UNIVERSITY OF SOUTH CAROLINA

2018-2019 Insurance Information Sheet

☐ Athletic Scholarship Athlete
☐ Non-Scholarship Athlete

Sport: _____

Name: _____ Date of Birth: ___/___/___ Sex: _____
Last Name First Name Middle Name

Social Security # _____--_____--_____ Student's Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Father: _____ Mother (include Maiden Name) : _____

HMO/PPO Information - Primary Care Physician: _____ Phone: _____

MEDICAL INSURANCE: ☐ **NO MEDICAL INSURANCE COVERAGE** ☐ **INTERNATIONAL STUDENT**

Insurance Company: _____ Group #: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co. Phone Number: _____

Employer/Group Name: _____

Subscriber: _____ Relationship to Athlete: _____

Subscriber's Date of Birth ___/___/___ Subscriber's SSN: XXX-XX- _____ (Last four digits only)

CHAMPUS/TRI-CARE INFORMATION: (If Applicable)

Sponsor: _____ Relationship to Athlete: _____

Sponsor's SSN: XXX-XX- _____ (Last four digits only) ID # from card: _____

Duty Station: _____ Effective Dates: ___/___/___to ___/___/___

DENTAL INSURANCE:

Insurance Company: _____ Group #: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co. Phone Number: _____

Employer/Group Name: _____

Subscriber: _____ Relationship to Athlete: _____

Subscriber's Date of Birth ___/___/___ Subscriber's SSN: XXX-XX- _____ (Last four digits only)

PRESCRIPTION MEDICATION COVERAGE: Rx Bin # _____ PCN/GROUP _____

I acknowledge I have read the letter regarding medical information, understand and will assist in the filing of accident claims. I attest the insurance coverage submitted is a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics. **If there is a material change in coverage or expiration of coverage, I agree to notify the University of South Carolina Athletic Medicine staff of this development and update the insurance information I have on file with them.** I understand and agree that the University of South Carolina will assume responsibility for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at the University of South Carolina – **provided I follow policies outlined in the letter received.**

_____ Date: ___/___/___ _____ Date: ___/___/___
Athlete's Signature Parent's/Guardian's Signature

Please return with a copy of the front AND back of insurance card.

5/6/18

STUDENT-ATHLETE CONSENT FORMS

Read the following three (3) consent forms carefully. If you have any questions about the consent forms, have them answered before signing. If you are under 18 years of age, your parents must also sign.

The basic content and purpose of each consent form is as follows:

I. **Medical Consent**: Allows the University of South Carolina team physicians and athletic trainers to treat any injury you receive while at the University of South Carolina.
II. **Authorization for Release of Information**: Allows medical staff to provide limited medical information to the Department of Athletics and associated agencies as listed below.
III. **Shared Responsibility for Sport Safety**: Acknowledges that there are certain inherent risks involved in participating in intercollegiate athletics and that you are willing to assume responsibility for such risks.

PART I – MEDICAL CONSENT

I hereby grant permission to the University of South Carolina team physicians and/or their consulting physicians to render any treatment and medical or surgical care to me that they deem reasonably necessary for my health and well-being. I also hereby authorize the University of South Carolina athletic trainers who are under the direction and guidance of the University of South Carolina athletic team physicians to render any preventative, first aid, and rehabilitative or emergency treatment to me that they deem reasonably necessary for my health and well-being. Also, when necessary for executing such medical care, I grant permission to be hospitalized at any accredited hospital.

I understand that this consent expires automatically 380 days from the date of my signature below. I further understand that I have the right to revoke my consent at any time by sending written notification to the USC Athletics Department (send to John Kasik, Associate Athletic Director/Sports Medicine); however, I understand that a revocation is not effective as to any medical treatment rendered to me prior to the effective date of my revocation

Name of Athlete: _____ SSN/Student ID: _____

Signature of Athlete: _____ Date: _____

If athlete is under 18 years of age, signature of parent or guardian on behalf of the athlete is required.

Parent or Guardian: _____ Date: _____

PART II – AUTHORIZATION FOR RELEASE OF INFORMATION

The privacy of your medical information is protected by law. Except under certain circumstances, your medical information will not be disclosed without your consent. USC medical staff is committed to maintaining the privacy of your medical information. By signing this Authorization, you agree to allow USC medical staff, including team physicians, consulting physicians and athletic trainers, to disclose your medical information as follows:

- USC medical staff will share pertinent information about your medical condition with any outside provider (e.g., medical equipment vendors, medical specialists, surgeons, pharmacies, etc.) whose assistance is necessary for your continuing treatment. For example, if you are injured and require a brace, pertinent medical information will be shared with the brace fitter so that you may be properly fitted.
- USC medical staff will provide appropriate information about your medical condition to your insurance company and prescription drug benefits manager, to Department of Athletics insurance carriers and prescription drug benefit managers, and to appropriate Department of Athletics personnel who assist with filing insurance information, for payment to USC medical staff for the treatment provided to you. This type of sharing of medical information is common to most health care providers and may be a condition of treatment.
- USC medical staff will share pertinent information about your medical condition with other medical staff members and individuals who need to be informed of your condition for legitimate reasons such as continuing treatment or determining whether you are able to practice, play or attend class.
- USC medical staff will share information about your medical condition with your coach(s) and appropriate Department of Athletics officials in order to make informed decisions about your return to practice, competition or class.

- USC medical staff will share pertinent information about your medical condition with appropriate Department of Athletics personnel for required disclosure to external governing bodies, such as the NCAA or the SEC.
- USC medical staff will disclose general status information about your medical condition to appropriate Department of Athletics Media Relations personnel. For example, if you are injured during a game, USC medical staff will communicate general information about your injury and status to Media Relations. Media Relations, in turn, will disclose your general status information to various media outlets (e.g., newspapers, magazines, television, etc.). USC medical staff and/or coaching staff will not release specific information about your medical condition (e.g., details of injury, results of diagnostic testing, operations, rehabilitation plan and/or timing of return to play) without your prior approval.
- USC medical staff will not share your medical information with professional agents, professional athletic teams or leagues, attorneys, or unrelated third parties without your independently-provided written consent, separate from this document, unless required to do so by state or federal laws or regulations.
- USC Medical staff will obtain information regarding your participation and attendance in mental health treatment within the Athletics Department, USC Counseling and Psychiatry Department, or community providers. Information beyond participation/attendance will require an additional release of information.
- USC Medical staff will obtain the results of any lab testing that directly affects your health and wellbeing as a student athlete.

I understand that my medical information will be disclosed by USC medical staff to the individuals and entities described above, and I hereby consent to and authorize such disclosure of my medical information.

I understand that this consent expires automatically 380 days from the date of my signature below. I further understand that I have the right to revoke my consent at any time by sending written notification to the USC Athletics Department (send to John Kasik, Associate Athletic Director/Sports Medicine); however, I understand that a revocation is not effective as to any action or disclosure of information that occurs prior to the effective date of my revocation

Name of Athlete: _____ SSN/Student ID: _____

Signature of Athlete: _____ Date: _____

If athlete is under 18 years of age, signature of parent or guardian on behalf of the athlete is required.

Parent or Guardian: _____ Date: _____

PART III – SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in intercollegiate athletics involves a risk of injury. Student-athletes have a right to assume that those who are responsible for the conduct of intercollegiate competition have taken reasonable precautions to minimize such risks and that their peers participating in the sport will not intentionally inflict injury upon them. Athletic trainers and physicians will periodically analyze injury patterns to refine rules and make safety decisions. However, the safety of student-athletes cannot be ensured solely by the existence of a rule book and equipment standards, or by officials responsible for enforcing compliance with such safety rules and guidelines. The safety of student- athletes requires a commitment by all student-athletes to share responsibility for complying with the intent and purpose of rules and guidelines designed to minimize the risks of injury. Even so, student-athletes participating in intercollegiate athletics are at risk of injury.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for such risks while participating in intercollegiate athletics at the University of South Carolina.

I understand that this consent expires automatically 380 days from the date of my signature below. I further understand that I have the right to revoke my consent at any time by sending written notification to the USC Athletics Department (send to John Kasik, Associate Athletic Director/Sports Medicine); however, I understand that a revocation is not effective as to any action that occurs prior to the effective date of my revocation.

Name of Athlete: _____ SSN/Student ID: _____

Signature of Athlete: _____ Date: _____

If athlete is under 18 years of age, signature of parent or guardian on behalf of the athlete is required.

Parent or Guardian: _____ Date: _____

UNIVERSITY OF SOUTH CAROLINA ATHLETIC TRAINING

MEDICAL INFORMATION PACK

Name of Athlete: _____

Print

Date of Exam: _____

Athletic Training Staff Note:

1) _____
2) _____
3) _____
4) _____
5) _____

Student Athlete's Name _____ Date of Birth ____ / ____ / ____
LAST FIRST MIDDLE MONTH DAY YEAR

Sport(s) _____ Gender _____ Academic Year _____ (i.e. 2016-17)

Banner ID _____ Social Security # ____--____--____ ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ 5th

Permanent Address: _____ City _____ State ____ Zip _____ Country _____

School Address: _____ City: _____ State ____ Zip _____

Student Cell Phone #_____ Parent's Phone Number _____

Student Email Address _____ Team Status ❑ Scholarship ❑ Walk-On ❑ Practice Player

IN CASE OF EMERGENCY

Name _____ Relationship _____ Cell Phone _____ Home Phone _____

Do you have ALLERGIES to the following?

Food	❑ YES ❑ NO	Specify:
Insect or Animals	❑ YES ❑ NO	Specify:
Latex, Iodine, Tape or Other Allergies	❑ YES ❑ NO	Specify:
Over-the-Counter and/or Prescription Medications	❑ YES ❑ NO	Specify:
Plants, grasses, pollens, dust or environmental factors	❑ YES ❑ NO	Specify:
Other	❑ YES ❑ NO	Specify:

FAMILY MEDICAL HISTORY

For each full-blooded relative listed, indicate if they have a history of the following (Do not include adoptive, step- , or foster relatives).

If yes, specify relationship ❑ **Check if you are adopted.**

		Relationship
High Blood Pressure	❑ YES ❑ NO	
Has anyone in the family dies of a heart related problem before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome?	❑ YES ❑ NO	
Has anyone in the family suffered a disability related to Heart disease before the age of 50:	❑ YES ❑ NO	
Pacemaker or Implanted Defibrillator	❑ YES ❑ NO	
High Blood Cholesterol	❑ YES ❑ NO	
Other Heart Problems	❑ YES ❑ NO	
Unexplained Fainting, Unexplained seizures, or Near Drowning?	❑ YES ❑ NO	
Asthma	❑ YES ❑ NO	
Stroke	❑ YES ❑ NO	
Kidney Disease	❑ YES ❑ NO	
Diabetes	❑ YES ❑ NO	
Hemophilia / Blood Clotting Disorder	❑ YES ❑ NO	
Does anyone have a specific heart condition (such as Marfan's Syndrome, Hypertrophic Cardiomyopathy (HCM), Arrhythmogenic Right Ventricular Cardiomyopathy (ARVD), Long QT or Short QT syndrome, Brugada Syndrome, or Catecholaminergenic Polymorphic Ventricular Tachycardia (CPVT)?	❑ YES ❑ NO	
Sickle Cell Trait / Disorder	❑ YES ❑ NO	
Tuberculosis	❑ YES ❑ NO	
Gout	❑ YES ❑ NO	
Cancer	❑ YES ❑ NO	
Epilepsy	❑ YES ❑ NO	
Mental Illness	❑ YES ❑ NO	
Drug and/or Alcohol Dependency	❑ YES ❑ NO	
Additional Family Medical Issues	❑ YES ❑ NO	

Do you have any personal beliefs that would prevent you from seeing a physician or taking medications?

❑ YES ❑ NO	*Explain:*

GENERAL MEDICAL

Has a physician ever told you that you had any of the following medical problems, and/or symptoms?

Rheumatic Fever	❑ YES ❑ NO	Ear Infection	❑ YES ❑ NO
Rheumatic Heart Disease	❑ YES ❑ NO	Muscular Disease	❑ YES ❑ NO
Pericarditis	❑ YES ❑ NO	Birth Defects	❑ YES ❑ NO
Any Heart Disease?	❑ YES ❑ NO	Appendicitis	❑ YES ❑ NO
Tumor, Growth, Cyst	❑ YES ❑ NO	Injury to the Spleen	❑ YES ❑ NO
Cancer	❑ YES ❑ NO	Stomach or Intestinal Ulcer	❑ YES ❑ NO
Any Ruptured Organs?	❑ YES ❑ NO	Colitis	❑ YES ❑ NO
Frequent Respiratory Infections	❑ YES ❑ NO	Bowel Disease	❑ YES ❑ NO
Gout	❑ YES ❑ NO	Irregular Bowels	❑ YES ❑ NO
Pleurisy	❑ YES ❑ NO	Bloody, Clay Colored Stools	❑ YES ❑ NO
Pneumonia	❑ YES ❑ NO	Frequent Heartburn	❑ YES ❑ NO
Pneumothorax	❑ YES ❑ NO	Frequent Diarrhea	❑ YES ❑ NO
Polio	❑ YES ❑ NO	Frequent Indigestion	❑ YES ❑ NO
Bronchitis	❑ YES ❑ NO	Constipation	❑ YES ❑ NO
Jaundice/Hepatitis	❑ YES ❑ NO	Frequent Headaches/Migraines	❑ YES ❑ NO
Tuberculosis	❑ YES ❑ NO	Neuritis	❑ YES ❑ NO
Malaria	❑ YES ❑ NO	Nervousness	❑ YES ❑ NO
Mumps	❑ YES ❑ NO	Frequent Nose Bleeds	❑ YES ❑ NO
Mononucleosis	❑ YES ❑ NO	Difficulty Swallowing	❑ YES ❑ NO
Measles	❑ YES ❑ NO	Swollen Feet/Ankles	❑ YES ❑ NO
Rubella	❑ YES ❑ NO	Chronic Cough	❑ YES ❑ NO
Chicken Pox	❑ YES ❑ NO	Unexplained Weight Loss	❑ YES ❑ NO
Asthma	❑ YES ❑ NO	Paralysis	❑ YES ❑ NO
Exercised Induced Asthma	❑ YES ❑ NO	Poor Appetite	❑ YES ❑ NO
Recurrent Sinusitis	❑ YES ❑ NO	Dizziness	❑ YES ❑ NO
Sinus Infection	❑ YES ❑ NO	Memory Loss	❑ YES ❑ NO
Whooping Cough	❑ YES ❑ NO	Loss of Consciousness	❑ YES ❑ NO
Nasal Polyps	❑ YES ❑ NO	Hepatitis and/or HIV	❑ YES ❑ NO
Nose Fracture	❑ YES ❑ NO	Amnesia	❑ YES ❑ NO
ADD/ADHD	❑ YES ❑ NO	Meningitis	❑ YES ❑ NO
Skin Disease	❑ YES ❑ NO	Diphtheria	❑ YES ❑ NO
Diabetes	❑ YES ❑ NO	Typhoid Fever	❑ YES ❑ NO
Sickle Cell Anemia/Trait	❑ YES ❑ NO	Hemophilia	❑ YES ❑ NO
Anemia	❑ YES ❑ NO	Seizure Disorder	❑ YES ❑ NO
Abnormal Bruising	❑ YES ❑ NO	Thyroid Disease / Goiter	❑ YES ❑ NO
Abnormal Bleeding	❑ YES ❑ NO	Hemorrhoids	❑ YES ❑ NO
Blood Disease	❑ YES ❑ NO	Hernia	❑ YES ❑ NO
Blood Clot or Embolisms	❑ YES ❑ NO	Arthritis	❑ YES ❑ NO
Kidney Injury/Disease	❑ YES ❑ NO	Joint Inflammation	❑ YES ❑ NO
Kidney Stones	❑ YES ❑ NO	Fever Blister	❑ YES ❑ NO
Blood in Urine	❑ YES ❑ NO	Sexually Transmitted Disease	❑ YES ❑ NO
Frequent Urinary Infections	❑ YES ❑ NO	Car or Air Sickness	❑ YES ❑ NO
Gall Bladder Disease	❑ YES ❑ NO	Hives	❑ YES ❑ NO
Liver Disease	❑ YES ❑ NO	Heat Illness (Cramps, Exhaustion, Stroke)	❑ YES ❑ NO
Hearing Loss	❑ YES ❑ NO		

VISION HISTORY

Have you ever been to an eye doctor?	❑ YES ❑ NO	Date:	Physician:
Have you had an eye injury?	❑ YES ❑ NO	Explain:	
Do you wear glasses or contacts when you train or compete?	❑ YES ❑ NO		
If yes, include your current prescription			
Are you legally blind in either eye?	❑ YES ❑ NO		
Do you have a color vision deficiency?	❑ YES ❑ NO		
Have you had any other problems with your eyes and/or vision?	❑ YES ❑ NO		

DENTAL HISTORY

Do you have a bridge or false teeth?	❑ YES ❑ NO	Comments:
Have you ever fractured a tooth?	❑ YES ❑ NO	Comments:
Have you ever had a tooth knocked out?	❑ YES ❑ NO	Comments:
Do you wear orthodontic appliances?	❑ YES ❑ NO	Comments:

INTERNAL MEDICAL HISTORY

Were you born with a complete and functional set of paired organs? (Eyes, ears, kidneys, ovaries/testicles, lungs)	❑ YES ❑ NO	If not, which organs were involved?		
Have you ever had surgery to repair or remove any organ? (Hernia, tonsils, appendix, spleen, etc.)	❑ YES ❑ NO	If yes, which organ?	Repaired?	Removed?
		Date:	Physician	Physician's Address

CARDIAC MEDICAL HISTORY

Have you ever felt dizzy or light-headed during exercise, not related to heat?	❑ YES ❑ NO
Have you ever had chest pain while exercising?	❑ YES ❑ NO
Have you ever had irregular heartbeats or heart palpations during exercise?	❑ YES ❑ NO
Have you ever been told you have a heart murmur	❑ YES ❑ NO
Have you ever been seen by a heart specialist (Cardiologist)?	❑ YES ❑ NO
If yes, Physician Name:	DATE:
Have you ever had an EKG or Echocardiogram?	❑ YES ❑ NO
Have you ever had a Stress (Heart) Exam?	❑ YES ❑ NO
Have you ever had a Syncope (Fainting) event during exercise?	❑ YES ❑ NO
Have you ever had unexplained shortness of breath during exercise?	❑ YES ❑ NO
Have you ever been restricted from participation in sports?	❑ YES ❑ NO
Have you ever been told you have high blood pressure?	❑ YES ❑ NO
Has a doctor ever told you that you have any heart problems	❑ YES ❑ NO
If so, check all that apply:	❑ High Blood Pressure ❑ High Cholesterol ❑ Kawasaki Disease ❑ A Heart Infection ❑ Other: _____

NUTRITIONAL HISTORY

How many meals a day do you eat?		
How many times do you snack during the day?		
Do you consciously watch your weight?	❑ YES ❑ NO	Explain:
Do you restrict your food intake to be at your competitive weight?	❑ YES ❑ NO	Explain:
Have you ever purged (vomited, used laxatives, and/or diuretics) to control your weight?	❑ YES ❑ NO	Explain:
Are there certain foods or food groups that you forbid yourself to eat?	❑ YES ❑ NO	Explain:
Have you ever dieted?	❑ YES ❑ NO	If yes, what age did you start dieting?
Are you a vegetarian or vegan?	❑ YES ❑ NO	Explain:
Do you eat red meat?	❑ YES ❑ NO	Explain:
Do you take an Iron, Calcium, and/or a Vitamin D supplement?	❑ YES ❑ NO	Explain:
Do you have a Gluten allergy or intolerance?	❑ YES ❑ NO	Explain:
Do you have, or have you ever, been diagnosed and/or treated with an eating disorder?	❑ YES ❑ NO	Explain:

HEALTH & WELLNESS

Have you ever...?			
Had psychological testing for ADD/ADHD?	❑ YES ❑ NO	Been prescribed medication for ADD/ADHD?	❑ YES ❑ NO
Had trouble sleeping	❑ YES ❑ NO	Attempted or thought about hurting yourself or others?	❑ YES ❑ NO
Felt sad or depressed	❑ YES ❑ NO		
Felt anxious and nervous much of the time	❑ YES ❑ NO	Seen a counselor, psychiatrist or psychologist for any reason or <u>been hospitalized for any mental health reason?</u>	❑ YES ❑ NO
Bled excessively after injury	❑ YES ❑ NO		
Had pins, staples, wires in body	❑ YES ❑ NO		
Worn Hearing Aids	❑ YES ❑ NO	Coughed up blood	❑ YES ❑ NO
Been advised to have any operation	❑ YES ❑ NO	Had any other illness than those already noted	❑ YES ❑ NO

HEALTH & WELLNESS cont.

Do you take or use any of the following?	Never	Occasionally	Frequently
Diet Pills	❑	❑	❑
Sleeping Pills	❑	❑	❑
Laxatives	❑	❑	❑
Anti-Histamines	❑	❑	❑
Anti-Inflammatories	❑	❑	❑
Tobacco (Dip, Snuff, Cigarettes, Cigars, etc.)	❑	❑	❑
Weight Gain, Weight Loss, or Performance Enhancement Supplements	❑	❑	❑
Other Diet, Nutritional, or Performance Enhancing Supplements	❑	❑	❑
Over-the-Counter Medications	❑	❑	❑

Are you presently taking any <u>PRESCRIBED</u> or over-the-counter medications? (Include Birth Control pills, Insulin, Allergy shots/pills, Asthma Inhalers, Anti-Depressants, Anti-Inflammatories including Aspirin, Medications for ADD/ADHD.

Name	Dose (Strength)	How many times daily and/or weekly	Reason

MEN'S MEDICAL HISTORY

Do you feel pain or burning with urination?	❑ YES ❑ NO	Explain:
Any blood in your urine?	❑ YES ❑ NO	Explain:
Has the force of your urine decreased?	❑ YES ❑ NO	Explain:
Have you had any kidney, bladder, or prostate infections with the last 12 months?	❑ YES ❑ NO	Explain:
Do you have any problems emptying your bladder completely?	❑ YES ❑ NO	Explain:
Any testicular torsion, pain, or swelling?	❑ YES ❑ NO	Explain:

WOMEN'S MEDICAL HISTORY

Have you ever had a menstrual period?	❑ YES ❑ NO	
At what age did your menstrual cycle start?		Any problems?
When was your most recent menstrual cycle?	Date:	Any problems?
On an average, how long has each period lasted?		Days: Week
How many periods have you had in the past 12 months?		
Are you currently taking any female hormones, such as estrogen, progesterone, birth control for regulating your period?	❑ YES ❑ NO	If yes, explain:
When was your last pelvic exam and pap smear?	Date:	Results:
Trouble with heavy menstrual bleeding?	❑ YES ❑ NO	Explain:
Bleeding between periods?	❑ YES ❑ NO	Explain:
Menstrual cramps/pain which affected you school or athletic performance?	❑ YES ❑ NO	Explain:
Have you ever gone more than 3 months between periods?	❑ YES ❑ NO	If yes, explain:
Have you ever seen a Medical Clinician/Physician because of irregular periods?	❑ YES ❑ NO	Explain:

HEAD AND NEUROLOGICAL MEDICAL HISTORY

Head Concussion	❑ YES ❑ NO	If yes, how many times?
Knocked Unconscious	❑ YES ❑ NO	If yes, how many times and for how long?
Has anyone ever used the word "Dinged" to describe a head injury?	❑ YES ❑ NO	Explain:
Long-term problems due to head injury, such as memory loss, headaches, dizziness, mood swings, and/or nausea?	❑ YES ❑ NO	If yes, Explain:
Have you had numbness, tingling, or weakness in the following areas: • Shoulder • Buttocks • Legs and/or Feet	❑ YES ❑ NO	If yes, Explain:
Seizure or epilepsy	❑ YES ❑ NO	Explain:
Migraine headaches	❑ YES ❑ NO	Explain:
Have you ever taken a baseline Neuro-Psych test?	❑ YES ❑ NO	If yes, which one? (i.e. Axon, ImPact, Headminder, etc.)
If YES, please include a copy of the test results.		
Have you ever been told to refrain from sport participation due to concussion(s)?	❑ YES ❑ NO	

ORTHOPEDIC MEDICAL HISTORY

Please Check if you have or had any of the below injuries. If your injury is not listed, indicate in the OTHER box.

NECK AND BACK MEDICAL HISTORY		
Facet Disorder or Disc Disease/Injury	❑ YES ❑ NO Date:	Explain:
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Whiplash Injury	❑ YES ❑ NO Date:	Explain:
Rib Injury	❑ YES ❑ NO Date:	Explain:
Burner or Stinger	❑ YES ❑ NO Date:	Explain:
Congenital Deformity	❑ YES ❑ NO Date:	Explain:
Back Pain or Stiffness	❑ YES ❑ NO Date:	Explain:
Spondylosis/Spondylolisthesis	❑ YES ❑ NO Date:	Explain:
Herniated Disc	❑ YES ❑ NO Date:	Explain:
Sacroiliac Disease	❑ YES ❑ NO Date:	Explain:
Sciatica	❑ YES ❑ NO Date:	Explain:
Scoliosis	❑ YES ❑ NO Date:	Explain:
Epidural(s)	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

SHOULDER GIRDLE, CLAVICLE AND UPPER ARM MEDICAL HISTORY		
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Subluxation or Dislocation	❑ YES ❑ NO Date:	Explain:
Muscle Strain or Ligament Sprain	❑ YES ❑ NO Date:	Explain:
Labrum Injury or Tear	❑ YES ❑ NO Date:	Explain:
Tendonitis or Bursitis	❑ YES ❑ NO Date:	Explain:
Impingement	❑ YES ❑ NO Date:	Explain:
Rotator Cuff Injury	❑ YES ❑ NO Date:	Explain:
Acromioclavicular (AC) Sprain or Instability	❑ YES ❑ NO Date:	Explain:
Shoulder Joint Instability	❑ YES ❑ NO Date:	Explain:
Injection(s)	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

ELBOW, FOREARM, HAND, WRIST AND FINGER MEDICAL HISTORY		
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Subluxation or Dislocation	❑ YES ❑ NO Date:	Explain:
Muscle Strain or Ligament Sprain	❑ YES ❑ NO Date:	Explain:
Tendonitis or Bursitis	❑ YES ❑ NO Date:	Explain:
Elbow Joint Instability	❑ YES ❑ NO Date:	Explain:
Numbness/Tingling/Weakness of Forearm and/or Hand	❑ YES ❑ NO Date:	Explain:
Injections	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

PELVIS, HIP AND THIGH MEDICAL HISTORY		
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Subluxation or Dislocation	❑ YES ❑ NO Date:	Explain:
Sprain or Strain of Muscle (Groin, Hamstring, Quad)	❑ YES ❑ NO Date:	Explain:
Tendonitis or Bursitis	❑ YES ❑ NO Date:	Explain:
Severe Contusion or Hip Pointer	❑ YES ❑ NO Date:	Explain:
Athletic Pubalgia/Sports Hernia/Core Injury	❑ YES ❑ NO Date:	Explain:
Calcium Deposits	❑ YES ❑ NO Date:	Explain:
Injections	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

KNEE MEDICAL HISTORY		
ACL, MCL, PCL, LCL Tear or Repair/Reconstruction	❑ YES ❑ NO Date:	Explain:
Meniscus Injury, Repair or Meniscectomy	❑ YES ❑ NO Date:	Explain:
Patellar Dislocation	❑ YES ❑ NO Date:	Explain:
Patellar Femoral Syndrome	❑ YES ❑ NO Date:	Explain:
Chondromalacia	❑ YES ❑ NO Date:	Explain:
Tendonitis or Bursitis	❑ YES ❑ NO Date:	Explain:
IT Band Syndrome	❑ YES ❑ NO Date:	Explain:
Locking or Instability (giving away)	❑ YES ❑ NO Date:	Explain:
Osgood Schlatter's	❑ YES ❑ NO Date:	Explain:
Injections	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

LOWER LEG OR ANKLE MEDICAL HISTORY		
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Subluxation or Dislocation	❑ YES ❑ NO Date:	Explain:
Muscle Strain or Ligament Sprain	❑ YES ❑ NO Date:	Explain:
Re-occurring Sprain	❑ YES ❑ NO Date:	Explain:
High Ankle (Syndesmosis) Sprain	❑ YES ❑ NO Date:	Explain:
Tendonitis or Bursitis (Achilles)	❑ YES ❑ NO Date:	Explain:
Chronic Instability	❑ YES ❑ NO Date:	Explain:
Shin Splints	❑ YES ❑ NO Date:	Explain:
Compartment Syndrome	❑ YES ❑ NO Date:	Explain:
Bone Chip or Bone Spur in joint	❑ YES ❑ NO Date:	Explain:
Injections	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

FOOT OR TOE MEDICAL HISTORY		
Traumatic or Stress Fracture	❑ YES ❑ NO Date:	Explain:
Subluxation or Dislocation	❑ YES ❑ NO Date:	Explain:
Muscle Strain or Ligament Sprain	❑ YES ❑ NO Date:	Explain:
Tendonitis	❑ YES ❑ NO Date:	Explain:
Instability	❑ YES ❑ NO Date:	Explain:
Bone Chip or Bone Spur in joint	❑ YES ❑ NO Date:	Explain:
Plantar Fasciitis	❑ YES ❑ NO Date:	Explain:
Turf Toe	❑ YES ❑ NO Date:	Explain:
Sesmoiditis	❑ YES ❑ NO Date:	Explain:
Injection(s)	❑ YES ❑ NO Date:	Explain:
Surgery	❑ YES ❑ NO Date:	Explain:
Other, pain or swelling	❑ YES ❑ NO Date:	Explain:

Have you had or do you have now any medical problems or injuries not listed on this form?	❑ YES ❑ NO
If yes, Explain:	
Do you have any medical or health problems in which you are currently receiving medical treatment?	❑ YES ❑ NO
If yes, Explain:	
Is there any reason that you are not able to participate in athletics?	❑ YES ❑ NO
If yes, Explain:	
Are there any additional health problems you would prefer to discuss privately with our team physician?	❑ YES ❑ NO

Do you wear any special protective or corrective equipment or devices to participate in your sport? (i.e. braces, goggles, etc.)

Device:	*Explain:*
Device:	*Explain:*

The undersigned, herewith,

- Certifies that the answers to these questions are correct and true;
- Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her; and
- Fully realizes that the University of South Carolina Athletics Department cannot be held responsible for any previous medical condition(s), or for any current medical conditions that he/she has, that may or may not have been previously diagnosed or disclosed to the University of South Carolina

Signature of Student Athlete _____ Date _____

PRINT Full name of Parent/Guardian or Legal Representative* _____

Capacity of Legal Representative* (*if applicable*): _____

May be requested to provide verification of representative status

Signature of Parent/Guardian or Legal Representative* (*if student-athlete is under 18 years of age*) _____ Date _____

Upon completion of this Medical History, it will be reviewed and signed by a Staff Athletic Trainer

Signature of USC Athletic Trainer _____ Date _____

Name: _____ Date of Birth ____/____/____

Physician Reminders

1. Do you feel stressed on more sensitive issues?
2. Do you feel safe at your home or residence?
3. Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
4. During the last 30 days, did you use chewing tobacco, snuff, or dip?
5. Do you drink alcohol or use any other drugs?
6. Have you ever taken anabolic steroids or used any other performance supplement?
7. Have you ever taken any supplements to help you gain or lose weight or improve your performance?
8. Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION			
Height	Weight	❑ Male ❑ Female	
BP / (/) Pulse	Vision Rt. 20/	Lt . 20/	Corrected ❑ Yes ❑ No
MEDICAL		**NORMAL**	**ABNORMAL FINDINGS**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency			
Eyes/Ears/Nose/Throat Pupils Equal Hearing			
Lymph Nodes			
Heart Murmurs (auscultation standing, standing, +/- Valsalva Location of point of maximal impulse (PMI)			
Pulses Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (Males Only)			
Skin HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [c]			
MUSCULOSKELETAL		**NORMAL**	**ABNORMAL FINDINGS**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			
Functional Duck walk, single leg hop			

Consider reviewing questions on cardiovascular symptoms (History questions 5-14)
Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

EKG Completed ❑ Reviewed by _____ MD or DO

ECHO Performed ❑

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

❑ Not Cleared

❑ Pending further evaluation ❑ Medical Disqualification

Reason _____

Recommendations _____

_____

I have examined the above-named athlete and completed the pre-participation physical evaluation. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/type) _____ Date _____/_____/_____

Signature of Physician _____ MD or DO

NOTES:

UNIVERSITY OF SOUTH CAROLINA – ATHLETICS DEPARTMENT

WAIVER AND RELEASE OF LIABILITY

I, _____, in consideration of being permitted to engage in a tryout, and to participate in athletic games and workouts for the purpose of showing my athletic skills and abilities at the University of South Carolina, do for myself, my heirs, executors, administrators and assigns, herby waive, release, and forever discharge the University of South Carolina, its officials, agents and employees, from any and every claim, demand, action or right of action, of whatever kind or nature which I now have or may hereafter acquire, arising from or by reason of any and all injury, including bodily injury or death, as well as any property damage, which may occur in connection with a tryout and participation in athletic games and workouts at the University of South Carolina athletic facilities, whether by negligence or not, to the extent permitted by law.

I understand and acknowledge that engaging in a try out, and participation in athletic games and workouts in the athletic facilities of the University of South Carolina, is voluntary and is solely at my own risk, and I assume full responsibility therefore. I am knowledgeable about the sport for which I am trying out; I have previously participated in the sport, and I am aware of the potential for injury while participating. I hereby further declare that I am physically sound, healthy and able to tryout and to participate in athletic activities.

I further state that I have carefully read the foregoing Waiver and Release of Liability, that I understand the contents hereof, and that I have executed this Release voluntarily.

Print Participant Name: _____

Participant Signature: _____

Date: _____

If Participant is under age 18:

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____