



ST. JOSEPH'S COLLEGE (NY) BROOKLYN ATHLETICS



STUDENT-ATHLETE MEDICAL CONSENT FORM - PAGE 1

Part 1 - Personal Information

Name: _____ Sex: Male Female
Last First MI

Date Of Birth: ____ / ____ / ____ Social Security #: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Date of Initial Entry to St. Joseph's College: Fall Spring Summer Year: _____

Academic Level: Freshman Sophomore Junior Senior
1-32 credits 33-64 credits 65-96 credits 96+ credits

Major: _____

Mother/Guardian:

Father/Guardian:

Name: _____

Name: _____

Social Security #: _____

Social Security #: _____

Employer: _____

Employer: _____

Work Address: _____

Work Address: _____

Work Phone: _____

Work Phone: _____

Home Address: (if different from above)

Home Address: (if different from above)

EMERGENCY CONTACTS:

Name: _____

Name: _____

Relation: _____

Relation: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____





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Part 2 – Assumption Of Risk And Consent For Treatment

I acknowledge that there is an inherent risk of injury associated with my participation in the Intercollegiate Athletics Program at St. Joseph's College and that such injury may result in permanent disability or death. In the event of routine emergency health examinations, diagnostic procedures, treatment of injuries/ or illness, permission is hereby granted to treat the above mentioned student athlete by St. Joseph's College Athletic Training Staff, Physicians associated with SJC, and/ or other community facilities as needed.

Parent/Guardian's Signature: _____ Date: _____
(If athlete is a Minor)

Athlete's Signature: _____ Date: _____

Part 3 – Insurance Information

Name of Policy Holder: _____

Policy Holder SS #: _____ Policy Holder Birthdate: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Address for Claims: _____

Insurance Co. Phone: _____

Does your plan require pre-authorization for services? Yes No
Is your plan part of an HMO that restricts treatment for services? Yes No
Insurance Plan Type HMO PPO

If HMO, Name and Number of Primary Care Physician: _____

All Student-Athletes Must Provide a Photocopy of their Insurance Card

Part 4 – Health Examination (performed by trainer)

Height: _____ Vision (if known): Right 20/____ Left 20/____

Weight: _____ Wear Glasses/Contacts? YES NO

Blood Pressure: _____ / _____ Vision w/ glasses: Right 20/____ Left 20/____

Pulse (at rest): _____ bpm Hearing (if known): Right ___/15 Left ___/15





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Part 5 – Health History

A. Have You Ever Had Any Of The Following? If Yes, Please Explain:

Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/Urinary Dysfunction	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bone/Joint Deformities	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chicken Pox	<input type="checkbox"/> YES <input type="checkbox"/> NO	Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Menstrual Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diphtheria	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mental Nervous Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mumps	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eye, Nose, Throat Dysfunction	<input type="checkbox"/> YES <input type="checkbox"/> NO	Poliomyelitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fainting Spells	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
German Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Headaches/Migraines	<input type="checkbox"/> YES <input type="checkbox"/> NO	Serious Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach/Bowel Difficulty	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hernia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
High/Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Whooping Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO
Infectious Mononucleosis	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Please explain any YES answers: _____

Are you taking any medications? YES NO

If YES, name medications and condition(s) being treated: _____

B. Are There Abnormalities In The Following Areas? If YES, Please Explain:

Abdomen	<input type="checkbox"/> YES <input type="checkbox"/> NO	Head, Face, Neck	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ano-rectal/Pilonidal	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lungs, Chest	<input type="checkbox"/> YES <input type="checkbox"/> NO
Back/Pelvis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lymph Nodes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ears	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mouth, Teeth	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emotional Stability	<input type="checkbox"/> YES <input type="checkbox"/> NO	Muscular Skeletal System	<input type="checkbox"/> YES <input type="checkbox"/> NO
Endocrine/Thyroid	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervous System	<input type="checkbox"/> YES <input type="checkbox"/> NO
Extremities	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nose, Throat, Sinus	<input type="checkbox"/> YES <input type="checkbox"/> NO
G.I. System	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please explain any YES answers: _____

Are you missing one (or more) of a paired organ? If YES, please explain: _____





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Part 6 – PHYSICAL EXAMINATION (performed by physician)

A. GENERAL EXAM

<u>Body Part</u>	<u>Normal</u>	<u>Abnormal/Comments</u>
Head, Eyes	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Ears, Nose, Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Chest (Lungs)	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Heart	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Glands	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Abdomen	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

B. ORTHOPEDIC EXAM

<u>Body Part</u>	<u>Normal</u>	<u>Abnormal/Comments</u>
Neck	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Shoulder	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Elbow	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Wrist & Hand	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Chest & Back	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Hip & Pelvis	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Knee	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Ankle & Foot	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

Part 7 – Medical Clearance (To be completed by Team physician)

Please check one of the following:

- Student may participate in unlimited physical education, intramural/intercollegiate athletics, and hospital and/or school internships.
- Student must be in a restricted or adapted program designed for her/his physical limitations.
Please indicate specific limit _____
- Student should not participate in any intramural/intercollegiate programs.

COMMENTS: _____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

PHYSICIAN'S NAME: _____

(Stamp Required)

ADDRESS: _____

PHONE #: _____

