

UNIVERSITY OF SOUTHERN MAINE
 University Health and Counseling Services
RETURNING ATHLETE PREPARTICIPATION HISTORY & EXAM

DATE _____	Name _____	Student ID (SS#) _____
Date of Birth _____	Age _____	Sex _____ Sport(s) _____

MEDICAL HISTORY UPDATE: Please answer questions as they relate to the past year.

YES	NO	Explain "Yes" answers below. Circle questions you don't know the answer to.
		1. Have you had any illnesses, surgery, hospitalizations or changes in your health in the past year?
		2. Have you had any injuries in the past year?
		3. Were you restricted from participation at any time in the past year? Why?
		4. During the past year have you experienced lightheadedness, dizziness, fainting, chest pain, palpitations (racing of heart), skipped heartbeats, excessive fatigue, wheezing, coughing, or shortness of breath during or after exercise?
		5. Have you had any decreased tolerance or ability to exercise in the past year?
		6. Have you had any change in your weight during the past year? Explain below.
		7. Are you taking any medications (prescription or over the counter) or any chemical, vitamin, herbal or other types of supplements? List below.
		8. Do you smoke or chew tobacco? How much? _____ How long? _____
		9. Do you have any ALLERGIES to medications or other things? List below.
		10. Has any family member or relative died from heart problems or sudden death before age 50?
		11. Has any family member or relative been diagnosed with Hypertrophic Cardiomyopathy or Marfan's Syndrome or any other heart problems?
		12. FEMALES ONLY: When was your most recent menstrual period? _____ Have you had at least 10 periods in the past year? _____ YES _____ NO (Explain Below)

EXPLAIN "YES" ANSWERS HERE (Identify by question number.)

Name _____

Student ID (SS#) _____

PHYSICAL EXAM:

BP _____ Weight _____

Other exam performed:

CLEARANCE:

____ Cleared for all activities

____ Cleared, with recommendations for further evaluation or treatment for: _____

____ Not Cleared because of _____

Please make a check if Release was signed to access outside records(if indicated)

Recommendations: _____

Clinician Signature: _____ Date _____

PHYSICIAN CONSULT:

Recommendations: _____

Physician's Signature: _____ Date _____

I, whose signature appears below, hereby state that, to the best of my knowledge, my answers to the above questions are complete and true. I have a responsibility to report any changes in my health status to the Athletic Training Staff or to UHS. I understand that having passed this physical exam does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at the time of this exam. I am aware of and accept the risks involved in participating in intercollegiate sports.

Athlete's Signature _____ Date _____

**University of Southern Maine
Student-Athlete
Emergency Contact/Medical Information**

Completion of requested information on this form is required prior to participating in athletics at USM

Name: Last: _____ First: _____ MI: _____

Background Information

Student ID #: _____ Date of Birth: _____ Graduation Year: _____ Sex: _____

Sports Participating in at USM

Sport 1: _____ Sport 2: _____ Sport 3: _____

Address Information:

Home/Permanent	Campus/Apartment
Street: _____	Street: _____

State: _____	State: _____
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Zip Code: _____	Zip Code: _____
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Phone: _____	Cell Phone: _____
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Email Address: _____

Emergency Contact Information:

Primary	Secondary
Name: _____	Name: _____

Address: _____	Address: _____
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Home Phone: _____	Home Phone: _____
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Work Phone: _____	Work Phone: _____
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Cell Phone: _____	Cell Phone: _____
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Medical Information:

Alerts (allergies, diabetes, asthma, etc):

Primary Care Physician or Practitioner:

Name: _____

Phone: _____

Medication(s): _____

Insurance Information: A photocopy of the front and back of your insurance enrollment card, or other official written documentation, is required prior to completing the Pre-participation Physical Examination (PPE). The PPE will not be administered to the student-athlete without this proof of insurance coverage.

As a student-athlete at USM, I understand that it is my responsibility to have adequate primary health insurance coverage in the event of illness or injury that may result during my participation in athletics. I furthermore understand that **any deductibles, co-payments, dollar limitations or any restrictions in coverage by this insurance are solely my responsibility**. I also will notify the Athletic Training Staff of any change in my insurance status.

Assumption of Risk: I understand that by participating in athletics I may become injured as a direct result of that participation. Although the risk of serious or life threatening injuries resulting from my participation in intercollegiate athletics is low I do know that this might occur. My signature below also gives the certified athletic training personnel at USM authorization to release the above emergency contact, medical and/or insurance information to medical providers in the event of an emergency.

Student-Athlete Signature: _____ Date: _____

Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

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 National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my protected health information will be used only by the NCAA's Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA, NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

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 or withhold 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 athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

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 athletics director at my institution I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete

Signature Date

**AUTHORIZATION for the Use and/or Disclosure
Of HEALTH INFORMATION
(Not to be used for Psychotherapy Notes)
UNIVERSITY OF SOUTHERN MAINE
UNIVERSITY HEALTH AND COUNSELING SERVICES**

**P0 BOX 9300
Portland, Me. 04104-9300
Ph: 207-780-4211
Fax: 207-780-4911**

**110 Upton Hall
37 College Ave.
Gorham, Me. 04038
Ph: 207-780-5411
Fax: 207-780-5032**

Name: _____ **Address:** _____

Telephone: _____ **Student ID#:** _____ **DOB:** _____

Instructions: Both State and Federal Law require all of the following sections of this form to be completed. Please note incomplete or inaccurately completed forms will not be honored by University Health and Counseling Services.

I hereby authorize the use and/or disclosure of my health information by University Health and Counseling Services and any employee or member of the workforce as described below. University Health and Counseling Services will only disclose information that it has generated unless additional information is specifically requested. List the type and amount of information to be used or disclosed, and dates of services if applicable:

Entire Record Women's Health Record including Paps Other List below

ATHLETIC PHYSICALS

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

A) HIV status information, I DO ___/DO NOT ___ (Check one) authorize the use and/or disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS, pursuant to 5 M.R.S.A. Ch. 501.

B) Substance Abuse Treatment Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse pursuant to 42 U.S.C.290dd-2 and 42 CFR Part 2. Treatment information disclosed pursuant to 42 CFR Part 2 may not be re-disclosed without the Individual's express written authorization or as otherwise permitted by law.

C) Mental Health Treatment Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to mental health treatment. Mental Health Treatment Information does not include "Psychotherapy Notes" under 45 CFR '164.501, which cannot be disclosed pursuant to this Authorization.

D) Sexually Transmitted Disease Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to testing, diagnosis or treatment of Sexually Transmitted Diseases.

Purpose of Use and/or Disclosure: **IN FULFILLMENT OF REQUIREMENTS FOR ATHLETICS DEPARTMENT**

Release Information to (Name of Facility): **USM ATHLETIC TRAINING SERVICES**

Address: **37 College Ave. Costello Sports Complex**

City/State/ZIP: **Gorham, ME 04038**

Subsequent Disclosures: I DO ___/DO NOT ___ (Check One) authorize subsequent disclosures to be made of the health information above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under 42 CFR Part 2, under section (B) above.

- * I understand I have the right to revoke this authorization at any time.
- * I understand if I revoke this authorization I must do so in writing and present my written revocation to Kristine Bertini, Director of University Health and Counseling Services.
- * I understand the revocation will not apply to information that has already been released in response to this authorization.
- * I understand that revocation may be the basis for the denial of health benefits or other insurance coverage or benefits.
- * Unless otherwise revoked, this authorization will expire in 30 months.
- * I understand that authorizing the disclosure of this health information is voluntary.
- * I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable), except (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create protected health information to be provided to a third party, then an authorization may be required.
- * I may refuse to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance or other adverse consequences.
- * Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.
- * I understand that I have a right to a copy of this authorization.
- * I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.

If I have questions about disclosure of my health information, I may contact Kristine Bertini, Director of University Health and Counseling Services.

Signature: _____ Date: _____

IF NOT SIGNED BY THE INDIVIDUAL, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Parent/Guardian: _____ Date: _____
(If under 18 years of age)

Personal Representative: _____ Date: _____

Relationship to the Individual: _____

Describe Authority to Act for Individual: _____

RE-DISCLOSURE OF MEDICAL RECORD INFORMATION IS STRICTLY FORBIDDEN BY RECIPIENTS UNLESS DULY AUTHORIZED BY THE PATIENT.

**AUTHORIZATION for the Use and/or Disclosure
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(Not to be used for Psychotherapy Notes)
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UNIVERSITY HEALTH AND COUNSELING SERVICES**

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I hereby authorize the use and/or disclosure of my health information from:

Name of Facility: USM Athletic Training Services

Address: 37 College Ave. Costello Sports Complex

City/State/Zip: Gorham, ME 04038

List the type and amount of information to be used or disclosed, and dates of service if applicable below:

Entire Record **Women's Health Record including Paps** **Other List below**

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

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Purpose of Use and/or Disclosure: _____

Release Information to:

**University of Southern Maine
Student Health Services
37 College Avenue
110 Upton Hall
Gorham, ME 04038
Phone 780-5411 Fax 780-5032**

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