SAN DIEGO STATE
ATHLETIC TRAINING

Medical Questionnaire for Returning Athletes

Name: _____ Red ID # _____ Cell Phone:_____

Date: _____ Year at SDSU: 2nd, 3rd, 4th, 5th, 6th Sport: _____

Since your last physical or returning medical questionnaire:

1. Have you experienced 1) chest pain/discomfort with exertion 2) fainting/near fainting or 3) excessive, unexpected or unexplained shortness of breath or fatigue associated with exercise? Yes_____ No_____
   If yes, please explain:_____
2. Have you been diagnosed with a heart condition or murmur or increased systemic blood pressure? Yes____ No____
   If yes, please explain:_____
3. Have you become aware of any premature deaths (sudden or otherwise), or significant disability from cardiovascular disease in close relative(s) younger than 50 yrs old or specific knowledge of the occurrence of certain conditions (e.g. hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan Syndrome, or clinically important arrhythmias)? Yes____ No____ If yes, please explain:_____
4. Have you had any surgery, developed a new drug allergy or new illness requiring the care of a physician since your last physical exam or questionnaire? Yes____ No____ If yes, please explain:_____
5. Have you been injured OR has any physician recommended you limit your sports participation since your season ended or during the summer, including Sickle Cell Trait diagnosis? Yes____ No____. If yes, please explain:_____
6. Please list any medications or nutritional supplements you are currently taking:_____
7. Do you feel you need to see a physician? Yes____ No____. If yes, please explain:_____
8. Do you currently have any symptoms of injury or illness? Yes ___ No ____ If yes, please explain:_____
9. Do you take any medications for ADHD and/or anabolic steroids for any reason? Yes___ No___
   If yes, please explain:_____
10. In the past year have you been diagnosed with an eating disorder or do you have any concerns regarding eating habits that you would like to discuss with a physician? Yes____ No____
    If yes, please explain:_____

Athlete name: _____Athlete Signature: _____Date:_____

Office Use Only:

Ht:____ Wt:____ Wt change in last year:____ BP:____/____ Pulse:____ Temp:____° SCT:_____

□ Reviewed/No action □ Action Required Initials/Date:_____/_____

ALLERGIES _____

SAN DIEGO STATE
ATHLETIC TRAINING

Insurance Information Form

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

NAME (Last) _____ (First)_____ (MI)_____ SPORT_____

SOC SEC # _____ RED ID #_____ CELLPHONE _____ DOB _____

EMAIL ADDRESS_____

PERMANENT ADDRESS (Street)_____(City)_____(State)____(Zip)_____

LOCAL ADDRESS (Street)_____(City)_____(State)____(Zip)_____

******PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION******

NAME (Last) _____ (First)_____ RELATION_____PHONE_____

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

PRIMARY Insurance Company_____

Policy Holder Name, DOB and SS#_____

Policy Holder Employee and Employer's address_____

Group # _____Policy # _____

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)

DENTAL Insurance Company_____

Policy Holder Name, DOB and SS#_____

Policy Holder Employee and Employer's address____

Group #_____Policy # _____

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)_____Phone_____

******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 me or my son/daughter will be allowed to participate in athletics.

Athlete name: _____Athlete Signature: _____Date: _____

Parent Name: _____Parent Signature: _____Date: _____

I hereby grant permission to the Physicians in the Athletic Medicine Department and Student Health Services at SDSU and those professional personal designated by them to treat me or 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 name: _____Athlete Signature: _____Date: _____

Parent Name: _____Parent Signature: _____Date: _____

SAN DIEGO STATE
ATHLETIC TRAINING

AZTEC ATHLETIC MEDICINE
HEALTH INSURANCE RELEASE AUTHORIZATION

TO: HEALTH INSURANCE CARRIER _____

ADDRESS _____

CITY_____ STATE _____

ZIP_____ PHONE _____ FAX _____

I HEREBY 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 92182-4313
Telephone (619) 594-5551 Fax (619) 594-7654

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

PRIMARY CARE PROVDER; 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#____-____-_____

SIGNATURE OF POLICY HOLDER _____ DATE _____

2. PATIENT NAME_____ SS#____-____-_____

SIGNATURE OF PATIENT_____ DATE _____

SAN DIEGO STATE
ATHLETIC TRAINING

Attention Deficit Hyperactivity Disorder Information Form

Please check the appropriate box and sign:

□ I have never been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). Please print and sign you name below and return this form to us. **You do not need to read or complete the rest of this form.**

□ I have been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). **Please read and complete the NCAA medical exemption documentation form and return it to us with the rest of the material**. This needs to be done yearly – last year's records are not enough.

Athlete name: _____Athlete Signature: _____Date: _____

Parent Name: _____Parent Signature: _____Date: _____
(If under 18)

SAN DIEGO STATE
ATHLETIC TRAINING

CONSENT TO MEDICAL TREATMENT FOR ADULTS (18 years & older)

Student-Athlete's Name (printed)	Date of Birth	Red ID #

To be read and signed by the Adult Student-Athlete:
I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide diagnostic tests or treatment that is deemed advisable, and is to be provided by medical practitioners of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff, and health care professionals to proceed with medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance of any specific diagnosis or treatment that may be required.

Signature	Date

PARENTAL CONSENT TO MEDICAL TREATMENT FOR A MINOR

Please choose an option below and sign for Minor Student-Athletes:

☐ I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide my minor (less than 18 years of age) son or daughter diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff, and health care professionals to proceed with any medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance of any specific diagnosis or treatment that may be required.

Parent/Guardian Name (printed)	Signature of Parent/Guardian

☐ I may choose a person employed at San Diego State University to serve as a "designated agent" to consent for treatment of my minor son or daughter. This person can then sign any consent forms that may be necessary for diagnosis or treatment of my child, whether at SDSU Student Health Services or another medical facility. (This designated agent can be any adult into whose care the minor has been entrusted. You may identify the authorized adult by titles and employer [for example, Director of Patient Services & Medical Records of SDSU Student Health Services] rather than by name.)

The undersigned parent/guardian of _____, a minor authorizes _____, as an agent for the undersigned, to consent to any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or any outside physicians or facilities as needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

Parent/Guardian Name (printed)	Signature of Parent/Guardian

FOR STUDENT HEALTH SERVICES USE ONLY
Telephone consent to treat the above named student-athlete was given by:

Name (printed)	Relationship to Patient	Phone Number

Director of Pt. Services Medical Records or Designee Signature	Witness Signature