

NORTH PARK UNIVERSITY

ATHLETICS PHYSICAL AND INSURANCE FORM

3225 West Foster Avenue, Chicago Illinois 60625 (773) 244-5682

North Park University employs Certified Athletic Trainers who are qualified to assess, treat and rehabilitate injuries you may incur while participating in our intercollegiate athletic program. The staff athletic trainers are under the guidance and direction of the medical director and team physician. The staff athletic trainers' qualifications include: certified by the National Athletic Trainers' Association Board of Certification, Inc., Licensed by the State of Illinois, certified in First Aid/AED and Cardiopulmonary Resuscitation of the Professional Rescuer, and a minimum of a Bachelors degree in the Athletic Training field. North Park University may also allow students from the Athletic Training Educational Program to assess, treat, and rehabilitate your injuries at the discretion of, and under the supervision of, the staff certified athletic trainer.

Please read each of these statements carefully and then sign each form. By signing, the student-athlete indicates that he/she understands and accepts these policies and that the student-athlete will not be permitted to participate in practice or competition until he/she has signed this form.

- I understand that my passing this physical examination does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me.
- I understand that, if the physical examination portion of this form is filled out by anyone other than a physician, or if I knowingly include any false information on any part of this form, I will be immediately excluded from participation, in any form, in intercollegiate athletics at North Park for one calendar year.

Printed Name

Signature

Date

Parent/Guardian (If athlete is under 18 years of age)

Sport

Office Use Only: _____ATC/ATS _____Sportsware

Informed Consent for Medical Treatment

I hereby grant my permission to the North Park University team physicians, athletic training staff, and athletic training students to assess, treat, and rehabilitate any injury that I may suffer as a result of my participation in the North Park University intercollegiate athletic program. I understand that any treatment, medical or surgical care that is provided to me will be done only if it is considered medically necessary for my health.

I hereby grant my permission to the North Park University team physicians and athletic training staff to refer me as they deem appropriate to the appropriate medical personnel, to a hospital, or any other medical facility for treatment for any injury or illness that I may suffer as a result of my participation in the North Park University intercollegiate athletic program.

Student-Athlete's Signature: _____ Date: ____/____/____

Parent/Guardian's Signature : _____ Date: ____/____/____
(If Student-Athlete is under 18 years of age)

Assumption of Risk and Shared Responsibility

Participation in intercollegiate athletic involves the inherent risk of injury, the severity of which may range from minor to catastrophic, or from temporary impairment to permanent disability, including paralysis or death.

Since the participation in sports requires an acceptance of the risk of injury by the student-athlete, he or she rightfully assumes that reasonable precaution will be taken to minimize the risk of serious injury. Student-athletes have this informed awareness of the risks and share the responsibility for minimizing those risks.

Student-athletes must comply with all safety guidelines, inspect their equipment daily, and follow athletic training room rules and procedures; report all physical problems to the athletic training staff and adhere to established injury management guidelines which include total rehabilitation and reassessments before being released to full participation.

Having read the above statement I am aware of the inherent risk of injury involved in athletic participation. Finally, I understand that in accepting the risks associated with athletic participation I will also share the responsibility of minimizing those risks.

Student-Athlete's Signature: _____ Date: ____/____/____

Parent/Guardian's Signature : _____ Date: ____/____/____
(If Student-Athlete is under 18 years of age)

STUDENT-ATHLETE AUTHORIZATION AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION TO NORTH PARK UNIVERSITY

TO STUDENT-ATHLETE:

1. HIPAA Protection and Potential Loss of HIPAA Protection. You understand that information related to your health is protected by federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) and that, under certain circumstances, North Park University may be precluded from disclosing such information without your authorization under HIPAA. You further understand that there is the potential that information disclosed pursuant to this authorization and consent might be re-disclosed by the recipient under circumstances such that the information will no longer be protected by HIPAA.

2. Your Authorization to Use and Disclose Certain Health Care Information. By signing this form, you authorize and consent to the use and disclosure of any information, other than psychotherapy counseling notes, whether oral or recorded in any form or medium, relating to: (i) your past, present, or future physical or mental health or condition; or, (ii) any services or supplies related to your past, present, or future physical or mental health or condition, including without limitation (a) any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, (b) any counseling, service, assessment or procedure with respect to your physical or mental condition or functional status affecting you or the structure or function of your body, (c) any sale or dispensing of a drug, device or equipment to you in accordance with a prescription or otherwise, or (d) any past, present or future financial rights or obligations of any person, entity, organization or governmental body with regard to the foregoing services and supplies. For purposes of this authorization and consent the information described in the preceding sentence is referred to as "Your Health Care Information".

3. Persons and Groups You Authorize to Use and Disclose Your Health Care Information and Purposes for Which You Authorize Your Health Care Information to be Disclosed. You authorize North Park University and its employed or otherwise affiliated physicians, athletic trainers, student athletic trainers, coaches, health care, and administrative personnel to use, and subject to the following paragraph, disclose Your Health Care Information for any purpose: (i) related to the rendering or delivery of any services or supplies, directly or indirectly, by any person, entity, organization or governmental body in furtherance of any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, or any counseling, service, assessment or procedure with respect to your physical or mental condition or functional status affecting you or the structure or function of your body; (ii) related to any past present or future financial rights or obligations of any person, entity, organization or governmental body with regard to the foregoing services and supplies; or (iii) related to your eligibility to participate in athletic activities or programs organized, sponsored, or otherwise supported by North Park University.

4. Persons to Whom You Authorize Your Health Care Information to be Disclosed. In furtherance of the purposes described in the preceding paragraph, you authorize North Park University and its employed or otherwise affiliated physicians, athletic trainers, coaches, health care, and administrative personnel to disclose Your Health Care Information to each other and to any person, entity, organization or governmental body that: (i) renders or delivers, or which has or is expected to render or deliver, directly or indirectly, any services or supplies in furtherance of any preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, or any counseling, service, assessment or procedure with respect to your physical or mental condition or functional

**STUDENT-ATHLETE AUTHORIZATION AND CONSENT
FOR DISCLOSURE OF HEALTH INFORMATION
TO NORTH PARK UNIVERSITY**

status affecting you or the structure or function of your body, (ii) has, has had, or may have, any financial rights or obligations with respect to the foregoing services and supplies, or (iii) provides oversight or requires reporting with respect to athletic activities or programs organized, sponsored, or otherwise supported by North Park University.

5. Your Right to Revoke This Authorization and Exceptions to That Right. You understand that, subject to the exceptions contained in this paragraph, you may revoke this authorization and consent at any time by delivering a written revocation to North Park University's Athletic Director. You understand that no revocation by you will be effective to the extent that North Park University has taken action, or allowed action to be taken on its behalf, in reliance on this authorization and consent. You further understand that, if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

6. Authorization Not a Condition of Treatment. You understand that this authorization and consent is voluntary and not required by North Park University for medical treatment, payment for treatment, enrollment in a health plan or for any benefits that North Park University may, in its sole discretion, offer or extend to you.

7. Expiration. This authorization and consent expires three hundred eighty (380) days after the last date that you participate in any athletic activity or program sponsored by North Park University.

8. Acknowledgement. By signing this authorization and consent you acknowledge that you have read, understand, and agree to the foregoing provisions and that you have received a signed copy of this authorization and consent.

Name of student-athlete

Date

Signature of student-athlete

If applicable:

Name of legal representative

Date

Signature of legal representative

Please describe the nature of your authority to act on behalf of the above student-athlete (e.g. parent, legal-guardian): _____

NORTH PARK UNIVERSITY MEDICAL HISTORY AND PHYSICAL FORM

(to be filled out by student-athlete)

Name: _____ Sport(s): _____

Explain all "Yes" answers. Circle all questions you don't know the answer to.

General:

Y N

1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have an ongoing medical condition (like diabetes or asthma?)
3. Are you currently taking any prescription or nonprescription medicines or pills?
4. Do you have allergies to medicines, pollens, foods, or stinging insects?
5. Have you ever passed out or nearly passed out DURING exercise?
6. Have you ever passed out or nearly passed out AFTER exercise?
7. Have you ever spent the night in a hospital?
8. Have you ever had a surgery?

Explain "Yes" answers: _____

Heart:

Y N

18. Have you ever had discomfort, pain, or pressure in your chest during exercise?
19. Does your heart race or skip beats during exercise?
20. Has a doctor ever told you that you have (circle) high blood pressure high cholesterol
a heart murmur a heart infection
21. Has a doctor ever ordered a test for your heart?
22. Has anyone in your family ever died for no apparent reason?
23. Has any family member or relative died of heart problems or of sudden death before age 50?
24. Does anyone in your family have a heart problem?

Explain "Yes" answers: _____

Disease and Illness

Y N

9. Has a doctor ever told you that you have asthma or allergies?
10. Do you cough, wheeze, or have difficulty breathing during or after exercise?
11. Is there anyone in your family who has asthma?
12. Were you born without a kidney, an eye, a testicle, or any other organ?
13. Have you ever had infectious mononucleosis (mono) within the last month?
14. Do you have any rashes, pressure sores, or other skin problems?
15. Have you had a herpes skin infection?
16. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?
17. Does anyone in your family have Marfan syndrome?

Explain "Yes" answers: _____

Eyes

Y N

25. Have you ever had problems with your eyes or vision?
26. Do you wear glasses or contact lenses?
27. Do you wear protective eyewear, such as goggles or a face shield?
28. Do you have sight in both eyes?

Head

Y N

29. Have you ever had a head injury/concussion? Did you go to the hospital? Any testing performed (CAT scan, MRI, ect)?
30. Have you ever been hit in the head and been confused or lost your memory?
31. Have you ever had a seizure?
32. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
33. Have you ever been unable to move your arms or legs after being hit or falling?
34. Do you have headaches with exercise?

Explain "Yes" answers: _____

Nutrition

Y N

- 35. Are you happy with your weight? Y N
- 36. Are you trying to gain or lose weight? Y N
- 37. Has anyone recommended you change your weight or eating habits? Y N
- 38. Do you limit/carefully control what you eat? Y N
- 39. Are you taking any type of dietary supplements? (protein, herbs, shakes) Y N

Explain "Yes" answers: _____

Bone and Joint

Y N

- 39. Have you ever had an injury like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? Y N

If yes, circle the affected area:

Explain: _____

Head	Neck	Shoulder	Upper Arm
Elbow	Forearm	Wrist/Hand	Chest
Upper Back	Low Back	Hip	Thigh
Knee	Calf/Shin	Ankle	Foot
		Fingers	Toes

- 40. Have you had any broken or fractured bones or dislocated joints? Y N

If yes, circle the affected area:

Explain: _____

Head	Neck	Shoulder	Upper Arm
Elbow	Forearm	Wrist/Hand	Chest
Upper Back	Low Back	Hip	Thigh
Knee	Calf/Shin	Ankle	Foot
		Fingers	Toes

- 41. 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? Y N

If yes, circle the affected area:

Explain: _____

Head	Neck	Shoulder	Upper Arm
Elbow	Forearm	Wrist/Hand	Chest
Upper Back	Low Back	Hip	Thigh
Knee	Calf/Shin	Ankle	Foot
		Fingers	Toes

- 42. Have you ever had a stress fracture? Y N

If yes, explain: _____

- 43. Have you been told that you have or have you had an x-ray for neck instability? Y N

If yes, explain: _____

- 44. Do you regularly use a brace or assistive device? Y N

If yes, explain: _____

Females only

Y N

- 45. Have you ever had a menstrual period? Y N

46. How old were you when you had your first menstrual period? _____

47. How many periods have you had in the last 12 months? _____



First Agency, Inc.
 5071 West H Avenue
 Kalamazoo, MI 49009-8501

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University North Park University
 Attention Justin Sjovall- Athletic Training
This form is to be completed by the Address 3225 West Foster Avenue Box 25
Parents, Guardians or Student City Chicago State IL Zip 60625

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
 If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____
 Social Security No or Passport No _____ Date of Birth _____
 College Address _____ College Phone (____) _____
 Home Address _____ Home Phone (____) _____
 City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION	MOTHER/GUARDIAN INFORMATION
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Father's Name _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
Employer _____	Employer _____
Address _____	Address _____
Telephone (____) _____	Telephone (____) _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____	Address _____
Policy Number _____	Policy Number _____
Telephone (____) _____	Telephone (____) _____
Is this plan an HMO or PPO? (Circle One) Other _____	Is this plan an HMO or PPO? (Circle one) Other _____
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE COMPLETE AUTHORIZATION ON THE NEXT PAGE



First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative of Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant

PHYSICAL EXAMINATION FORM

(to be filled out by a physician)

Name: _____ Date of birth: _____

Height: _____ Weight: _____ Pulse: _____ BP _____/_____

Vision R 20/____ L 20/____ Glasses: Y / N Contacts: Y / N

	NORMAL	ABNORMAL	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg			
Ankle			
Foot/Toes			
High Risk Behaviors	Not At Risk	AT Risk	
Including but not limited to handling stress, mental health, eating disorders, amenorrhea, ect.			

Notes: _____

Name of Physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____, MD or DO

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

- Not cleared for: All sports Certain sports: _____
 Recommendations/Reason: _____
