



SAN DIEGO STATE AZTECS

ATHLETIC TRAINING

MEMORANDUM

TO: Athletes Trying Out
FROM: Tom Abdenour, DHSc, ATC, CES *TA*
Head Athletic Trainer
RE: Pre-Participation Exam
DATE: August, 2011

It is required that you have a physical exam on file with the San Diego State Athletic Medical office as part of your try out opportunity. **You must return these forms to your sport before your try out date in order to be eligible.** This exam must be conducted by a licensed medical or osteopathic physician and, as per NCAA guidelines, cannot be paid for by SDSU.

The following forms are included for your convenience and must be completed prior to your try out:

- SDSU Athletic Medical Examination
- SDSU Pre-participation Physical Examination history
- Awareness of Risk
- Authorization/Consent to disclose health information
- SDSU Intercollegiate athletic accident policy
- Student-athlete insurance information and release authorization

In addition, information regarding the sickle cell trait is included. We strongly recommend that you know your sickle cell trait status prior to trying out for your team.

If you have any questions, please contact me at tabdenour@shsmail.sdsu.edu

Thank you.

SDSU Preparticipation Physical Evaluation

Date Form Completed: _____/_____/_____

Name:	Sex:	Age:	Date of Birth:
Varsity Sport:	Cell Phone:	Email:	
Local Address:			
Red ID #:			

**Explain "Yes" answers, more space in box at end.
Circle questions you don't know the answer to.**

	YES	NO		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason? Why _____	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)? List: _____	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? List: _____	<input type="checkbox"/>	<input type="checkbox"/>	26. Do you currently use an inhaler or take asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, what? _____	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion? If so, when was your last one? _____ How many have you had? _____ Any current problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply): <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart (for example, ECG, echocardiogram)?	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery? If so, on what?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
If you have answered YES to any of the above questions please complete the Musculoskeletal History Section, page 3/3.			43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommend you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or an assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or have you ever been given an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	47. Do you take any medications for ADHD and/or anabolic steroids for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY:		
			48. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			49. How old were you when you had your first menstrual period?		
			50. How many periods have you had in the last 12 months?		

Please number and explain "Yes" Answers Here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct

Print Name of athlete: _____ Date: _____

Signature of athlete: _____ Signature of Parent/Guardian: _____

Musculoskeletal History Section:

Please list fractures, sprains, strains, dislocations, cartilage injuries, etc.

If you need more room use lines at end of the section.

Type of Injury	Date	Treatment	Fully Resolved
Ankle R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Foot R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Knee R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Hip/Leg R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Hand R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Wrist R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Elbow R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Shoulder R			<input type="checkbox"/> yes <input type="checkbox"/> no
L			<input type="checkbox"/> yes <input type="checkbox"/> no
Chest/Ribs			<input type="checkbox"/> yes <input type="checkbox"/> no
Neck (burners, stingers, etc)			<input type="checkbox"/> yes <input type="checkbox"/> no
Back			<input type="checkbox"/> yes <input type="checkbox"/> no
Head/Face			<input type="checkbox"/> yes <input type="checkbox"/> no
Any other significant injury to your body? (please explain) _____			

General Questions:

Have you ever been hospitalized overnight? (please explain) _____

Have you ever had any surgeries? (please explain) _____

Do you have ANY medical problems you have not yet listed that require regular treatment or medical attention? _____

Have you seen a doctor in the last year? _____

Are you currently experiencing any symptoms or in any way feel not well? _____

I hereby certify that I have completed this questionnaire completely and correctly to the best of my ability and knowledge. I certify that there are no illnesses or injuries, current or previous, that I have incurred, other than those I have listed on the preceding pages.

Print Name of athlete: _____ Date: ____ / ____ / ____

Signature of athlete: _____

Please check a response for each of the following: I...

	Always	Usually	Often	Sometimes	Rarely	Never	Score
1. Am terrified about being overweight	<input type="radio"/>	___					
2. Avoid eating when I am hungry	<input type="radio"/>	___					
3. Find myself preoccupied with food	<input type="radio"/>	___					
4. Have gone on eating binges where I feel that I may not be able to stop	<input type="radio"/>	___					
5. Cut my food into small pieces	<input type="radio"/>	___					
6. Aware of the calorie content of foods that I eat	<input type="radio"/>	___					
7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	<input type="radio"/>	___					
8. Feel that others would prefer if I ate more	<input type="radio"/>	___					
9. Vomit after I have eaten	<input type="radio"/>	___					
10. Feel extremely guilty after eating	<input type="radio"/>	___					
11. Am preoccupied with a desire to be thinner	<input type="radio"/>	___					
12. Think about burning up calories when I exercise	<input type="radio"/>	___					
13. Other people think that I am too thin	<input type="radio"/>	___					
14. Am preoccupied with the thought of having fat on my body	<input type="radio"/>	___					
15. Take longer than others to eat my meals	<input type="radio"/>	___					
16. Avoid foods with sugar in them	<input type="radio"/>	___					
17. Eat diet foods	<input type="radio"/>	___					
18. Feel that food controls my life	<input type="radio"/>	___					
19. Display self-control around food	<input type="radio"/>	___					
20. Feel that others pressure me to eat	<input type="radio"/>	___					
21. Give too much time and thought to food	<input type="radio"/>	___					
22. Feel uncomfortable after eating sweets	<input type="radio"/>	___					
23. Engage in dieting behavior	<input type="radio"/>	___					
24. Like my stomach to be empty	<input type="radio"/>	___					
25. Enjoy trying new rich foods	<input type="radio"/>	___					
26. Have the impulse to vomit after meals	<input type="radio"/>	___					

1. Have you gone on eating binges where you feel that you may not be able to stop? (Eating much more than most people would eat under the same circumstances?)

No _____ Yes _____ How many times in the last 6 months? _____

1. Have you ever made yourself sick (vomited) to control your weight or shape?

No _____ Yes _____ How many times in the last 6 months? _____

2. Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?

No _____ Yes _____ How many times in the last 6 months? _____

3. Have you ever been treated for an eating disorder?

No _____ Yes _____ How many times in the last 6 months? _____

4. Have you recently thought of or attempted suicide?

No _____ Yes _____ When? _____

Have you ever been diagnosed as having an eating disorder (anorexia, bulimia, or both)?

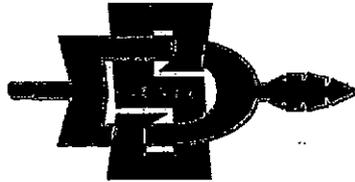
No _____ Yes _____

Please list your:

highest weight _____, lowest weight _____, goal weight _____

Print Name of athlete: _____ Date: ____/____/____

Signature of athlete: _____



SAN DIEGO STATE AZTECS
ATHLETIC TRAINING

AWARENESS OF RISK STATEMENT

In an effort to recognize the responsibility for sports safety of administrators, coaches, physicians, athletic trainers and student athletes, I, the undersigned, am aware that there is a certain risk of injury involved in my participation in Intercollegiate Athletics at San Diego State University. I understand that this includes the risk of spinal cord and brain injury that may result in paralysis and the possibility of permanent injury. I accept the responsibility for reporting my injuries and illnesses to San Diego State University's medical staff, including signs and symptoms of concussions.

I have been informed that the San Diego State University Intercollegiate Athletics insurance has provisions which require that I report current and previous injuries to the athletic trainer immediately.

Student-Athlete Signature _____

Date _____

SDSU Athletic Medicine

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Background:

This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

Participating in varsity intercollegiate sports by its nature puts an athlete in the public eye. Both television and print media will be following and reporting on the team and sometimes on individual athletes. They are often interested in illnesses or injuries that will result in missed game time or limit performance.

As a varsity athlete you enter into an agreement with the Athletic Department with unique rights and responsibilities as described in the Student Athlete Handbook. Sharing medical information about your injuries or illnesses with coaches and other Athletic Department administrators is helpful (such as when a coach is planning a roster for an upcoming competition) and sometimes necessary (such as when applying for a "medical redshirt"). Personal health information must be sent to the Mountain West Conference when applying for a medical redshirt.

Often other athletes are within hearing distance while you are being treated in the training room or on the field for your athletic injuries and illnesses.

Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:

Athletic injuries and illnesses: This may refer to any injury or illness that impacts your ability to play and/or perform for San Diego State University's varsity intercollegiate sports. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities. If a professional team requests information about your *athletic injuries and illnesses* we will release such information to the team **ONLY** if you give us specific written consent.

Athletic Medicine Staff: This refers to all persons working under the direction of the Medical Director of Athletic Medicine and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, graduate assistant athletic trainers, student athletic trainers, registered dietician, and administrative assistant for medical billing.

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Consent:

I, _____, acknowledge that I have read and understand the
Name of Student Athlete

Background and Definitions above and that I have been given a copy of, read and understand a separate document "SDSU Athletic Medicine – Notice of Privacy Practices"

I, _____, hereby authorize San Diego State University
Name of Student Athlete

and its *athletic medicine staff* (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my *athletic injuries and illnesses* to the following groups/persons:

List A: Groups/Persons

SDSU Athletic Department Administrators including but not limited to coaches, compliance officer, and Director of Media Relations
Media outlets and their employees or agents (such as newspapers and television)
Teammates and other varsity athletes
Parents or guardians
Mountain West Conference and its employees or agents
NCAA Injury Surveillance System (ISS)

I understand that the information released may have different purposes and is dependant on to whom the information is released. These purposes may include but are not limited to:

List B: Purposes

Athletic Department operations
Answering media questions
Explaining the typical course of an injury or illness to another athlete
Informing concerned parents or guardians
Asking the MWC to grant a medical redshirt (hardship) or exemption
Allowing the NCAA to track injury statistics

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 health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

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 media outlets, Mountain West Conference, parents and guardians, and other varsity athletes are not covered by the Buckley Amendment or HIPAA and that this policy does not apply to their use or disclosure of my *athletic injury and illness* information.

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 director of athletic medicine at SDSU. 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

San Diego State University
INTERCOLLEGIATE ATHLETIC ACCIDENT POLICY

SDSU, like most NCAA Athletic Departments, provides an athletic insurance policy for its student-athletes (SDSU intercollegiate athletic accident policy). **The SDSU athletic accident insurance policy will only cover medical costs related to injuries that occur while participating in a supervised practice or competition for SDSU. This is not a comprehensive insurance policy.** For example, if the athlete requires surgery for an appendicitis or hospitalization for a kidney infection these expenses would not be covered. Likewise, expenses will not be covered if an athlete fractures a bone while engaged in an activity outside of a formal university practice or competition. **It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover these expenses.**

The SDSU athletic accident insurance policy is designed to act as a secondary insurance policy. **If a student-athlete is covered by a personal, family, or private insurance policy it will be used first. Medical expenses will not be paid under the secondary insurance policy carried by SDSU until any existing personal medical insurance policy is exhausted.**

In order to qualify for coverage under the SDSU athletic accident insurance policy the student-athlete must have their medical care coordinated and authorized by the Athletic Medicine staff (Certified Athletic Trainers or Team Physicians) . The Athletic Medicine staff must coordinate all necessary care for athletically related injuries. Any medical claims or expenses for the student-athlete, resulting from an accidental injury during a supervised scheduled university athletic activity, practice or competition, will be filed first with the student-athlete's personal insurance company (their primary insurance). After the claim has been filed and paid by the student-athlete's primary insurance, you should receive an "Explanation of Benefits" (EOB) statement from your insurance. This EOB will list any expenses that were not covered or paid. This information should be immediately forwarded to the Athletic Medicine Department at SDSU. Forwarding us the EOB is the easiest way to inform us. Co-pay payments may be required by the outside provider at the time the services are rendered. The student-athlete should submit these co-pay receipts to SDSU Athletic Medicine Department for reimbursement. Please submit EOB statements and co-pay receipts to: Pat Dulin, Insurance Coordinator SDSU Athletics Department 5500 Campanile Drive, San Diego, CA 92182-4313. The Athletic Department will cover the remaining balance of the injury claims so there should be no out-of-pocket expenses for the student-athlete if the injury occurred during a supervised scheduled university athletic activity, practice or competition at SDSU.

If the student-athlete does not have any primary insurance, we will ask the outside medical provider to bill SDSU athletics directly. Payments will be made according to the schedule of benefits of the SDSU intercollegiate athletic accident policy. There should be no out-of-pocket expense for the student-athlete if the injury occurred during a supervised scheduled university athletic activity practice or competition at SDSU.

The SDSU intercollegiate athletic accident policy will only cover expenses incurred during the 2 years (104 weeks) following the date of injury. The limit of insurance coverage is \$75,000.00 per injury. Expenses beyond \$75,000 will be submitted to the NCAA Catastrophic Injury policy for review.

Student-Athlete & Parent Statement of Understanding

By my signature below I acknowledge that I have read the information listed above and understand and attest to the statements that follow:

1. The Athletic Medicine Staff will coordinate all necessary care for athletic related injuries. The Athletic Department will not bear financial responsibility for medical bills that are not authorized by the Athletic Medicine staff.
2. Failure to report injuries to university athletic medical personnel, obtain authorization for outside medical care, or to meet scheduled medical appointments may void university responsibility for medical expenses resulting from athletic injuries.
3. I understand that the SDSU intercollegiate athletic accident insurance policy will only cover expenses incurred during the 2-years (104 weeks) following the injury date and up to \$75,000, whichever comes first.
4. If a student-athlete is covered by a personal, family, or private insurance policy it will be used first. Medical expenses will not be paid under the secondary insurance policy carried by SDSU until any existing personal medical insurance policy is exhausted.
5. I understand that if I do not have personal medical insurance SDSU will ask outside providers to bill SDSU intercollegiate athletic accident insurance policy directly.
6. If these policies are followed there will not be any out-of-pocket expenses for the student-athlete or their family for injuries occurring during SDSU supervised practices and competitions.
7. The SDSU athletic accident insurance policy will only cover medical costs related to injuries that occur while participating in a supervised practice or competition for SDSU. This is not a comprehensive insurance policy.
8. It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover these expenses.

Student-Athlete:

Printed Name: _____

Signature: _____

Date: _____

Parent/Guardian:

Printed Name: _____

Parents of student-athletes under the age of 18 – please sign below.

I hereby grant permission to the Physicians in the Athletic Medicine Department and Student Health Services at SDSU and those professional personnel designated by them to treat my son/daughter in the event of any injury or illness. In the event of a serious injury and if unable to contact me, this consent is to include any and all emergency procedures deemed necessary by the attending physician.

Parent/Guardian Signature: _____

Date: _____

**San Diego State University
Athletic Training Department
Insurance Information Form**

*******ATHLETE'S INFORMATION*******

NAME (Last) _____ (First) _____ (MI) _____ SPORT _____
 SOC SEC # _____ RED ID # _____ CELL PHONE _____ DOB _____
 EMAIL ADDRESS _____
 PERMANENT ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____
 LOCAL ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____

*******PARENT/GUARDIAN INFORMATION*******

NAME (Last) _____ (First) _____ (MI) _____ PHONE _____
 EMPLOYER _____ DOB _____ SS# _____
 EMPLOYER ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____

Attach copy of insurance card ******* INSURANCE INFORMATION******* **Attach copy of insurance card**

PRIMARY Insurance Company _____ Policy Holder Name, DOB and SS# _____ _____ Group Number _____ Policy Number _____ Phone _____ fax _____ Billing Address (Street, City, State, Zip Code) _____ _____ HMO (Y or N) PPO (Y or N) Military (Y or N) Insurance covers prescriptions (Y or N) Primary Care Physician's Name (if applicable) _____	DENTAL Insurance Company _____ Policy Holder Name, DOB and SS# _____ _____ Group Number _____ Policy Number _____ Phone _____ fax _____ Billing Address (Street, City, State, Zip Code) _____ _____ HMO (Y or N) PPO (Y or N) Military (Y or N) Insurance covers prescriptions (Y or N) Phone _____
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*******NOTE TO PARENT/GUARDIAN AND ATHLETE*******

I understand this insurance information must be COMPLETELY and ACCURATELY provided and on file with the Athletic Training Department before my son/daughter will be allowed to participate in athletics. I further understand that any medical expenses resulting from an ACCIDENTAL INJURY while participating in a scheduled university athletic activity will not be paid under the accident insurance policy carried by SDSU until any existing policy I have covering these expenses is exhausted. If I do not have insurance, payments will be made according to the schedule of benefits of the SDSU intercollegiate athletic accident policy. I understand the limits of insurance coverage under SDSU's insurance policy will be for 104 weeks or \$75,000.00 per injury, whichever comes first. I further understand that failure to report injuries to university athletic medical personnel or to meet scheduled medical appointments may void university responsibility for medical expenses resulting from athletic injuries.

I also understand that this accident insurance policy **does not cover medical illnesses unrelated to sports**. For example, if the athlete requires surgery for an appendicitis or hospitalization for a kidney infection these expenses would not be covered. Furthermore, expenses will not be covered if an athlete fractures a bone while engaged in an activity outside of a formal university practice or competition. It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover these expenses.

Parent/Guardian Signature: _____ Date _____
 Athlete Signature: _____ Date _____

I hereby grant permission to the Physicians in the Athletic Medicine Department and Student Health Services at SDSU and those professional personnel designated by them to treat my son/daughter in the event of any injury of illness. In the event of a serious injury and if unable to contact me, this consent is to include any and all emergency procedures deemed necessary by the attending physician. Athlete may sign if 18 years of age or older.

Parent/Guardian Signature _____ Date _____



**AZTEC ATHLETIC MEDICINE
HEALTH INSURANCE RELEASE AUTHORIZATION**

TO: HEALTH INSURANCE CARRIER _____
ADDRESS _____
CITY _____ STATE _____
ZIP _____ PHONE: _____ FAX: _____

I HEARBY AUTHORIZE AND REQUEST YOU TO RELEASE INFORMATION REGARDING MY HEALTH INSURANCE INFORMATION AS LISTED BELOW TO:

Aztec Athletic Medicine
San Diego State University
San Diego, CA 92182-4314
Telephone (619) 594-5551 Fax (619) 594-7654

THIS RELEASE COVERS ALL HEALTH INSURANCE INFORMATION INCLUDING BUT NOT LIMITED TO:

PRIMARY CARE PROVIDER; ELIGIBILITY & BENEFITS; DEDUCTIBLE LEVEL AND AMOUNT MET; COPAYS; EXPLANATION OF BENEFITS (EOB)

THIS AUTHORIZATION WILL REMAIN VALID UNTIL REVOKED BY ME IN WRITING. A COPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

1. **POLICY HOLDER NAME** _____ SS# ____ - ____ - _____

X _____
SIGNATURE OF POLICY HOLDER DATE

2. **PATIENT NAME** _____ SS# ____ - ____ - _____

X _____
SIGNATURE OF PATIENT DATE

Sickle Cell Trait and the Student-Athlete

SDSU Athletic Medicine recommends that all athletes be screened for Sickle Cell Trait. The test is paid for by Athletic Medicine.

What is Sickle Cell Trait?

Sickle Cell trait in itself is not a disease. It is an inherited condition where a person has one normal gene for hemoglobin (which carries oxygen in the blood) and one abnormal gene for hemoglobin. This is NOT the same as sickle cell anemia disease, which is when the individual has two abnormal hemoglobin genes. It has persisted because it confers some protection against malaria.

Who is Affected?

The carrier rate is as high as 30% in Nigeria, 25% in eastern Saudi Arabia, and 30% in parts of Greece. These affected populations have migrated over time, and consequently the gene can now be found in other countries, such as the U.S. As reported by the NCAA, 8-10% of the U.S. black population has sickle cell trait. It is also found in non-black athletes, but at a much lower frequency (0.8%). Sickle cell trait is present at all levels of athletic competition, and is NOT considered a barrier to athletic performance.

Why Get Tested?

Sickle cell trait is someone who carries only one abnormal gene, and therefore has no symptoms. It can put an athlete at a higher risk of heat illness. It is important for individuals with sickle cell trait to be aware they have it for when they decide to become a parent. If both parents of a child have sickle cell trait there is a 25% chance their child could have sickle cell disease – a serious disease.

It is believed that sickle cell trait is linked to other medical problems associated with strenuous exertion:

Exercise-induced rhabdomyolysis: a type of heat illness that is characterized by disintegration of muscle tissue. To date, no direct causal evidence has been found, and the relationship is unclear.

Exercise-associated sudden death (Sickling Collapse): studies done in the military suggest there is an increased risk in those with sickle cell.

What if the Test is Positive?

Athletes with sickle cell trait are not restricted from playing any sport. Serious medical problems associated with sickle cell trait are rare. If the test is positive, it is recommended that the athlete become educated on how to train safely for strenuous exercise and avoid high risk situations. It is also recommended they undergo genetics counseling before they consider having children.