The Department of Sports Medicine is pleased to have you as a student-athlete at the University of New Orleans. We wish you nothing but success both academically and athletically during your time with us! Enclosed with this letter are forms that must be completed in order to participate in intercollegiate athletics at the University of New Orleans. Please thoroughly read and complete the enclosed paperwork. Student-athletes are required to return the completed forms to the Department of Sports Medicine prior to their team’s pre-participation physical exam.

YOU WILL NOT BE PERMITTED TO PARTICIPATE UNTIL ALL INFORMATION FROM THIS PACKET HAS BEEN RECEIVED AND YOU HAVE BEEN MEDICALLY CLEARED BY A UNO TEAM PHYSICIAN.

Please pay careful attention to the following key policies when reviewing this packet:

- Each year, the University of New Orleans Department of Sports Medicine will provide ALL student-athletes with a pre-participation physical exam that meets NCAA standards. This physical is provided free of charge to every student-athlete at UNO.
  - In accordance with NCAA regulations, all prospective student-athletes must receive medical clearance from a physician prior to participation in any intercollegiate sport activity (tryouts, practice, workouts, etc.).
  - You are expected to disclose all major and minor injuries, illnesses, and/or surgeries that could affect your participation in athletics at the University of New Orleans. Failure to do so may negatively affect your eligibility for competition, athletically related financial aid, and/or your ability to file a claim under the UNO Department of Athletics secondary insurance policy.

- The University of New Orleans sports medicine team and all affiliated providers have the final authority to medically clear a student-athlete for participation.

- Your personal health insurance is used as primary for all costs related to intercollegiate athletic injuries.

- The medical information requested by the UNO Department of Sports Medicine is in addition to, and not in place of, medical information requested of all students by UNO Student Health Services.

- This packet must be submitted via email as a PDF file, fax, or by mail to your athletic trainer.

The University of New Orleans Department of Sports Medicine serves and supports each student-athlete by working collaboratively with a variety of health care professionals to provide the most comprehensive and evidence based healthcare practices, while maintaining the highest level of professionalism and integrity.

If you have any questions at anytime please don’t hesitate to contact us at (504) 280-7028.
Student-Athlete Medical Packet Checklist

The following checklist is intended to assist you with completion of every aspect of the University of New Orleans medical packet.

**EACH** of the following must be completed prior to returning the medical packet.

Failure to do so will result in an incomplete medical packet and the student-athlete WILL NOT be permitted to participate in intercollegiate athletics at the University of New Orleans.

- **Page 3:** Student-Athlete Information
- **Page 4:** Health Insurance Information
  - All University of New Orleans student-athletes are **required** to be covered by an individual health insurance plan before they are allowed to participate in intercollegiate activity
- **Page 5:** Photocopy of Health Insurance card (front & back)
  - Include prescription, dental, vision and any other medical insurance cards
- **Pages 6:** Consent to Treat, Acknowledgement of Risks, and Waiver of Claims Form
- **Page 7-11:** Medical History Forms
- **Page 13:** Drug Abuse Education & Drug Testing Program Informed Consent
- **Page 15:** Sickle Cell Test Agreement, Release and Waiver of Liability
- **Page 16:** Medical Care, Insurance, and Medical Payment Policies and Procedures Acknowledgement
- **Page 17:** Transfer Student Information (if applicable)
- **Scan & email Medical Packet as a PDF file, fax or mail to your respective athletic trainer**
  - The medical packet may also be dropped off in person to the Athletic Training Room

Should you have questions, please don’t hesitate to contact the University of New Orleans Department Of Sports Medicine at (504) 280-7028. You may also contact your team’s athletic trainer.

Allan Chase  
Baseball, Golf  
Allan.Chase@ochsner.org  
815-302-9577

Becky Younger  
Indoor Volleyball, Track and Field/XC  
Rebecca.Younger@ochsner.org  
908-278-2685

Nick Holtgrieve  
Men’s Basketball, Men’s and Women’s Tennis  
Nicholas.Holtgrieve@ochsner.org  
816-838-0879

Pete Aune  
Women’s Basketball, Beach Volleyball  
Peter.Aune@ochsner.org  
989-619-0591
STUDENT-ATHLETE INFORMATION

(Please write legibly using blue or black ink)

Last Name: ___________________________  First Name: ___________________________  MI: _______

Date of Birth: ______/_____/_______ (MM/DD/YY)  □ Male  □ Female

SS #: ______ - ______ - ______  UNO ID #: ___________________________  Ochsner MRN #: ___________________________

Sport: ___________________________  □ Freshman □ Sophomore □ Junior □ Senior □ 5th year □ Masters/PhD

Cell Phone: (____) - ______  Email Address: ___________________________

School/Temporary Address:

__________________________________________

City State Zip Code

Home/Permanent Address:

(USA Address only)

__________________________________________

City State Zip Code

International Student-Athletes Only

Passport #: ___________________________  Issuing Country: ___________________________

Immigration Status (circle one):  F-1   F-2   J-1   J-2

Foreign/Home Address: ___________________________

Emergency Contacts

Primary Contact: ___________________________  Relationship to Student-Athlete: ___________________________

________________________  __________________________

Cell Phone #  Alternate Phone #

Secondary Contact: ___________________________  Relationship to Student-Athlete: ___________________________

________________________  __________________________

Cell Phone #  Alternate Phone #

In an emergency, I authorize the UNO Department of Sports Medicine and affiliated providers to contact the person(s) listed above.

Student-Athlete’s Signature ___________________________  Date _____________

Updated: April 2016
INSURANCE INFORMATION FORM

Name: __________________________ DOB: ________ / _______ / _______ SS #: ___________________

1. Are you currently covered under a health insurance policy/plan? □ Yes □ No
2. If you answered “yes” to #1, is this a Medicaid policy/plan? □ Yes □ No
3. If you answered “yes” to #1, is this an International health insurance policy/plan? □ Yes □ No

• If you answered “no” to #1, please leave this page blank & continue with remainder of packet.
• If you answered “yes” to #3, please complete the University of New Orleans Insurance Coverage Evaluation Form as it pertains to your immigration status & return to the Office of International Students and Scholars http://oiss.uno.edu/UNOinsurancereq2.cfm

POLICY HOLDER/SUBSCRIBER’s INFORMATION

Subscriber: __________________________ Subscriber’s DOB: ________ / _______ / _______ SS#: ___________________

Home Address: __________________________ Street __________________________ Street __________ City __________________________ City __________ State __________ State __________ Zip Code __________________________ Zip Code __________________

Cell Phone: __________________________ Alternate Phone: __________________________

Employer: __________________________

Employer Address: __________________________ Street __________________________ Street __________ City __________________________ City __________ State __________ State __________ Zip Code __________________________ Zip Code __________________

Insurance Company: __________________________ Insurance Company Phone #: __________________________

Insurance Address: __________________________ Street __________________________ Street __________ City __________________________ City __________ State __________ State __________ Zip Code __________________________ Zip Code __________________

Policy/ID#: __________________________ Group #: __________________________ Effective Date: ________ Expiration Date: ________

Type of Insurance: □ HMO □ PPO □ Indemnity □ Other ___________ Does this policy include dental coverage? □ YES □ NO

Primary Care Physician: __________________________ Physician Phone #: __________________________

PLEASE READ CAREFULLY

• The University Of New Orleans Department Of Intercollegiate Athletics’ accident policy which provides insurance for student-athletes for injuries occurring while participating in the play or practice of intercollegiate athletics is considered “EXCESS” or “SECONDARY” to any other collectible group insurance benefits. This simply means all claims must first be filed with the primary insurance company of the student athlete before the University of New Orleans will assist with any payment of the claim. After all applicable copayments and deductibles have been paid by the subscriber and all available benefits have been paid by the primary insurance company; the university’s athletic insurance company will consider remaining amounts based on REASONABLE and CUSTOMARY charges. The University of New Orleans DOES NOT have the option of waiving the requirement of filing with your group insurance.

• I hereby authorize the University of New Orleans Department of Intercollegiate Athletics, hospitals & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.

• I agree to supply any & all information requested by my primary insurance, the University of New Orleans Department of Intercollegiate Athletics & their excess insurance company in a timely manner.

• I hereby authorize the University of New Orleans Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.

• I hereby authorize the University of New Orleans Department of Sports Medicine and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.

• A photocopy of this authorization shall be deemed as effective & valid as the original.

_________ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained.

Initial ________ I agree to notify the University of New Orleans Department of Sports Medicine immediately (within 10 days) upon any change in the above health insurance information. Should I fail to do so, I fully understand that I may be responsible for any & all charges incurred.

I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge. It is illegal to knowingly provide false information on this form.

Student-Athlete - Signature __________________________ Date: __________________________
Parent/Guardian - Signature __________________________ Date: __________________________
(if athlete is under 18 years old)
INSURANCE CARD

Name: ________________________ DOB: _____ / _____ / _____ Sport: ________________________

Please include ALL Prescription, Dental, Vision & any other medical insurance cards.

Should you choose not to use this exact page to provide a copy of your insurance card, please follow the below format including: student-athlete’s name, date of birth and sport at the top of the page.

Copy FRONT of insurance card below

Copy BACK of insurance card below
Consent to Treat, Acknowledgement of Risks, and Waiver of Claims Form

Name: _______________________________ DOB: _____ / _____ / _____ Sport: _______________________

**CONSENT TO TREATMENT AND DISCLOSURE OF INFORMATION**

Consent is hereby granted by the undersigned to the University of New Orleans, including its Sports Medicine Department, health care professionals, and consultants, to proceed with any medical or minor surgical care or treatment, including without limitation x-ray examination, imaging studies or testing, that the professional staff considers to be necessary for the student-athlete named below. Authorization and consent is hereby granted by the undersigned to the University of New Orleans, including its Sports Medicine Department, health care professionals, and consultants, to obtain and release health information and records for treatment, payment, and operations purposes, including for the purpose of processing insurance claims. Authorization and consent is hereby granted by the undersigned to the University of New Orleans to contact a parent/guardian in the event of a mental health emergency.

I understand and agree that information, including information about my injury/condition, may be disclosed to the staff and personnel of the University of New Orleans Department of Athletics in relation to my participation in any physical activity.

This Consent to Treatment and Disclosure of Information is a required condition for participation in the athletics program and shall remain valid until revoked in writing.

Student-Athlete - Signature ___________________________________________ Date ________________

Parent/Legal Guardian - Signature ___________________________________________ Date ________________

**ACKNOWLEDGMENT OF RISKS AND WAIVER OF CLAIMS**

I understand, recognize, and acknowledge that participating in any sport or physical activity can be dangerous and can involve many risks of serious injury and/or death. I understand that the dangers and risks include, but are not limited to, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, bones, and other parts of the skeletal/muscular system, and other serious physical and other injuries. I understand that the dangers and risks also include other impairment of health and well-being, including impairment affecting the future ability to earn a living, engage in educational, occupational, social, and recreational activities, and generally enjoy life. I acknowledge that it is my responsibility to understand and obey instructions and rules for any sport or other physical activity or use of equipment, and to seek help from the coaching, athletic training, and other staff if I have questions. I understand that, notwithstanding precautions taken by The University of New Orleans, however, there are risks of serious injury and/or death.

I am voluntarily participating in sports and other physical activities and using equipment while at The University of New Orleans with knowledge of the dangers and risks involved. I hereby assume and accept any and all risks associated with my participation in sports or other physical activities at the University of New Orleans (whether at the University of New Orleans’s athletic facilities or elsewhere).

In consideration of being presented an opportunity to participate in sports and other physical activities at the University of New Orleans and to use associated equipment, I (on behalf of myself any my heirs and assigns) do hereby release, hold harmless, and forever discharge and agree not to sue the University of New Orleans and its trustees, officers, agents, volunteers and employees from and for any and all claims, responsibilities, liabilities, demands, damages and causes of action of any nature whatsoever for, on account of, or by reason of my participation in sports or other physical activities at the University of New Orleans (whether at the University of New Orleans athletic facilities or elsewhere), whether or not caused by the ordinary negligence of the University of New Orleans.

I have read and understand this document, and I voluntarily agree to be bound by it.

Student-Athlete - Signature ___________________________________________ Date ________________

Parent/Legal Guardian - Signature ___________________________________________ Date ________________

*(if athlete is under 18 years old)*

Updated: April 2016
# FEMALE STUDENT-ATHLETE HISTORY INFORMATION FORM

Name: ___________________  DOB: ___/___/___  Sport: ___________________

Please answer the following questions to the best of your knowledge.

Please continue to page 7 if you are a male student-athlete.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Circle</th>
<th>Explanation if necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age of first menstrual cycle?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number of menstrual cycles in last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>What is the longest you have gone between cycles (in weeks or months)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you experience irregular menstrual cycles? This may include heavy or missed cycles.</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you worry about your weight or body composition?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you limit or carefully control the food you eat?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you try to lose weight to meet weight or image/appearance requirements for your sport?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Has anyone (family, coach, teammate, etc) ever recommended that you change your weight or eating habits?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Does your weight affect the way you feel about yourself?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you worry that you have lost control over how much or how little you eat?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are you a vegetarian or vegan?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you make yourself vomit or take diuretics, diet pills or laxatives?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Have you ever been clinically diagnosed with an eating disorder?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you ever eat in secret?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Have you ever had a stress fracture?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Have you ever been diagnosed with anemia (low iron)?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Are you currently taking birth control pills or other hormone therapies?</td>
<td>YES NO</td>
<td>Please list medication &amp; dosage:</td>
</tr>
<tr>
<td>18</td>
<td>Are you currently pregnant?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Have you ever been pregnant?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Would you like to speak to a doctor concerning any gynecological or nutrition concerns?</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Have you received the Human Papillomavirus (HPV) vaccine?</td>
<td>YES NO</td>
<td>Please include date:</td>
</tr>
</tbody>
</table>
STUDENT-ATHLETE MEDICAL HISTORY INFORMATION FORM

Name: ___________________________ DOB: ___ / ___ / _____ Sport: ____________________

Please answer the following questions to the best of your knowledge.

I hereby certify that the information provided on pages 7-11 (Female Athlete (if applicable), Medical, Orthopedic, General Medical, and Allergy & Medication History Forms) is correct and accurate, and that I will report any and all changes to this information immediately to the University of New Orleans Department of Sports Medicine Staff. I realize that any failure to adequately disclose any information on pages 7-11 of this packet may negatively affect my eligibility for competition, athletically related financial aid, and/or my ability to file a claim under the UNO Department of Athletics secondary insurance policy.

Student-Athlete - Signature ___________________________ Date ________________

Parent/Legal Guardian - Signature ___________________________ Date ________________
(If athlete is under 18 years old)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you ever been restricted from competition or practice due to an injury, illness or concussion?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3</td>
<td>Are you currently being treated for any injuries that are not completely healed?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4</td>
<td>Have you ever been hospitalized overnight for an illness or injury?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5</td>
<td>Have you been diagnosed with a significant medical illness in the last year?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>7</td>
<td>Have you ever fainted or become dizzy?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>8</td>
<td>Have you ever suffered from heat illness, fainted, or become dizzy due to heat?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>9</td>
<td>Have you ever experienced muscle cramps during exercise?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>10</td>
<td>Have you ever suffered from shortness of breath or wheezing?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>11</td>
<td>Have you ever had a high blood pressure reading?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>13</td>
<td>Have you ever experienced chest pain, chest discomfort, or chest pressure?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever experienced a racing heartbeat or skipped heartbeats?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>15</td>
<td>Do you tire more quickly than your teammates or friends during competition or practice?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>18</td>
<td>Have you ever experienced a loss of consciousness or been ‘knocked out’?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>20</td>
<td>Have you ever experienced a pinched nerve or had numbness or tingling in your arms or legs?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>22</td>
<td>Do you wear eye glasses, contact lenses, or protective eyewear?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>23</td>
<td>Do you require any special equipment during competition or practice (brace, pad etc)?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>24</td>
<td>Have you gained or lost 10+lb (4.5kg) in the last year?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>25</td>
<td>Have you received a tetanus shot in the last year?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>27</td>
<td>Do you wish to speak to one of our team doctors regarding any medical concerns?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>28</td>
<td>Have you ever experienced a joint subluxation or dislocation?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
# STUDENT-ATHLETE ORTHOPEDIC HISTORY INFORMATION FORM

**Name:** __________________________  **DOB:** ________ / ______ / ______  **Sport:** __________________________

Please answer the following questions to the best of your knowledge. Place a check mark in the appropriate box if you have sustained any of the injuries listed below. Please indicate on which side injury occurred (right (R) or left (L)).

### Head/Face
- [ ] Concussion
- [ ] Fracture (Nose, Jaw, etc)
- [ ] TMJ
- [ ] Surgery
- [ ] Other: ________________________

### Torso/Trunk
- [ ] Rib Injury
- [ ] Pectoral Muscle Injury
- [ ] Abdominal Strain
- [ ] Surgery
- [ ] Other: ________________________

### Spine
#### Cervical Spine/Neck
- [ ] Stinger
- [ ] Herniated Disc
- [ ] Fracture (Spondy)
- [ ] Ligament/Joint Sprain
- [ ] Muscle/Tendon Strain
- [ ] Surgery
- [ ] Other: ________________________

#### Thoracic Spine/Middle
- [ ] Rib Injury
- [ ] Herniated Disc
- [ ] Fracture (Spondy)
- [ ] Ligament/Joint Sprain
- [ ] Muscle/Tendon Strain
- [ ] Surgery
- [ ] Other: ________________________

#### Lumbar Spine/Lower
- [ ] SI Joint Dysfunction
- [ ] Sciatica
- [ ] Herniated Disc
- [ ] Fracture (Spondy)
- [ ] Ligament/Joint Sprain
- [ ] Muscle/Tendon Strain
- [ ] Surgery
- [ ] Other: ________________________

### Shoulder
- [ ] R  L Rotator Cuff Injury
- [ ] R  L Scapular Dyskinesia
- [ ] R  L Dislocation
- [ ] R  L Subluxation
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Muscle/Tendon Strain
- [ ] R  L Tendinitis
- [ ] R  L Bursitis
- [ ] R  L Fracture (Humerus, etc)
- [ ] Surgery
- [ ] Other: ________________________

### Elbow/Forearm
- [ ] R  L UCL Injury (Tommy John)
- [ ] R  L Dislocation
- [ ] R  L Subluxation
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Muscle/Tendon Strain
- [ ] R  L Tendinitis
- [ ] R  L Bursitis
- [ ] R  L Fracture (Elbow, Forearm, etc)
- [ ] Surgery
- [ ] Other: ________________________

### Wrist/Hand
- [ ] R  L Dislocation
- [ ] R  L Subluxation
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Muscle/Tendon Strain
- [ ] R  L Tendinitis
- [ ] R  L Fracture (Wrist, Finger, etc)
- [ ] Surgery
- [ ] Other: ________________________

### Hip/Thigh
- [ ] R  L Dislocation
- [ ] R  L Subluxation
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Muscle/Tendon Strain
- [ ] R  L Tendinitis (Hip Flexor, etc)
- [ ] R  L Bursitis
- [ ] R  L Fracture (Pelvis, Femur)
- [ ] R  L Stress Fracture (Pelvis, Femur)
- [ ] Surgery
- [ ] Other: ________________________

### Knee
- [ ] R  L Dislocation
- [ ] R  L Subluxation
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Meniscus Injury
- [ ] R  L Tendinitis (Quad, Patellar, etc)
- [ ] R  L Bursitis
- [ ] R  L Fracture (Tibia, Patella, etc)
- [ ] Surgery
- [ ] Other: ________________________

### Lower Leg/Ankle/Foot
- [ ] R  L Dislocation
- [ ] R  L Plantar Fasciitis/Arch Pain
- [ ] R  L Shin Splints
- [ ] R  L Ligament/Joint Sprain
- [ ] R  L Muscle/Tendon Strain
- [ ] R  L Tendinitis (Achilles, etc)
- [ ] R  L Bursitis (Calcaneus)
- [ ] R  L Fracture (Tibia, Fibula, etc)
- [ ] R  L Fracture (Tibia, etc)
- [ ] R  L Stress Fracture (Tibia, etc)
- [ ] Surgery
- [ ] Other: ________________________

Updated: April 2016
STUDENT-ATHLETE GENERAL MEDICAL HISTORY INFORMATION FORM

Name: ___________________________ DOB: ___ / ___ / _____  Sport: __________________________

Please answer the following questions to the best of your knowledge.

General Medical Conditions
Place a check mark in the appropriate box if YOU currently have or have ever been diagnosed with any of the below conditions

- ADD/ADHD
- Amenia
- Asthma
- Anxiety
- Autoimmune Disorder
- Blindness
- Blood/Bleeding Disorder
- Cancer
- Cardiac/Heart Disease
- Depression
- Diabetes Type I (Insulin Dependent)
- Diabetes Type II
- Epilepsy/Seizures
- Gastrointestinal Disorder
- Gout
- Hearing Problems
- Heart Murmur
- Hemophilia
- Hernia
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Hepatitis
- Marfan’s Syndrome
- Migraine Headaches
- Mononucleosis
- Osteopenia/Osteoporosis
- Respiratory Disorder
- Rheumatic Fever
- Syncope (Fainting spells)
- Skin Disease
- Sleep Troubles
- Thyroid Disorder
- Tuberculosis
- Ulcers
- Other: __________________________

If you placed a check mark next to any of the above conditions, please explain:

__________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Family History
Place a check mark in the appropriate box if your Mother, Father, Brothers, Sisters, Grandmother/fathers, Aunts, or Uncles has been diagnosed with any of the below conditions

- ADD/ADHD
- Amenia
- Asthma
- Anxiety
- Autoimmune Disorder
- Blindness
- Blood/Bleeding Disorder
- Cancer
- Cardiac/Heart Disease
- Depression
- Diabetes Type I (Insulin Dependent)
- Diabetes Type II
- Epilepsy/Seizures
- Gastrointestinal Disorder
- Gout
- Hearing Problems
- Heart Murmur
- Hemophilia
- Hernia
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Hepatitis
- Marfan’s Syndrome
- Migraine Headaches
- Mononucleosis
- Osteopenia/Osteoporosis
- Respiratory Disorder
- Rheumatic Fever
- Syncope (Fainting spells)
- Skin Disease
- Sleep Troubles
- Thyroid Disorder
- Tuberculosis
- Ulcers
- Other: __________________________

If you placed a check mark next to any of the above conditions, please explain:

__________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
**STUDENT-ATHLETE ALLERGY & MEDICATION HISTORY INFORMATION FORM**

Name: ___________________________ DOB: _____ / _____ / _____ Sport: ___________________

Please answer the following questions to the best of your knowledge.

### Allergies

Place a check mark in the appropriate box if you currently have or have ever been diagnosed with any of the below conditions

<table>
<thead>
<tr>
<th>Medication</th>
<th>Food</th>
<th>Latex</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None</td>
<td>□ None</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Aspirin</td>
<td>□ Dairy</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Barbiturates (General Anesthesia)</td>
<td>□ Nuts</td>
<td></td>
</tr>
<tr>
<td>□ Cephalosporins</td>
<td>□ Shellfish</td>
<td></td>
</tr>
<tr>
<td>□ Insulin</td>
<td>□ Other: ______________</td>
<td></td>
</tr>
<tr>
<td>□ Iodine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Lidocaine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Novocain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Penicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Sulfonamides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Non-Steroidal Anti-Inflammatories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other: ______________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you require an EPI-PEN for any allergy?

☐ Yes  ☐ No

Do you suffer from seasonal allergies?

☐ Yes  ☐ No

### Past & Current Medications/Supplements

Please list ALL prescription, non-prescription, and supplements (vitamins, protein powders, etc) you are CURRENTLY TAKING or HAVE TAKEN in the last 12 months.

<table>
<thead>
<tr>
<th>Medication/Supplement</th>
<th>Dosage</th>
<th>Reason</th>
<th>Start/End Date</th>
<th>Currently Taking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

By signing below, I certify that all the information on the Female Athlete (if applicable), Medical, Orthopedic, General Medical, and Allergy & Medication History Forms (pages 6-10) are correct and true to the best of my knowledge.

Student Athlete - Signature ____________________________________________ Date _______________
Substance Abuse Education & Drug Testing Program

The University of New Orleans (UNO) Department of Athletics is committed to maintaining a safe, healthy, and productive environment that supports its educational and athletic missions. The use of alcohol and/or illegal substances as well as the abuse of prescription medications and/or nutritional supplements by its student-athletes directly interferes with that mission and poses specific and serious health risks. UNO Athletics recognizes its responsibility to educate student-athletes regarding problems associated with use of drugs and alcohol. For that reason, the UNO Department of Athletics has developed a substance abuse education program that will be supplemented with selected drug testing as deemed necessary by the National Collegiate Athletic Association (NCAA) and UNO Department of Athletics.

Purpose of the Substance Abuse Education & Drug Testing Program
Each student-athlete will participate in the UNO Department of Sports Medicine’s NCAA banned substances meeting at least once per academic year. This meeting will include a video describing NCAA drug policies and each student-athlete will receive a list of NCAA banned substances. The NCAA banned substances list, as well as other health risk information is posted in the Athletic Training Room (Arena Room 164) and https://www.ncaa.org/2015-16-ncaa-banned-drugs. Online educational modules will be provided by the UNO Department of Sports Medicine throughout the year for emphasis of the above objective.

Drug Testing
Student-athletes are subject to NCAA drug testing year-round. During an NCAA drug test, all classes of NCAA banned drugs are tested. The complete list of NCAA banned and tested drug classes are displayed in the Athletic Training Room (Arena Room 164) and/or can be obtained by visiting www.NCAA.org/2015-16/ncaa-banned-drugs

The University of New Orleans Department of Athletics reserves the right to collect and analyze a urine specimen from any person participating in sanctioned intercollegiate activities in any capacity. An Informed Consent MUST BE SIGNED by each student-athlete acknowledging an understanding of the program, its purpose and subsequent enforcement implications following a positive test result. If selected for a drug test (NCAA or UNO), the student-athlete will be contacted within 24 hours of the test via telephone or direct contact by a member of the UNO Sports Medicine Staff. The importance of answering phone calls and/or returning voicemails is crucial.

Positive Drug Testing
The UNO Department of Athletics and the NCAA penalties for a positive test are strict and automatic. In the event of a positive drug test, sanctions will be imposed upon the student-athlete. Sanctions are based upon the most current policies and procedures. Failure to be present for assigned drug testing date will result in a positive test. Full disclosure of the UNO Department of Athletics drug testing policy can be made available by contacting the Assistant Athletic Director for Compliance. Visit www.NCAA.org/drugtesting for questions regarding the NCAA’s policy.

Medical Exceptions
Medical exceptions may be granted for substances in all classes with the exception of street drugs. Pre-approval is required for the use of peptide hormones, anabolic agents, stimulants (including ADD/ADHD medications), beta 2-agonists (including Asthma medications), beta blockers (including cardiovascular medications), etc. Please complete the NCAA Medical Exception Documentation Reporting Form (http://www.ncaa.org/health-and-safety/sport-science-institute/2015-16-drug-testing-exceptions-procedures-medical-exceptions) if you are taking a prescribed banned substance.

Proper documentation from the prescribing physician MUST BE submitted to the UNO Department of Sports Medicine and forwarded to the NCAA for approval. Please contact the Department of Sports Medicine for more information regarding medical exemptions.

Nutritional Supplement Advisory
Student-athletes are responsible for any substance he or she ingests. Nutritional supplements may contain NCAA banned substances. This may lead to a positive drug test and loss of NCAA eligibility. Visit www.DrugFreeSport.com/REC for more information.

Confidentiality
The University of New Orleans Department of Athletics and Sports Medicine, as well as student-athletes, are required to adhere to the policies and procedures as stated in the Notice of Privacy Practices document.
Substance Abuse Education & Drug Testing Program
Informed Consent

I ________________________________ have read and understand the information pertaining to the Drug Abuse
Education & Drug Testing Program within the University of New Orleans Department of Intercollegiate Athletics. The
program’s objectives have been clearly defined. I understand that all results of the screening will be keep confidential to
the best of the University of New Orleans’ ability according to the described procedure. I, therefore, fully consent to
participate in the program, undergo all the required tests, and cooperate in its administration. In consideration of
participation in the Intercollegiate Athletic Program, I release the University of New Orleans, the Sports Medicine
Department and its employees from any and all liability and waive any and all claims against the University of New
Orleans and the Sports Medicine Department arising out of the Substance Abuse Education & Drug Testing Program,
unless such claim is base on negligent or wrongful conduct of the University of New Orleans, the Sports Medicine
Department and its employees.

Student-Athlete - Signature ________________________________ Date _________________

Parent/Legal Guardian - Signature ________________________________ Date _________________
(if athlete is under 18 years old)
SICKLE CELL TRAIT

WHAT IS SICKLE CELL TRAIT?
Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

DO YOU KNOW IF YOU HAVE SICKLE CELL TRAIT?
People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

HOW CAN I PREVENT A COLLAPSE?
- Know your sickle cell trait status.
- Engage in a slow and gradual preseason conditioning regimen.
- Build up your intensity slowly while training.
- Set your own pace. Use adequate rest and recovery between repetitions, especially during "gassers" and intense station or "mat" drills.
- Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.
- If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.
- During intense exercise, red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or "sickle."
- Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles.
- During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.
- Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

- Sickle cell trait occurs in about 8 percent of the U.S. African-American population, and between one in 2,000 to one in 10,000 in the Caucasian population.
- Most U.S. states test at birth, but most athletes with sickle cell trait don't know they have it.
- The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.
- Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, allowing you to thrive in your sport.

For more information and resources, visit www.NCAA.org/health-safety
Sickle Cell Trait Test Agreement, Release and Waiver of Liability

NCAA Division I Legislation requires that all current and prospective student-athletes who wish to participate in INTERCOLLEGIATE ATHLETIC ACTIVITY must: (1) show proof of a prior sickle cell test, (2) have a sickle cell test performed, or (3) sign a waiver releasing the University from liability if declining a sickle cell test. I understand that I will not be able to participate in INTERCOLLEGIATE ATHLETIC ACTIVITY until one of the three options is provided to the University of New Orleans Department of Sports Medicine staff.

I have read the NCAA Sickle Cell Trait Fact Sheet for student-athletes (page 14). I also understand it is not a complete or exhaustive list of possible complications/issues. Further, as a participant INTERCOLLEGIATE ATHLETIC ACTIVITY, I acknowledge the nature of the activity and the fact that not all of the stresses and hazards connected with the activity can be foreseen or prevented even though reasonable precautions are taken. I understand I have the personal responsibility to follow the established safety rules and procedures set forth and established by the UNO sports medicine staff and physicians, for this condition/disease. I understand can discontinue my participation in INTERCOLLEGIATE ATHLETIC ACTIVITY at any time.

Please choose only ONE of the options below. Choosing more than one option will require a new form to be completed.

Option #1: Sickle Cell Trait Testing Verification
I verify that, ______________________, was tested for Sickle Cell Trait on ___/___/_____.

Student-Athlete – Printed Name

The result of the Sickle Cell Trait Test:
☐ Positive  ☐ No
☐ Negative  ☐ Restricted to:

Physician Signature ______________________ Date __________

Physician Name (Printed): __________________________________________

Physician Office Contact information:
Address: _____________________________________________________________

Phone #: (______) ___________ Fax #: (______) ___________

Option #2: CONSENT to Sickle Cell Trait Testing
I, _____________________________, the undersigned voluntarily CONSENT to take a sickle cell trait test arranged by the University of New Orleans Department of Sports Medicine and provide said results to the UNO Department of Sports Medicine staff.

Student-Athlete Signature __________________________ Date __________

Parent/Guardian Signature __________________________ (if student athlete is under 18 years old)

Option #3: DECLINE Sickle Cell Trait Testing
Because I desire to participate in intercollegiate athletics at the UNO, and in consideration of the University’s willingness to allow me to participate in accordance with the policies governing intercollegiate athletics, on behalf of me, my heirs and next of kin, personal representatives, agents, insurers, successors and assigns, or any other persons claiming by or through me, I do hereby FOREVER WAIVE, RELEASE, AND RELINQUISH any and all claims, demands, causes of action, liabilities, costs or expenses (including, but not limited to, attorneys’ fees) (all the foregoing being referred to collectively as “Claims”), against UNO, the President of UNO, and past, present and future members of the Board of Regents, and officer, employee, representative, or agent of UNO, any team physician, athletic trainer or coach, and any entity associated with, or controlled by UNO. The waiver and release set forth herein waives and releases any and all Claims under any federal or state laws, as well as any common law cause of action, whether in contract, tort, or any other legal theory.

I, _____________________________, the undersigned voluntarily DECLINE to take a sickle cell trait test and fully release the University of New Orleans from all liability mentioned above.

Student-Athlete Signature __________________________ Date __________

Parent/Guardian Signature __________________________ (if student athlete is under 18 years old)
Medical Care, Insurance, and Medical Payment Policies and Procedures
Acknowledgement Form

Before signing this form, you must read and review the
Medical Care, Insurance, and Medical Payment Policies and Procedures

I, ____________________________, hereby attest that I have read and reviewed the entire
Medical Care, Insurance, and Medical Payment Policies and Procedures for the University of New Orleans Department of
Sports Medicine. All questions, if any, have been answered to my satisfaction. By signing my name below, I attest that I fully understand my rights and responsibilities if I am injured while competing in intercollegiate athletic activities at the University of New Orleans and verify that I will follow all of the policies and procedures.

Student-Athlete - Signature ____________________________                        Date ____________

Parent/Legal Guardian - Signature ____________________________                     Date ____________
(if athlete is under 18 years old)
Transfer Student-Athlete Information

Name: __________________________ DOB: _____ / _____ / _____ Sport: __________________

Complete this form ONLY if you have *previously competed* at a 4 year college/university or 2 year junior/community college

School #1: ____________________________________________________________
Years Attended: ________________________________________________________
Head Athletic Trainer: ____________________________________________________
Phone #: (_____) _______ - _________
Email: __________________________________________________________________
Address: __________________________________________________________________
________________________________________________________________________
City                               State                               Zip Code

School #2: ____________________________________________________________
Years Attended: ________________________________________________________
Head Athletic Trainer: ____________________________________________________
Phone #: (_____) _______ - _________
Email: __________________________________________________________________
Address: __________________________________________________________________
________________________________________________________________________
City                               State                               Zip Code

School #3: ____________________________________________________________
Years Attended: ________________________________________________________
Head Athletic Trainer: ____________________________________________________
Phone #: (_____) _______ - _________
Email: __________________________________________________________________
Address: __________________________________________________________________
________________________________________________________________________
City                               State                               Zip Code