In addition to the completion of the physical exam and immunization** record that must be completed by all students, each of the following documents and tasks must be completed and returned to the Lasell College Athletic Training Office by all first year student-athletes before participation is permitted.

- Athletic Health History Questionnaire
- Emergency Medical Information/Demographic Form
- Authorization for Disclosure of Protected Health Information
- Medical Consent, Sports Safety and Medical Statements
- Insurance Statement
- Front and Back Copy of Insurance Card
- All documents completed, dated, and signed by athlete (and parent/guardian if under 18 years of age)
- Either the Sickle Cell Waiver Form or the Sickle Cell Disclosure Form

**All first year student-athletes must have a physical exam within 6 months of initial participation.

Please mail or fax all completed documents to:
Lasell College Athletic Training Office
1844 Commonwealth Ave.
Newton, MA 02466
Fax: 617-243-2037

To Be Completed by Certified Athletic Trainer

Clearance for participation in athletics with no limitations. ________
Clearance pending further evaluation or testing. (Please explain)

________________________

Referral to other health care professional prior to clearance. (Please explain)

________________________

Clearance with limitations. (Please explain)

________________________

Disqualification from participation in athletics at this time. (Please explain)

________________________

Signature of Certified Athletic Trainer Date
### Name: ____________________________  Height: ____________________________

<table>
<thead>
<tr>
<th>Student ID#:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #:</td>
<td>Resting Blood Pressure:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Resting Heart Rate:</td>
</tr>
<tr>
<td>Current Age:</td>
<td>Vision: R: L: Glasses/Contacts</td>
</tr>
<tr>
<td>Expected Year of Graduation:</td>
<td>Urinalysis: Blood: Protein:</td>
</tr>
</tbody>
</table>

**To be completed by Athletic Training Staff**

**Please fill-in and answer all questions as completely as possible, including dates and side (Right/Left) involved.**

### Family History

Have any of your blood relatives had any of the following conditions?

- [ ] Yes  [ ] No  Sudden Death (Before Age 55)  Relation: ____________________________
- [ ] Yes  [ ] No  Diabetes  Relation: ____________________________
- [ ] Yes  [ ] No  Seizures  Relation: ____________________________
- [ ] Yes  [ ] No  Heart Disease  Relation: ____________________________
- [ ] Yes  [ ] No  Blood Disease (Leukemia, Sickle Cell, etc.)  Relation: ____________________________
- [ ] Yes  [ ] No  High Blood Pressure  Relation: ____________________________
- [ ] Yes  [ ] No  Marfan Syndrome  Relation: ____________________________
- [ ] Yes  [ ] No  Alcohol or Drug Dependency  Relation: ____________________________

### Personal Medical History

#### I. General

1. Have you ever been diagnosed or treated for either of the following conditions?

- [ ] Yes  [ ] No  a. Attention Deficit Disorder (ADD)  Date: ____________________________
- [ ] Yes  [ ] No  b. Attention Deficit Hyperactivity Disorder (ADHD)  Date: ____________________________

If yes, are you currently taking prescribed medication for this condition? Name of Medication(s): __________

*Due to new NCAA regulations please be prepared to provide us with appropriate documentation*

2. Have you ever had any of the following medical conditions?

- [ ] Yes  [ ] No  a. Thyroid Disease  Date: ____________________________
- [ ] Yes  [ ] No  b. Skin Disease  Date: ____________________________
- [ ] Yes  [ ] No  c. Blood in Urine  Date: ____________________________
- [ ] Yes  [ ] No  d. Urinary Infection  Date: ____________________________
- [ ] Yes  [ ] No  e. Muscular Disease  Date: ____________________________
- [ ] Yes  [ ] No  f. Birth Defects  Date: ____________________________
- [ ] Yes  [ ] No  g. Travel Sickness  Date: ____________________________
- [ ] Yes  [ ] No  h. Skin Infections  Date: ____________________________

3. Have you been treated for any of the following during the past year?

- [ ] Yes  [ ] No  a. infectious mononucleosis (“mono”)  Date: ____________________________
- [ ] Yes  [ ] No  b. viral pneumonia  Date: ____________________________
- [ ] Yes  [ ] No  c. tuberculosis  Date: ____________________________
- [ ] Yes  [ ] No  d. other infectious diseases including: hepatitis, measles, mumps, etc.  Date: ____________________________

- [ ] Yes  [ ] No  4. Have you ever been treated for Rheumatic fever?  Date: ____________________________
5. Have you ever been diagnosed or treated for high blood pressure (hypertension)?
If yes, are you currently taking prescribed medication for this condition? Name of Medication(s): ________

6. Have you ever been diagnosed or treated for circulatory problems?

7. Have you ever been diagnosed with any of the following?
   a. Abnormal bruising or bleeding
   b. Blood disease
   c. Blood clotting disorders
   d. Anemia
   e. Sickle Cell Trait or Sickle Cell Anemia

8. Have you ever suffered a seizure or been diagnosed with epilepsy?
If yes, are you currently taking prescribed medication for this condition? Name of Medication(s): ________

9. Have you ever suffered from or been treated for any of the following?
   a. Amnesia
   b. Emotional Disorder
   c. Eating Disorder
   d. Drug/Alcohol Abuse
   e. Steroid Use

10. Have you ever been diagnosed with diabetes?
If yes, how is this condition being treated? Medication, exercise, diet? ________________

11. Have you had a tetanus shot in the past 5 years? Date: ________________

12. Are you missing any paired organs (eye, kidney, ovary, and testicle)?

13. Have you ever been treated for a hernia? Date: ________________ Treatment: ________________

14. Have you had your appendix removed?

15. Are you allergic to any medications? List: ________________

16. Do you have any other allergies? (food, insect, environmental) ________________

17. Have you had any recent (within the past 2 years) surgery? ________________

18. Do you suffer from any menstrual cycle irregularities (amenorrhea, dysmenorrhea)? ________________

19. Has your weight fluctuated 20 pounds or more during the past year? ________________

II. Cardio-Respiratory

20. Have you ever been diagnosed with any of the following?
   a. Heart Murmur
   b. An enlarged heart (hypertrophic cardiomyopathy)
   c. An irregular heartbeat (arrhythmia)
   d. Marfan syndrome
   e. Any other heart related conditions

21. Do you ever experience chest pain or discomfort during exercise?

22. Do you experience episodes of near-fainting during exercise?

23. Do you ever experience excessive unexplained shortness of breath or fatigue during exercise?

24. Have you ever been treated for asthma?
If yes, are you currently on prescribed medication for asthma? Name of Medication(s): ________________

III. Head and Neck

25. Have you been knocked unconscious or suffered a concussion during the past?
   a. 1 year? If yes, how many times? _______
   b. 3 years? If yes, how many times?
   c. If yes, were you treated by a physician or other health care professional?
26. Have you experienced any other mild head injuries (“gotten your bell rung”) that required you to seek medical attention during the past:
   □ Yes  □ No  
   a. 1 year? If yes, how many times?
   □ Yes  □ No  
   b. 3 years? If yes, how many times?

27. Have you ever suffered or been treated for amnesia? ____________

28. Do you suffer from migraine or cluster headaches? If yes, do you take medication for them? ____________

29. Have you ever suffered a whiplash type injury to your neck that required you to seek medical care?

30. Have you a history of brachial plexus injuries (burners or stingers)?

31. If you answered yes to # 28, have you been required to wear a neck protective device such as a neck roll or collar for collision sports (football, lacrosse)?

32. Have you ever suffered a fracture (broken bone) to any of the vertebrae in your neck?

IV. Vision, Hearing, Dental, Facial

33. Do you have vision in both eyes? If no, give details: ____________

34. Do you wear glasses or contact lenses? Please Circle

35. Do you wear glasses or contact lenses while participating in sports? Please Circle

36. Do you have hearing in both ears?

37. Do you have any condition that requires you to wear a hearing aid?

38. Do you currently wear any dental appliances (braces, permanent bridge)? ____________

39. Have you ever been treated for TMJ syndrome, a condition affecting the jaw?

40. Have you ever broken your nose? Date: ____________

V. Shoulder and Arm

41. Do you have a history of any of the following shoulder injuries?
   □ Yes  □ No  
   a. shoulder dislocation  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   b. subluxation (partial dislocation)  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   c. “separated” shoulder  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   d. rotator cuff muscle strain  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   e. impingement syndrome  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   f. other muscular strain  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   g. biceps tendonitis  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   h. bursitis  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   i. Thoracic outlet syndrome  □ Right  □ Left  Date: ____________

42. Have you ever had surgery to correct a shoulder injury? Date: ____________

43. Have you ever fractured (broken) your arm? □ Right  □ Left Date: ____________

44. Have you ever fractured your clavicle? □ Right  □ Left Date: ____________

VI. Elbow and Forearm

45. Do you have a history of any of the following elbow or forearm injuries?
   □ Yes  □ No  
   a. elbow dislocation  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   b. sprained elbow  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   c. epicondylitis (tennis elbow)  □ Right  □ Left  Date: ____________

46. Have you ever broken either of the bones in your forearm (radius or ulna)? Circle
   □ Right  □ Left  Date: ____________

47. Have you ever had surgery to correct an elbow or forearm injury? Date: ____________

VII. Wrist, Hand and Fingers

48. Have you had any of the following wrist injuries?
   □ Yes  □ No  
   a. dislocated carpal (wrist) bones  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   b. fractured (broken) carpal (wrist) bones  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   c. sprained wrist  □ Right  □ Left  Date: ____________
   □ Yes  □ No  
   d. carpal tunnel syndrome  □ Right  □ Left  Date: ____________
□ Yes □ No  49. Have you ever had surgery to correct a wrist injury?  
Details: ____________________________________________  
Date: __________________________

□ Yes □ No  50. Have you ever broken any bones in your hand?  
Details: ____________________________________________  
□ Right □ Left Date: __________________________

□ Yes □ No  51. Have you ever dislocated any fingers?  
Details: ____________________________________________  
□ Right □ Left Date: __________________________

□ Yes □ No  52. Have you ever broken any fingers?  
Details: ____________________________________________  
□ Right □ Left Date: __________________________

VIII. Chest and Abdomen

□ Yes □ No  53. Have you ever had any of the following chest injuries?  
□ Right □ Left Date: __________________________

a. broken ribs
b. separated ribs (costochondral injury)
c. pneumothorax/ hemothorax (lung injury)

□ Yes □ No  54. Have you ever had any of the following abdominal injuries?  
□ Right □ Left Date: __________________________

a. kidney Disease/ Stones  
Date: __________________________  
□ Yes □ No  b. stomach Ulcer  
Date: __________________________  
□ Yes □ No  c. ruptured Organ  
Date: __________________________  
□ Yes □ No  d. other internal organ (liver, kidney, spleen, stomach, etc.) injury?  
Date: __________________________

Details: ____________________________________________

IX. Back

□ Yes □ No  55. Have you ever suffered any of the following injuries to your back?  
□ Right □ Left Date: __________________________

a. muscular strain
b. SI (sacroiliac) joint sprain
c. intervertebral disc injury
d. spondylolisthesis or spondylolysis

e. fractured (broken) vertebrae

Please give details for any back injuries you have had: ____________________________________________

□ Yes □ No  56. Have you ever been diagnosed with scoliosis?

□ Yes □ No  57. Have you ever been diagnosed with lordosis or kyphosis?

□ Yes □ No  58. Have you ever had any surgery performed on your back?  
Details: ____________________________________________

X. Hip and Thigh

□ Yes □ No  59. Have you ever had any fractures or dislocations of your hip?  
□ Right □ Left Date: __________________________

□ Yes □ No  60. Have you ever fractured (broken) your femur (thigh bone)?  
□ Right □ Left Date: __________________________

XI. Knee

□ Yes □ No  61. Have you ever injured any of the following knee structures?  
Details: ____________________________________________  
□ Right □ Left Date: __________________________

a. anterior cruciate ligament (ACL)
b. posterior cruciate ligament (PCL)
c. medial collateral ligament (MCL)
d. lateral collateral ligament (LCL)
e. medial meniscus (cartilage)
f. lateral meniscus (cartilage)

□ Yes □ No  62. Have you ever had surgery to correct a knee condition?  
Details: ____________________________________________  
Date: __________________________

□ Yes □ No  63. Have you ever had any of the following injuries to your patella (kneecap)?  
Details: ____________________________________________  
□ Right □ Left Date: __________________________

a. dislocation
b. subluxation (partial dislocation)
c. fracture

□ Yes □ No  64. Have you ever been diagnosed with any other knee conditions?  
Details: ____________________________________________
### XII. Lower Leg, Ankles, Feet and Toes

<table>
<thead>
<tr>
<th>Question</th>
<th>Right</th>
<th>Left</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>65. Have you ever fractured the tibia in either leg?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>66. Have you ever fractured the fibula in either leg?</td>
<td></td>
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<tr>
<td>67. Do you have a history of “shin splints”?</td>
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<tr>
<td>68. Do you have a history of ankle sprains?</td>
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<tr>
<td>69. Have you ever had a fracture or dislocated ankle?</td>
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<tr>
<td>70. Have you ever fractured any of the bones in your foot?</td>
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<td></td>
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<tr>
<td>71. Have you ever fractured or dislocated any of your toes?</td>
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</tbody>
</table>

I have read this document and attest that all of the information provided is accurate and complete to the best of my knowledge.

__________________________________________  Date

Student-Athlete’s Signature  

__________________________________________  Date

Parent/Guardian’s Signature (If student-athlete is under 18 years of age)  

__________________________________________  Date
### Demographic Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

- **□** Male  **□** Female  Sport(s):  Date of Birth:  
- Year of Graduation:  Social Security Number:  -  -  -

### PERMANENT ADDRESS

<table>
<thead>
<tr>
<th>Street</th>
<th>Street/Dorm Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home phone</th>
<th>Cell phone</th>
</tr>
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</table>

### LOCAL/SCHOOL ADDRESS

<table>
<thead>
<tr>
<th>Street</th>
<th>Street/Dorm Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>State</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home phone</th>
<th>Cell phone</th>
</tr>
</thead>
</table>

### EMERGENCY CONTACT INFORMATION

- **Name:**  **Name:**
- Relationship:  Relationship:
- **Address:**  **Address:**
  - Street
  - City  State  Zip
- Home phone  Cell phone
- Work phone  Other
- Work phone  Other

### INSURANCE INFORMATION

- **□** I am currently enrolled in the Medical Insurance Plan offered through Lasell College
- **Subscriber’s Name:**  **Insurance Company:**
- **Subscriber’s D.O.B.:**  
- **Address:**
- Type of Plan:  HMO  PPO  POS
- **Policy #:**  **Plan/Group #:**  **Phone (  )**

### Primary Care Physician

- **Name:**  **Phone (  )**

Are you enrolled in a supplemental □ Vision  □ Dental  □ Prescription Insurance Plan?  □ YES  □ NO  If yes, please complete:

- **Name:**  **Phone (  )**  
- **Name:**  **Phone (  )**

- **ID #**  **Group #:**  
- **ID #**  **Group #:**  

- **Address:**

- Insurance card verified by AT:  Initials:  Expiration?  Date:  

---
Authorization for Disclosure of Protected Health Information

The Athletic Training/Sports Medicine Staff consists of the Certified Athletic Trainers, Team Physicians, and Health Center staff. This document also allows for the release and sharing of information to consulting physicians/surgeons.

Authorization for Disclosure of Protected Health Information

I (□ DO □ DO NOT) authorize the Certified Athletic Training Staff permission to release any information relating to the diagnosis or treatment of injuries or illnesses received during my eligible participation in athletics at Lasell College. This information may include:

* Information contained in my personal medical record, including health history information, relevant to injuries and illnesses that may affect participation in athletics at Lasell College.
* Information concerning my medical status, medical condition, injuries, prognosis, diagnosis and other related personally identifiable health information, including injury reports, test results, X-rays, progress reports and any other documentation regarding my health status.

Authorization is granted for release of my protected health information to (Please check all that apply):

☐ The Lasell College Team or Consulting Physician, Certified Athletic Trainers, and Health Center Staff.
☐ Qualified health care providers that are directly involved in my health care including other Physicians, Physician Assistants, Nurse Practitioners and Certified Athletic Trainers.
☐ The Lasell College coaches and athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
☐ Lasell College administrators and academic departments for the purpose of making decisions regarding my ability and suitability to perform academically while I am a student-athlete.
☐ Any and all applicable insurance providers for the purpose of processing insurance claims while I am a student-athlete.
☐ Additional personnel as listed below, such as parent/guardian(s) and/or spouse, for the purpose of assisting me in making healthcare decisions while I am a student-athlete.

Name: ___________________________ Relation: ________________ Phone: __________________

Name: ___________________________ Relation: ________________ Phone: __________________

Name: ___________________________ Relation: ________________ Phone: __________________

The Lasell College Athletic Training Staff is in compliance with the Health Information Privacy and Portability Act (HIPPA). Medical information will only be released to treating physicians/medical staff for treatment purposes and to insurance companies for billing purposes. In some cases, additional forms will be necessary to allow the release of information. If at any time a student athlete wishes to discontinue the release of information to a provider outside of the athletic training staff, he or she must do so in a written statement.

I have read and understand the above Medical Consent and Authorization Statements and reserve the right to revoke all or part of this authorization at any time by notifying Lasell College Athletic Office in writing.

_______________________________  _____________________________
Signature of Student-Athlete     Date

_______________________________  _____________________________
Signature of Parent/Guardian     Date

(If student-athlete is under 18 years of age.)
Lasell College Athletics
Medical Consent, Sports Safety and Medical Statements

Please read carefully and sign each statement.

Medical Consent

I (☐ DO □ DO NOT) grant the Lasell College Certified Athletic Training Staff permission to provide my son/daughter/self any treatment, medical or surgical care that they deem reasonably necessary to the health and well-being of my son/daughter/self within their scope of practice. In addition, when necessary for executing such care, I grant my permission for hospitalization.

__________________________________________  ____________________________
Signature of Student- Athlete                      Date

__________________________________________  ____________________________
Signature of Parent/Guardian                      Date
(If student-athlete is under 18 years of age)

Student-Athlete Medical Statement

* I understand that I must refrain from practice/participation when ill or injured, or when advised to by the athletic training staff, regardless of whether or not I am currently receiving treatment.
* I understand that I may not resume practice/participation until cleared by the treating physician and/or the athletic training staff.
* I understand that having met the criteria of the athletic training staff and the team physician does not mean that I am physically qualified to engage in athletics, only that the evaluators did not find a medical reason to disqualify me from participation in athletics.
* I understand that I may be held out of athletic participation if the athletic training staff, the health center staff or the counseling center staff deem that I maybe a harm to myself or others.

__________________________________________  ____________________________
Signature of Student Athlete                      Date

__________________________________________  ____________________________
Signature of Parent/Guardian                      Date
(If student-athlete is under 18 years of age)

Shared Responsibility for Sports Safety

Participation in a sport requires an acceptance of risk of injury. Athletes rightfully assume that those responsible for the conduct of a sport have taken reasonable precautions to minimize such risk and that their peer’s participation in the sport will not intentionally inflict injury upon them. Athletes also acknowledge that in spite of all precautions, injuries may still occur, some of which may be catastrophic.

I acknowledge that I have chosen willfully to participate in intercollegiate athletics at Lasell College. With that decision I accept that I have a responsibility to follow all rules and regulations governing the sport in which I participate. I understand that I have a responsibility through my actions to protect the health and safety of fellow athletes. I can accept that in spite of safety measures I may become injured, which may include an injury which affects my quality of life.

__________________________________________  ____________________________
Signature of Student- Athlete                      Date

__________________________________________  ____________________________
Signature of Parent/Guardian                      Date
(If student-athlete is under 18 years of age)
Lasell College Athletics
Insurance Statement

Lasell College, in accordance with NCAA guidelines, requires that student-athletes be covered under a medical insurance plan during participation in intercollegiate athletics. It is the responsibility of the student-athlete to inform the Athletic Training Staff of any changes in their medical insurance status. A yearly update must be completed and proof of insurance must be on file at the beginning of each sports season in order to gain clearance for athletic participation. The insurance information provided will be kept on file in the Athletic Training Room. This information will be transported to and from away contests in the team medical kit.

For more information about the Student Accident and Sickness Insurance plan, please refer to Consolidated Health Plans insurance brochure or log onto https://consolidatedhealthplan.com/

I understand the insurance requirements for participation in intercollegiate athletics. By choosing not to enroll in the Lasell College Student Health Insurance plan, I assume the responsibility for all medical bills stemming from athletic injury. Furthermore, I understand that Lasell College, the Athletic Department or any individual sports team will not provide financial assistance with medical bills not covered by my insurance company.

Please attach a photocopy of the front and back of your medical insurance card. This must be on file in the Athletic Training Room prior to any participation in intercollegiate athletics.

_________________________________________  _________________________
Signature of Student-Athlete                     Date

_________________________________________  _________________________
Signature of Parent/Guardian                     Date

**Please refer questions pertaining to the Lasell College Student Health Insurance Plan to Student Financial Planning at 617-243-2103**