

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University Auburn University at Montgomery

Attention Athletic Training Department

**This form is to be completed by the
Parents, Guardians or Student**

Address PO Box 244023

City Montgomery State AL Zip 36124-4023

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 _____

Date of Birth _____

College Address _____ College Phone () _____

Home Address _____ Home Phone () _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

MOTHER/GUARDIAN INFORMATION

Father's Name _____

Mother's Name _____

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? Yes No

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

Is a second opinion required before surgery? Yes No

Student-Athlete's Full Name _____
Last
First
Middle
Nickname

Medical History

Please answer each of the following questions by circling **YES** or **NO**. Fill additional information as needed. The information provided is strictly confidential and used for health care purposes only.

Family History:

Has any parent, grandparent, or sibling had:

Cancer	YES	NO
Leukemia	YES	NO
Tuberculosis	YES	NO
Diabetes	YES	NO
Heart disease	YES	NO
High blood pressure	YES	NO
Asthma	YES	NO
Liver disease	YES	NO
Migraine headaches	YES	NO
Emphysema	YES	NO
Stroke	YES	NO
Epilepsy/Seizures	YES	NO
Bleeding disorder	YES	NO
Kidney disease	YES	NO
Glaucoma	YES	NO
Sickle cell anemia	YES	NO
Arthritis	YES	NO
Alcohol or drug abuse	YES	NO
Nervous or mental disease	YES	NO
Other serious disease	YES	NO
Sudden death before age 50	YES	NO

Medications:

Are you currently taking any drugs, medicines, birth control pills, or vitamins (prescription and non-prescription)?

What? _____

Allergies:

Latex	YES	NO
Penicillin	YES	NO
Sulfa drugs	YES	NO
Other antibiotics	YES	NO

What? _____

Aspirin

Other drug/medicine

What? _____

Any food item

What? _____

Bee stings/Insect bites

Other allergy

What? _____

Personal History:

Do you smoke? YES NO

Do you use any other forms of tobacco? YES NO

If yes, what? _____

How much? _____

Do you drink:

Beer? YES NO

Wine? YES NO

How much? _____

Do you use drugs? YES NO

Are you on a special diet? YES NO

Have you lost weight in the past year? YES NO

Health History (continued):

Neck injury YES NO

What? _____

Shoulder injury YES NO

What? _____

Elbow injury YES NO

What? _____

Are you satisfied with your weight? YES NO

Do you think you have an eating disorder? YES NO

Health History:

Do you now, or have you in the past had any of the following:

Concussion YES NO

Loss of consciousness YES NO

Memory loss YES NO

Numbness/weakness in arm or leg YES NO

Migraine headaches YES NO

Mouth/tooth/tongue problem YES NO

Recurrent nosebleeds YES NO

Epilepsy/Seizures YES NO

Heat related illness YES NO

Glaucoma YES NO

Cataracts YES NO

Blindness (either eye) YES NO

Blurred vision (not corrected by

glasses) YES NO

Ear infections YES NO

Deafness/Hearing Deficiency YES NO

Difficulty sleeping YES NO

Asthma YES NO

Shortness of breath/wheezing YES NO

Coughing up blood YES NO

Hay fever YES NO

Chronic Bronchitis YES NO

Tuberculosis YES NO

Heart murmur YES NO

Pain/pressure in chest YES NO

Rheumatic fever YES NO

High blood pressure YES NO

Mononeucleosis YES NO

Hepatitis YES NO

Acid Reflux disease YES NO

Stomach or Duodenal Cancer YES NO

Colon trouble YES NO

Rectal trouble YES NO

Bladder/Urinary tract infection YES NO

Kidney infection YES NO

Kidney stones YES NO

Loss of kidney YES NO

Other kidney disease _____

Anemia YES NO

Poor blood clotting YES NO

Diabetes YES NO

Taking insulin? YES NO

Overactive thyroid YES NO

Underactive thyroid YES NO

Arthritis YES NO

Phlebitis YES NO

Recurrent boils YES NO

Changing mole YES NO

Other skin disease YES NO

What? _____

Depression/Anxiety YES NO

Serious emotional illness YES NO

Wrist/hand injury YES NO

What? _____

Back injury YES NO

What? _____

Hip/thigh/groin injury YES NO

What? _____

Knee injury YES NO

What? _____
 Ankle/foot/lower leg injury YES NO
 What? _____
 Broken bone YES NO
 What? _____
 Stress fracture YES NO
 What? _____
 Facial injury YES NO
 What? _____
 Surgery YES NO
 Please explain. _____

Women
 Menstrual difficulty YES NO
 Ovarian cyst YES NO
 Regular periods YES NO
 Breast lump YES NO
 Other GYN problems _____
Men
 Loss of testicle YES NO
 Other _____

Please provide further information if needed for any of the previous questions. _____

Do you have any condition or disease not listed on this form? YES NO
 Please explain: _____

Authorization and Consent
Statement by Student-Athlete or Parent/Guardian, if Student-Athlete is Under Age 18

This authorization allows our licensed athletic training staff to treat you, refer you to a physician for treatment, or obtain emergency treatment for you, while you are a student-athlete at Auburn University at Montgomery. If you are over age 18, we will proceed without notifying parents prior to treatment. If you are under 18, your parent or legal guardian must also sign this authorization.

This authorization is also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibit the disclosure of PHI unless written authorization is given. Therefore, in order to communicate with your coaches, parents/guardian, or other health care providers about your injury and/or condition, the athletic training staff must obtain your permission.

- A. I have personally reviewed the information provided in this Sports Health Information Summary and attest that it is true and complete to the best of my knowledge.
- B. I understand that participation in sports requires an acceptance of risk for injury.
- C. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the athletic training staff, including physician referral. I

understand that I am responsible for all medical costs incurred when physician referral is necessary.

- D. I understand that I (my son/daughter) must refrain from practice or play while ill or injured until I (he/she) am/is discharged from treatment or given permission by the athletic training staff to restart participation despite continuing medical treatment.
- E. I understand that having passed the sports physical examination does not necessarily mean that I (my son/daughter) am/is physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
- F. I hereby give my permission to the athletic training staff to disclose my (my son's/daughters) personal health information when it pertains to my (his/her) athletic injury/illness, treatment, and/or ability to participate in collegiate athletics to my (his/her) coaches, parents/guardian, and/or other health care providers involved in my (his/her) medical care (ie. AUM Athletic Training, referring physicians, etc...).
- G. I understand that if I feel that my privacy has been violated without my consent, I may file a complaint to the U.S. Health and Human Resources Department.

Student-Athlete Name (print) _____

Signature of Student-Athlete _____

Date _____

Signature of Parent/Guardian (if student is under age 18) _____

Date _____

Freshmen and Transfers please provide the address and phone number of the Primary Care and Orthopedic Physician who has treated you in the past. _____

Auburn University Montgomery
Athletic Physical Examination (To be completed by a Physician)

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Social Security Number: _____ Date: _____

Sport (s): _____ Year in School: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Uncorrected: Right 20/____ Left 20/____ Corrected: Right 20/____ Left 20/____
 Contacts: Yes _____ No _____
 Glasses: Yes _____ No _____

	Satisfactory		Physician's Comments	Follow-up	
	Y	N		Y	N
Skin					
Head					
Ear, Nose, Throat					
Eyes					
Thorax/Lungs					
Abdomen					
Heart					
Musculoskeletal:					
Neck					
Shoulder					
Elbow					
Wrist, Hand, Fingers					
Hip					
Knee					
Ankle					
Foot, Toes					

Athlete Participation Approved: Yes _____ No _____

Additional Comments/Limitations:

Physician's Signature: _____ Date: _____

Physician's Office Phone Number: _____

**Auburn University Montgomery
Student-Athlete Concussion Compliance Form**

I, _____, have been informed by the athletic trainer's of the signs and symptoms of a concussion, closed head injury, and/or brain trauma.

I have also been informed of Auburn University Montgomery Concussion Management Plan. I understand I have an important role in the plan and my disclosure of any signs and symptoms throughout the management process is integral to my health and welfare. Therefore, it is my responsibility to inform the athletic training staff of the onset of these signs and symptoms.

Failure to disclose signs and symptoms of a concussion, closed head injury, and/or brain trauma can lead to increased or prolonged risk of post-concussive symptoms, post concussive syndrome, and irreversible long-term health issues.

By my signature below, I state my acknowledgement, understanding and compliance with Auburn University Montgomery Concussion Management Plan.

Date: _____ Signature: _____

Witness Signature: _____

<p>What is a Concussion?</p> <ul style="list-style-type: none"> • Is caused by a blow to the head or body. <ul style="list-style-type: none"> -From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball. • Can change the way your brain normally works. • Can range from mild to severe. • Presents itself differently for each athlete. • Can occur during practice or competition in ANY sport. • Can happen even if you do not lose consciousness. <p>How Can I prevent a Concussion?</p> <ul style="list-style-type: none"> • Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet. • Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions. 	<p>What are the Symptoms of a Concussion?</p> <p>You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.</p> <ul style="list-style-type: none"> • Amnesia • Confusion • Headache • Loss of Consciousness • Balance problems or dizziness • Double or fuzzy vision • Sensitivity to light or noise • Nausea (feeling that you might vomit) • Feeling sluggish, foggy or groggy • Feeling unusually irritable • Concentration or memory problems • Slowed reaction time <p>Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms to reappear or get worse.</p>
<p>What should I do if I think I have a Concussion?</p> <p>1. Don't Hide it! 2. Report it! 3. Get checked out! 4. Take time to recover</p>	