

PERSONAL INFORMATION

Name of Student _____ SEX: M F
Sport _____
Home Address _____
City _____
State _____ Postal Code _____ Country _____
School Address _____
City _____
State _____ Zip Code _____
Home Phone _____
Cell Phone: _____
Email: _____
Date of Birth ____ / ____ / ____
S.S.# ____ - ____ - ____
B.U. ID# _____

FATHER

MOTHER

Name _____	Name _____
Address _____	Address _____
City,State,Zip _____	City,State,Zip _____
S.S.# _____	S.S.# _____
_____ Employer _____	_____ Employer _____
_____ Employer _____	_____ Employer _____
_____ Work Phone _____	_____ Work Phone _____
_____ Home Phone _____	_____ Home Phone _____
_____ Email _____	_____ Email _____

EMERGENCY CONTACT: _____ Relation: _____
Phone (day): _____ (Evening): _____

INSURANCE INFORMATION

Please provide the following information to assist us in processing insurance claims.

ATTACH COPIES OF THE FRONT & BACK OF INSURANCE AND PRESCRIPTION CARDS.

Do you have the B.U. Student Health Insurance Plan as your primary insurance coverage? YES NO

If YES, please proceed to page 4. If NO, please complete the following:

Do you have Group Medical Insurance Coverage through yourself or your parents? YES NO

Policy Holder (parent / self) _____ Policy Holder's Birth Date: ____ / ____ / ____

Employer: _____

Employer Address: _____

Insurance Company: _____ Mother's Maiden Name: _____

Insurance Policy #: _____ Group# _____

Insurance Company Address: _____

Ins. Company Phone #: _____ After Hours Phone# _____

TYPE OF PLAN: (Circle One Choice)

Health Maintenance Organization (HMO)

Preferred Provider Organization (PPO)

Point Of Service (POS)

Commercial (COM)

Does your insurance require:

A Primary Care Physician's referral for diagnostic tests or to see a specialist? _____ YES _____ NO

A second opinion for surgery? _____ YES _____ NO

Pre-authorization for services? _____ YES _____ NO

Supplemental Plans (Please attach card or plan information)

Prescription Plan _____ YES _____ NO

Vision Plan _____ YES _____ NO

Dental Plan _____ YES _____ NO

Primary Care Physician / Health Care Provider

Name _____ Phone # _____

**Boston University Sports Medicine
Insurance Information**

Secondary Insurance Coverage

Is this student-athlete covered by a secondary insurance policy? _____YES _____NO

Policy Holder: _____ Birth Date: _____

Employer: _____

Employer Address: _____

Insurance Company: _____ Mother's Maiden Name: _____

Insurance Policy # _____ Group# _____

Insurance Company Address _____

Ins. Company Phone #: _____ After Hours Phone# _____

Dental Insurance Coverage

Is this student-athlete covered by a secondary insurance policy? _____YES _____NO

Policy Holder: _____ Birth Date: _____

Employer: _____

Employer Address: _____

Insurance Company: _____ Mother's Maiden Name: _____

Insurance Policy # _____ Group# _____

Insurance Company Address _____

Ins. Company Phone #: _____ After Hours Phone# _____

I hereby certify that the information provided is true, complete and correct to the best of my knowledge. I understand that the insurance I have listed above must be utilized prior to Boston University's secondary insurance.

Student's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

**Boston University Sports Medicine
Insurance Information**

CONSENT TO TREAT AND MEDICAL INFORMATION RELEASE

To be **Read** and **Signed** by the **Student-Athlete**
and the **Parents / Guardian** if Student-Athlete is under 18 years old.

Permission is hereby granted by the undersigned to Boston University to proceed with any needed medical or minor surgical treatment, x-ray examination, imaging studies or testing, in the best interests of the student-athlete named below. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician, health care provider, or B.U. Sports Medicine personnel, to contact my parents / guardians in the most expeditious manner possible. If said health care personnel is unable to communicate with my parents / guardians, the treatment necessary for the best interest of the named student-athlete may be given.

This authorization permits the Boston University Sports Medicine staff, physicians, and consultants to obtain and release medical information and records in the course of medical treatment and for the purpose of processing insurance claims. *I understand and agree that my injury / condition may be discussed with the coaching staff and Athletics Communications only as it effects my participation in intercollegiate athletics.*

The Release and Authorization is a required condition for participation in the Intercollegiate Athletic Program and shall remain valid until revoked in writing.

Student-Athlete's Signature	Date of Birth	Age	Date
Parent/Guardian's Name (PRINT)	Parent/Guardian's Signature		Date

INFORMED CONSENT AND WAIVER OF CLAIM FORM

To be **Read** and **Signed** by the **Student-Athlete**
and the **Parents / Guardian** if Student-Athlete is under 18 years old.

I am aware that participating in any sport can be a dangerous activity involving many RISKS OF INJURY. I understand that the dangers and risks of participating in sports include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and aspects of the muscular system, and serious injury or impairment to other aspects of my body, general health, and well being. I understand that the dangers and risks of participating in sport may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, engage in other business, social and recreational activities, and generally enjoy life. Because of the dangers of participating in sports, I recognize the importance of following coaches instructions regarding playing techniques, training and other team rules, etc., and to agree to obey such instructions.

In consideration of being presented this opportunity to participate in intercollegiate sports at Boston University and in acknowledging that I am aware of and willing to assume the risks associated with intercollegiate sports, I hereby voluntarily agree to waive, hold harmless and indemnify Boston University and its trustees, agents, volunteers and employees from any and all claims, demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, by reason of my voluntary participation in intercollegiate sports while at Boston University. I understand the content of this document, and I execute this INFORMED CONSENT AND WAIVER OF CLAIM form of my own free will and accord.

Student-Athlete's Signature	Date of Birth	Age	Date
Parent/Guardian's Name (PRINT)	Parent/Guardian's Signature		Date

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

Please use the space provided or additional sheets to explain any positive (YES) answers.

YES	NO	01 DISEASE AND ILLNESS
		1-1. Have you ever suffered from heat related illness, hyperthermia, heat stroke or heat exhaustion? Please explain dates and details.
		Have you ever suffered from cold related illness, hypothermia? Please explain dates and details.
		1-2. Have you ever had one of the following? When? Explain.
		Hepatitis
		Chicken Pox
		Rheumatic Fever
		Measles
		Mumps
		1-3. Have you or anyone in your family been treated for infectious mononucleosis, viral pneumonia, or any other infectious disease? List and give dates.
		1-4. Have you or anyone in your family been tested or treated for diabetes? If yes, explain.
		1-5. Do you or anyone in your family have a history of sickle cell trait or disease? If yes, explain.
		1-6. Do you or does anyone in your family have a history of Marfan's Syndrome? If yes, explain.
		1-7. Have YOU ever had the following symptoms of HEART problems? Check all that apply and Please explain dates and details.
		Chest pains
		Fatigue easily
		Heart murmur / Irregular heart beat / Arrhythmia
		Shortness of breath
		Frequent awareness of heart beat
		Other
		1-8. Has anyone in your FAMILY ever had a history of HEART problems or the following symptoms of HEART problems? Please explain dates and details.
		Chest pains
		Fatigue easily
		Heart murmur / Irregular heart beat / Arrhythmia
		Shortness of breath
		Frequent awareness of heart beat
		Close relative under 50 years old dies of heart disease
		Hypercholesterolemia

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	01 DISEASE AND ILLNESS (cont'd)
		1-9. Has anyone in your family ever died suddenly of a heart problem or unknown causes? If yes, please describe their age and the circumstances.
		1-10. Do you or does anyone in your family have a history of Cardiomyopathy? If yes, explain.
		1-11. Have you ever passed out during exercise? Explain.
		1-12. Have you or anyone in your family ever had a history of Lung problems? Please explain dates and details.
		Asthma
		Bronchitis
		Other
		1-13. Do you or anyone in your family have a history of high or low blood pressure? If yes, explain who, what problem and if medications are taken.
		1-14. Have you ever had episodes of dizziness or fainting spells? Have these episodes been recurrent? Explain.
		1-15. Do you or anyone in your family have a history of epilepsy or seizures? If yes, explain.
		1-16. Have you had any illness requiring bed rest of one week or longer during the past year? Please explain dates and details.

YES	NO	02 EYES AND DENTAL
		2-1. Do you have loss of sight in either eye? Please explain dates and details.
		2-2. Do you wear glasses, hard lens contacts or soft lens contacts? What is your prescription? Please explain details.
		2-3. If you wear glasses / contacts, do you wear them during athletic competition?
		2-4. Do you wear any dental appliance - permanent bridge, crown / jacket, temporary cap, removable partial plate, partial plate? Please explain dates and details.
		2-5. Do you have any dead teeth? Indicate location.
		2-6. Have you had your wisdom teeth out? Please explain dates and details.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	03 HEAD AND NECK INJURIES
		3-1. Have you ever been "knocked out", had your "bell rung", or experienced a concussion or head injury during the past three years? Give dates and details.
		If yes, did the attending physician have you stay overnight in a hospital? Explain.
		3-2. Have you ever had a fracture of your nose or jaw? Please explain dates and details.
		3-3. Have you ever had an injury to the neck involving nerves, vertebra (bones), or intervertebral disks that affected you for a week or longer? Please explain dates and details.
		3-4. Have you ever suffered a throat injury? Explain.
		3-5. Do you suffer from recurrent or severe headaches or migraines? Explain.
		3-6. Have you ever experienced a "stinger," "burner" or pinched nerves or had numbness or tingling in your arms, hands, legs or feet? Explain.
		3-7. Do you have a loss of hearing in either ear? Explain.

YES	NO	04 UPPER EXTREMITIES
		4-1. Have you ever had a shoulder dislocation, subluxation, AC separation / sprain or other shoulder injury? Please explain dates and details, include side & severity.
		4-2. Have you ever been advised to have surgery or rehabilitation to correct a shoulder condition? Has surgery been completed? Please explain dates and details, include side & severity.
		4-3. Have you ever experienced an elbow injury? Please explain dates and details, include side & severity.
		4-4. Have you ever experienced a hand, wrist, thumb or finger injury? Please explain dates and details, include side & severity.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	05 LOWER EXTREMITIES
		5-1. Have you ever sustained a HIP POINTER or other hip injury? Please explain dates and details, include side & severity.
		5-2. Have you ever sustained a GROIN pull, strain or tear? Please explain dates and details, include side & severity.
		5-3. Have you ever sustained a QUADRICEP muscle pull, strain or tear? Please explain dates and details, include side & severity.
		5-4. Have you ever sustained a HAMSTRING muscle pull, strain or tear? Please explain dates and details, include side & severity.
		5-5. Have you experienced a sprain (injured or torn ligaments) of either knee with swelling accompanying the injury? Please explain dates and details, include side & severity.
		5-6. Have you ever been told that you injured the cartilage or meniscus or had patello-femoral problems of either knee? Please explain dates and details, include side & severity.
		5-7. Have you ever been advised to have surgery or rehabilitation on a knee to correct a condition? Please explain dates and details, include side & severity.
		5-8. If you have had surgery or rehabilitation, has it been completed? Please explain dates and details. Include a copy of post-op notes.
		5-9. Have you ever been treated for Osgood-Schlatter's disease? Please explain dates and details, include side & severity.
		5-10. Have you ever sustained a severe sprain or twist of the ankle? Please explain dates and details, include side & severity.
		5-11. Have you ever been advised to have surgery or rehabilitation on an ankle to correct a condition? Please explain dates and details, include side & severity.
		5-12. Have you ever had shin splints or low leg stress fractures? Please explain dates and details, include side & severity.
		5-13. Do you wear ankle or knee braces? Please explain dates and details.
		5-14. Do you wear orthotics? Please explain dates and details.
		5-15. Do you have foot problems? Please explain dates and details, include side & severity.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	06 BACK INJURIES
		6-1. Have you ever been told that you have scoliosis? Please explain dates and details.
		6-2. Have you ever had an injury to your back? Please explain dates and details.
		6-3. Do you experience back pain? Please explain dates and details. Include frequency, intensity & duration of pain.
		6-4. Do you think your back is weak?
		6-5. Have you ever had a spinal fusion? Please explain dates and details. Include date, doctor and hospital.

YES	NO	07 SURGERY / SUPPORTS
		7-1. Have you had any other operations during the past 2 years? Please explain dates and details. Include body part, date, doctor and hospital.
		7-2. Do you have a metal screw, plate, or rod somewhere in your body as a result of bone or joint surgery? Please explain dates and details. Include body part, date, doctor and hospital.
		7-3. Have you ever had a bone graft? Please explain dates and details. Include body part, date, doctor and hospital.
		7-4. Have you ever been told that you have a hernia? Please explain dates and details.
		7-5. If yes, has the hernia been surgically repaired? Please explain dates and details.
		7-6. Have you ever undergone surgery (other than already noted) (tonsillectomy, appendectomy, hernia, etc). Please explain dates and details.
		7-7. Have you ever been required to stay overnight at a hospital but did NOT require surgery (food poisoning, mono, head injury, etc)? Please explain dates and details.
		If you have ever sustained any injury that did require surgery, please be sure to include all Post Operative and Physical Therapy notes when returning this form.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	08 ALLERGIES AND MEDICATIONS
		8-1. Do you or have you ever had a substance abuse problem - alcohol or other drugs? Please explain dates and details.
		8-2. If yes, has rehabilitation been completed? Please explain dates and details on comments page.
		8-3. Have you used or are you currently using recreational drugs (marijuana, cocaine, ecstasy, heroine, etc.)? If yes, provide the names, dosage, frequency and details.
		8-4. Have you used or are you currently using alcohol? If yes, provide the amounts, frequency and details.
		8-5. Are you currently taking any non-prescription / over the counter (OTC) medication? Indicate medication and amount.
		8-6. Are you currently taking any prescribed medication on a permanent or semi-permanent basis? Including birth control pills (BCP), insulin, ritalin, motrin, claritin, ventolin, etc? Please explain dates and details.
		8-7. Are you allergic to any medication (aspirin, penicillin, sulfa, codeine, etc)? Please explain dates and details.
		8-8. Do you have hay fever / allergic reactions (insect bites, foods)? Please explain dates and details.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	09 OTHER CONDITIONS
		9-1. Do you have any other physical disability? Please explain dates and details.
		9-2. Have you lost a lung or lung function? Please explain dates and details.
		9-3. Have you lost a kidney or kidney function? Please explain dates and details.
		9-4. Have you lost either a testicle or an ovary? Please explain dates and details.
		9-5. Have you ever been involved in a motor vehicle accident? Describe any injuries you sustained.
		9-6. Have you ever been treated for myositis ossificans (calcium deposits in the muscle)? Please explain dates and details.
		9-7. Have you ever had a fractured / broken bone? Please explain dates and details.
		9-8. Have you had recent weight gain or loss? Do you want to weigh more or less than you do currently? Please explain dates and details.
		9-9. Have you ever been concerned about or diagnosed with an eating disorder? Please explain dates and details.
		9-10. Are you currently modifying your diet in an attempt to lose weight? If yes, please provide details.
		9-11. Have you consulted a nutritionist?
		9-12. Do you have stomach or intestinal trouble? Please explain dates and details.
		9-13. Do you experience frequent anxiety? Have you ever been treated for anxiety? Please explain dates and details.
		9-14. Do you experience frequent depression? Have you ever been treated for depression? Please explain dates and details.
		9-15. Are you currently ill in any way? Please explain dates and details.
		9-16. Do you have any incompletely healed injury? Please explain dates and details.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

		9-17. Do you have any skin disorders (psoriasis, chronic acne, etc)? Please explain dates and details.
		9-18. Do you use any special protective or corrective devices (knee or ankle brace, neck roll, orthotics, retainer or hearing aid)? Please explain dates and details include device type and body part.
		9-19. Have you ever been advised by a medical doctor NOT to participate in any sport? Please explain dates and details.
		9-20. Do you know of, or do you believe there is any health reason which may affect your participation in either the B.U. intercollegiate athletic program or in your academic endeavors? Please explain dates and details.
		9-21. Do you suffer from any blood clotting disorders? Please explain details.
		9-22. Do you suffer from Deep Vein Thrombosis? Please explain details.
		9-23. Are you now or have you been treated for any type of cancer? Please explain details.
		9-24. Are you currently taking nutritional supplements? What are they and for what purpose are you taking them?
		9-25. Are you currently taking vitamins? If yes, please provide type, dosage, details and reason.
		9-26. Have you ever been diagnosed and/or treated for Attention Deficit Disorder (ADD)? If so, please provide the diagnosing physician's name and contact information. Also, please provide any documentation (official testing results, prescriptions for medication) you may have relating to the diagnosis. *

*This information is necessary for both the NCAA and Boston University Drug student-athlete drug testing programs.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

YES	NO	10 FEMALES ONLY
		10-1. Do you suffer from irregular periods? Please explain dates and details.
		10-2. Do you suffer from severe cramps? Please explain dates and details.
		10-3. Do you suffer from excess flow? Please explain dates and details.
		10-4. Have you ever had a pelvic exam? List dates and results.
		10-5. Have you ever had an abnormal PAP Smear? If yes, Please explain dates and details.
		10-6. Are you pregnant at this time? If yes, Please explain dates and details stage and due date.
		10-7. Have you ever stopped menstruating? If so please explain the details.

**Boston University Sports Medicine
Student-Athlete Health Questionnaire**

COMMENTS: