Sacroiliac Joint:

Have you ever suffered an injury to your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a spine / low back / sacroiliac joint injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever had surgery of any kind on your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- ♦ When? _____ Surgeon? _____
- ♦ Please Describe _____

Have you ever had numbness/tingling down one (1) or both legs? ☐ YES ☐ NO

- ♦ Date(s)/Time Missed? _____
- ♦ Please Describe? _____

Have you ever been advised not to participate in athletic activities due to a spine, low back, or sacroiliac joint injury? ☐ YES ☐ NO

- ♦ Please Describe _____

XIII. Hip / Groin:

Have you ever suffered an injury to your hip / groin *(including hernias and/or sports hernias)?* ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever had surgery for a hip / groin injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury? ☐ YES ☐ NO

Please Describe _____

XIV. Thigh / Hamstring / Quadriceps:

Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a thigh, hamstring, and/or quadriceps injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever had surgery for a thigh, hamstring, and/or quadriceps injury? ☐ YES ☐ NO

- ♦ When? _____ Surgeon? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, or quadriceps injury? ☐ YES ☐ NO

- ♦ Please Describe _____

XV. Knee / Patella:

Have you ever suffered an injury to your knee and/or patella (kneecap)? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for a knee and/or patella injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever had surgery for a knee and/or patella injury? ☐ YES ☐ NO

- ♦ When? _____ Surgeon? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a knee / patella injury? ☐ YES ☐ NO

- ♦ Please Describe _____

Have you ever/do you presently wear a knee brace? ☐ YES ☐ NO

- ♦ Which Knee? _____ Brand / Model of Brace? _____

Reason for Wearing ? _____

XVI. Ankle / Lower Leg:

Have you ever suffered an injury to your ankle / lower leg? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever been hospitalized for an ankle/ lower leg injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever had surgery for an ankle / lower leg injury? ☐ YES ☐ NO

- ♦ When? _____ Surgeon? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to an ankle / lower leg injury? ☐ YES ☐ NO

- ♦ Please Describe _____

Do you presently ☐ Tape Your Ankle(s) ☐ Use Ankle Brace(s) ☐ Other

- ♦ Please Describe _____

XVII. Foot / Toes:

Have you ever suffered an injury to your foot / toe(s)? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever had surgery for a foot / toe injury? ☐ YES ☐ NO

- ♦ When? _____ Surgeon? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a foot and/or toe injury? ☐ YES ☐ NO

- ♦ Please Describe _____

XVIII. Ribs / Thorax / Chest:

Have you ever suffered an injury to your rib / thorax / chest? ☐ YES ☐ NO

- ♦ List Date(s) / Time (e.g. practices or games) Missed _____
- ♦ Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever had surgery for a rib / thorax / chest injury? ☐ YES ☐ NO

- ♦ When? _____ Where? _____
- ♦ Please Describe _____

Have you ever been advised not to participate in athletic activities due to a rib, thorax, and/or chest injury? ☐ YES ☐ NO

Please Describe _____

XIX. Abdomen:

Have you ever been diagnosed with a problem with your stomach, abdomen, intestines, or rectum? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Have you ever suffered an injury to your abdomen? ☐ YES ☐ NO

- List Date(s) / Time (e.g. practices or games) Missed _____
- Please Describe _____

Were any diagnostic tests performed? (check all that apply) ☐ YES ☐ NO

☐ X-Ray ☐ MRI ☐ CT-Scan ☐ Bone Scan ☐ Other _____

Have you ever had surgery for an abdomen injury? ☐ YES ☐ NO

- When? _____ Where? _____
- Please Describe _____

Do you routinely suffer from severe or recurrent abdominal pain? ☐ YES ☐ NO

- Please Describe _____

Do you routinely suffer from chronic or recurrent diarrhea? ☐ YES ☐ NO

- Please Describe _____

Do you have only one of two paired, functioning organs (e.g. kidney, testicles, ovary, etc.)? ☐ YES ☐ NO

- Please Describe _____

Do you suffer from any type of urological or genital disorder? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to an abdomen injury? ☐ YES ☐ NO

- Please Describe _____

XX. Medical Testing:

Have you ever been diagnosed with a communicable disease (e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphyllis, Tuberculosis)?

☐ YES ☐ NO

- List Dates/Time Missed _____

Please Describe _____

XXI. Dermatological:

Do you have any skin problems that we should be aware of (e.g. itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please Describe _____

Have you been diagnosed with a MRSA or Staphylococcus infection? ☐ YES ☐ NO

- Please Describe _____

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to a skin condition? ☐ YES ☐ NO

- Please Describe _____

XXII. Prescription Medications:

Please List **ALL** Prescription & Over-the-Counter Medications That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

XXIII. Supplements / Ergogenic Aids:

Please List **ALL** Supplements / Ergogenic Aids That You Are **CURRENTLY** Taking or **Have Taken** In The PAST Two (2) Years, & For What Purpose:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

XXIV. Heat Related Problems:

Have you ever suffered from a heat related injury? ☐ YES ☐ NO (check all that apply):

- ☐ Heat Cramps- Date(s)? _____
- ☐ Heat Syncope (Fainting)- Date(s)? _____
- ☐ Heat Exhaustion- Date(s)? _____
- ☐ Heat Stroke- Date(s)? _____

Have you ever received intravenous fluids (IV) for a heat related problem? ☐ YES ☐ NO

- Date(s)? _____

Have you ever been hospitalized for a heat-related problem? ☐ YES ☐ NO

- Date(s)? _____ Where? _____

Have you ever been advised not to participate in athletic activities due to a heat related injury? ☐ YES ☐ NO

Please Describe _____

XXV. Diabetic History:

Have you ever been diagnosed with diabetes? ☐ YES ☐ NO

- Date? _____

Do you have a family history of diabetes? ☐ YES ☐ NO

- Please Describe _____

Are you presently taking or have you taken any diabetic medications? ☐ YES ☐ NO

Medication	Form	Dosage	Frequency

Do you monitor your blood sugar level daily? ☐ YES ☐ NO

- How Many Times Per Day? _____ What Is Your Average Level? _____

Have you had your A1C level checked within the last three (3) months? ☐ YES ☐ NO Level _____

Have you had any hypoglycemic episodes (low blood sugar) within the last twelve (12) months? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised not to participate in athletic activities due to diabetes? ☐ YES ☐ NO

- Please Describe _____

Please list any precautions that you take and/or additional information not mentioned above:

_____

XXVI. Sickle Cell Anemia:

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Date? _____ Result? _____

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe _____

Have you ever been advised that you carry the Sickle Cell Trait / have Sickle Cell Anemia? ☐ YES ☐ NO

- Please Describe _____

XXVII. For Females Only:

At what age did you have your first menstrual period? _____

☐ YES ☐ NO Have you had menstrual periods within the past 12 months?

- If yes, how many? _____ When was your most recent menstrual period? _____
- How much time do you usually have from the start of one period to the start of another? _____
- What was the longest time between menstrual periods within the past year? _____

☐ YES ☐ NO Do you have painful or heavy menstrual periods?

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? _____

☐ YES ☐ NO Do you take birth control pills? If yes, what brand? _____

☐ YES ☐ NO Have you ever had any problems with your breasts?

☐ YES ☐ NO Have you had a pelvic examination within the last year?

☐ YES ☐ NO Any history of stress fractures? Dates:_____ Areas:_____

XXVIII. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Have you ever been diagnosed or suspected of having ADD/ADHD? ☐ YES ☐ NO

If yes, please answer the following questions:

Have you ever had a clinical evaluation completed related to ADD/ADHD? ☐ YES ☐ NO

Have you ever taken medication for ADD/ADHD? ☐ YES ☐ NO

If yes, please list medication/ dosage/ dates _____

Are you **currently** taking medication for ADD/ADHD? ☐ YES ☐ NO

If yes, please list medication and dosage _____

Name of prescribing physician_____ Phone number _____

**Please note that if you currently take medication related to ADD/ADHD you will need to contact the athletic training staff to obtain additional paperwork that is required to be completed by you and the prescribing physician.

XXIX. Please Answer: *{All questions are strictly **CONFIDENTIAL** & will not be shared with parents or coaches!}*

☐ YES ☐ NO Have you ever had any injury or illness other than those already noted?
☐ YES ☐ NO Do you have any ongoing or chronic illnesses?
☐ YES ☐ NO Have you ever been hospitalized overnight?
☐ YES ☐ NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
☐ YES ☐ NO Are you currently under a physician's care for any medical conditions?
☐ YES ☐ NO Have you ever been under the care of a psychiatrist and/or psychologist?
☐ YES ☐ NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years?
☐ YES ☐ NO Have you ever had a rash or hives develop during and/or after exercise?
☐ YES ☐ NO Do you cough, wheeze, or have trouble breathing during or after exercise / practice?
☐ YES ☐ NO Have you ever been told that you have kidney disease?
☐ YES ☐ NO Have you ever had Rubella ("German Measles") and/or Rubeola ("Red Measles")?
☐ YES ☐ NO Have you ever had a stomach and/or duodenal ulcer?
☐ YES ☐ NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ YES ☐ NO Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES ☐ NO Have you ever had gall bladder disease and/or a urinary problem?
☐ YES ☐ NO Do you have ringing in your ears or trouble hearing?
☐ YES ☐ NO Do you have frequent ear infections or nosebleeds?
☐ YES ☐ NO Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ YES ☐ NO Do you require any special equipment (braces, neck rolls, dental, orthotics, hearing aids, etc.)
☐ YES ☐ NO Have you ever had the chickenpox? If yes, when? _____
☐ YES ☐ NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Coastal Carolina University?
☐ YES ☐ NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
☐ YES ☐ NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____

☐ YES ☐ NO Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form?
☐ YES ☐ NO Do you use alcohol? If yes, how often? _____
☐ YES ☐ NO Have you ever used / tried marijuana, cocaine, or any other illicit "street" drugs?
☐ YES ☐ NO Do you have any questions regarding drugs, tobacco, or alcohol?
☐ YES ☐ NO Do you feel stressed out? If yes, do you feel as though you get the necessary support to deal with your stress?
☐ YES ☐ NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
☐ YES ☐ NO Are you a vegetarian? If yes, what type? _____
☐ YES ☐ NO Do you regularly lose weight to participate in your sport?
☐ YES ☐ NO Do you want to weigh more or less than you presently do?
☐ YES ☐ NO Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size?
☐ YES ☐ NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ YES ☐ NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?

If you have answered YES to any of the above, please explain: _____

_____

_____

Please describe below any further injury information, which is knowledgeable to you and not required on this form.

I, the undersigned, hereby acknowledge, affirm, and represent that all statements on pages one (1) through fourteen (14) are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that I will be responsible for any medical charges incurred.

Student-Athlete Signature _____ Date _____

Student-Athlete Print Name _____

Parent/Guardian Signature *(if under 18 years of age)* _____ Date _____

Parent/Guardian Print Name _____

Witness _____ Date _____

Reviewed By:

Reviewer's Signature _____ Date _____

Reviewer Print Name _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, HEREBY AUTHORIZE RELEASE OF ALL MEDICAL INFORMATION TO ALL TEAM PHYSCIANS AND MEMBERS OF THE SPORTS MEDICINE STAFF OF COASTAL CAROLINA UNIVERSITY. THESE MEDICAL RECORDS MAY BE USED TO HELP US FILE WITH OUR SECONDARY INSURANCE. MEDICAL INFORMATION IS NORMALLY CONFIDENTIAL AND, EXCEPT AS PROVIDED IN THIS RELEASE, WILL NOT BE OTHERWISE RELEASED BY THE PARTIES IN CHARGE OF THE INFORMATION.

THIS RELEASE REMAINS VALID UNTIL REVOKED BY ME IN WRITING.

SIGNED_____DATE: _____

Coastal Carolina University Department of Intercollegiate Athletics
Student-Athlete Authorization/Consent

For Uses and Disclosures of Protected Health Information

I, _____, hereby authorize _____
(Name of Student-Athlete) (Name of my Institution)
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 the to below listed agents and their stated purposes.

Authorization is granted for release of my protected health information to:

- The media, including specifically the Coastal Carolina University Media Relations Office, to advise the print, radio, television, and other media of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses for the purpose of reporting on it while I am a student-athlete.
- Professional athletic teams, their scouts, athletic trainers, physicians, servants, or employees for the purpose of making decisions regarding my prospect as a professional athlete.
- My parents/guardian and/or spouse for the purpose of assisting me in making a healthcare decisions while I am student-athlete.
- The coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
- My teammates so that they may be aware of limitations that I may be under while I am a student-athlete.
- The student athletic trainers and other students who are participating in the provision of sports medicine healthcare to assist and participate in the provision of healthcare to me while I am a student-athlete.
- The Big South Conference and National Collegiate Athletic Association for the purpose of making determination regarding my eligibility status while I am a student athlete.
- Applicable insurance providers for the purpose of processing insurance claims while I am student-athlete.

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 healthcare 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 above listed agents and their purposes are not covered by the Buckley Amendment or HIPAA and that these regulations will not apply to the above listed agent's use of disclosure of my injury/illness information.

This authorization/consent expires upon date of graduation, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at Coastal Carolina University. 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 Date

STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

I, _____, acknowledge that I am currently taking and/or have
Student-Athlete Print Name

(within the past 6 months) taken the following ergogenic aids, creatine powder, amino acids, protein supplements, or other similar substances, hereinafter referred to as "Supplements." *(Use the back of this form if necessary.)*

NAME	DOSAGE	MAIN INGREDIENTS	COMMENTS

I understand and agree:

a) The Coastal Carolina University Department of Intercollegiate Athletics neither approves of nor condones the use of Supplements;
b) I have been informed of the Coastal Carolina University Department of Intercollegiate Athletics, Big South Conference, National Collegiate Athletic Association (NCAA), and United States Olympic Committee (USOC) policies with regards to the use of Supplements, and have had any questions about these policies answered;
c) ***The use of Supplements may result in serious harm to me, possible permanent injury to my health, and even death.***
d) I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance;
e) I must list all Supplements on the Chain of Custody Forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at anytime in the future any form of Supplements.

I further understand and agree the Coastal Carolina University, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, and/or future use of Supplements. I agree to hold harmless, indemnify, and irrevocably and unconditionally release the State of South Carolina, Coastal Carolina University, and their officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of Supplements.

I understand the statements in this form, and have had all questions about the information in this from answered to my satisfaction.

_____ _____
Student-Athlete's Signature Date

_____ _____
Parent / Guardian's Signature *(if under 18 years old)* Date

Coastal Carolina University
Pre-Participation Physical

Name:_____Sport:_____Grade:_____

Height : _____ ft. _____ in.
Weight: _____ lbs.
Pulse: _____ bpm (Reg/Irreg)

Vision: R ___/20L ___/20
Corrected: Y N
Contacts: Y N

Blood Pressure: _____/_____ Re-check required: Y N _____/_____

Recommendations:

ENT Examination

Eyes (Including Funduscope) Normal/Abnormal
Abnormal: _____

Ears, Nose, Throat Normal/Abnormal
Abnormal: _____

Cardiac Examination

Heart Normal/Abnormal
Abnormal: _____

Lungs Normal/Abnormal
Abnormal: _____

Internal Examination

Skin Normal/Abnormal
Abnormal: _____

Abdomen Normal/Abnormal
Abnormal: _____

Genitourinary Normal/Abnormal
Abnormal: _____

Recommendations: _____

Physician: _____ Pass Fail

Date of Exam:_____

Orthopedic Examination

Neck/Back Normal/Abnormal

R_____

Normal/Abnormal

L_____

Shoulder Normal/Abnormal

R_____

Normal/Abnormal

L_____

Hand/Wrist/Elbow Normal/Abnormal

R_____

Normal/Abnormal

L_____

Knee Normal/Abnormal

R_____

Normal/Abnormal

L_____

Ankle Normal/Abnormal

R_____

Normal/Abnormal

L_____

Foot Normal/Abnormal

R_____

Normal/Abnormal

L_____

X-Rays: _____

Recommendations: _____

_____

_____

Physician: _____ Pass Fail

Date of Exam:_____

Revised 5/19/2010