



SEAWOLVES SPORTSMEDICINE
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MEDICAL ELIGIBILITY INSTRUCTION FOR ALL NEW SSU STUDENT-ATHLETES

To the Student-Athletes and Parents of Sonoma State University:

We are pleased to have you or your son/daughter as a member of our University's athletic family. We hope that the opportunity presented here at SSU, athletically and academically will be a rewarding experience.

Below is information (in bullet form) designed to help you through the medical eligibility process. Please print, fill out and send the forms that follow to the address above.

- **_____ Medical History Portion of Sports Physical**
 - Athletic training room staff will contact you at the phone number given with notification for approval to schedule a SHC physical
 - Physical MUST be completed on campus by Student Health Center (SHC) Dr. Sports physical Fees are due at the time of service. A "NO SHOW" fee will be charged. Please cancel scheduled appointments 24 hours in advance.
 - Athlete sign and date bottom of form.
 - Schedule physical appointment date BEFORE classes begin; on a campus visit, or before or after SOAR (student orientation).
 - Fall sports must have a physical complete prior to the start of double days (men's soccer, women's soccer, volleyball, cross country)
 - Arrive to physical appointment at least 15 minutes prior to scheduled time.
 - Bring eyeglasses or contact lenses that you wear to the physical.
 - Photocopy of completed physical MUST be on file in the athletic training room prior to any participation by student-athlete.
 - Under NCAA guidelines you MUST report accurate medical information now as well as any future health changes to the athletic training staff, team physician, or the primary care physician providing clearance.
 - For more information regarding the SHC there website is www.sonoma.edu/shc

- _____ **Immunization Records**
 - Please send one (1) copy of immunization records with medical eligibility packet.
 - Proof of shots that are required;
 - Measles & Rubella (MMR)
 - Tetanus and/or Booster – within the last 7-10 years
 - Hepatitis B
 - Immunizations are available at the SHC for a nominal fee

- _____ **Athlete Medical Insurance Policy (Form 1A)**
 - Please review and retain this form for your records.
 - Your student-athlete will be presented with this information at a pre-season team meeting where they will verify and acknowledge the procedures by signing a form.

- _____ **Sports Participation Insurance Questionnaire (Form 1B)**
 - Please complete all information requested on form.
 - Student-athlete and both parents **MUST** sign form regardless of age or insurance status. Signatures verify that you have read and understand SSU insurance policy (Form 1A) as well as all information is current.

- _____ **Release of Medical Information Authorization Form**
 - Student-athlete print name, sport and date
 - Student-athlete sign
 - Parent signature also required **IF** student-athlete is 17 years of age or younger

- _____ **Personal, Medical, Risk Consent Form**
 - Fill out emergency contact information and insurance in top half
 - Student-Athlete read and sign the bottom consent and assumption of risk
 - Parents sign **IF** student-athlete is 17 years or younger.

- _____ **Authorization to consent medical treatment for minors**
 - To be filled out if student-athlete will be under the age of 18 at the time they report for double days or school

- _____ **Insurance card**
 - Please print a copy of the front and back of your insurance card
 - Out-Of-Area HMO-PCP Restricted Care
 - If you are outside of a two (2) hour window from SSU
 - Transfer Primary Care Physician to Dr Ty Affleck – SSU Team Physician – General Practitioner with Sports Medicine Certificate

- Phone number (707) 546-9400 please make sure that you tell the office staff that you are an SSU student-athlete.
- **_____ Medical Records / Written Clearances – Necessary for any surgeries or injuries in the last five (5) years**
 - If you have had a Surgery (s) or Hospitalizations we will need;
 - Surgery Report
 - Patients Notes – Follow up notes – anytime student-athlete saw dr after surgery
 - Written clearance note from primary care physician or surgeon
 - If you have had an Injury(s) or bone/joint/muscle problems we will need;
 - Any injury that required rehabilitation or a limitation of athletic participation for more than ten (10) days
 - Written medical clearance is required from primary care physician
 - If you have had an Illness (s) we will need;
 - Any illness that caused you to miss more than ten (10) days of athletic participation or school or
 - An illness you are still under care for by your primary care physician
 - Written medical clearance is required from primary care physician
 - If you have a Current or recurrent medical problems we will need documentation of and a clearance for;
 - Any issue that might influence your athletic participation or needs treatment i.e. asthma, heart problems, epilepsy, mononucleosis, hepatitis, etc.
- Please make sure that your student-athlete has been accepted to SSU and that you have paid the Early Registration Deposit (ERD)
 - Required to have a physical completed on campus
- Please make sure that you have sent required paperwork a minimum of three (3) weeks prior to your SOAR student orientation.
 - Please send information to the Athletic Training Room and NOT the coach
- The Athletic Training Room will notify you at the phone number given when we have received the required paperwork. The phone call will tell you;
 - If your packet is complete
 - If not what is missing
 - What the process will be from that point on
- If you have any question feel free call or email Bo Owens or Julie Miller
 - Bo Owens, Head Athletic Trainer
 - bo.owens@sonoma.edu, (707) 664-4316
 - Julie Miller, Assistant Athletic Trainer
 - Julie.miller@sonoma.edu, (707) 664-2937

SSU ATHLETIC PRE-PARTICIPATION MEDICAL HISTORY

Athletic Pre-participation Examination For (sport): _____ Age _____

Name _____ Birth-date / / SS# _____

Current or Address @ SSU _____ Phone () _____

Street or Dorm City State Zip

Permanent Address _____ Phone () _____

Street City State Zip

INSTRUCTIONS: Student athlete must fill out this **Medical History** completely and sign it. It must be reviewed and signed off by the examining physician. **Failure do so may invalidate athletic insurance coverage and/or interfere with your eligibility to participate in intercollegiate athletics.**

Do you now have or have you ever had any of the following?	Yes	No	Additional Information
Allergy to medications, bee stings, Foods: please list:			
Anemia or bleeding problem?			
Asthma, or severe hay-fever?			
Excessive shortness of breath or wheezing with exercise?			
Intense chest pain/pressure with exercise or exertion?			
Dizziness or fainting with exercise or exertion?			
Heart trouble/heart murmur/irregular heartbeat/abnormal EKG?			
High blood pressure/ enlarged heart?			
Heat stroke, heat exhaustion, or other heat related illness?			
Chronic or recurrent illness such as diabetes, epilepsy, sickle cell etc.?			
Other significant illness or exposures (hepatitis, tuberculosis, etc.)?			
Loss of consciousness, loss of memory, or convulsions?			
Weakness, passing out, or severe headaches?			
Head injury, concussion, or skull fracture?			
Surgery or been advised to have an operation?			
Hospitalization(s)? List reason:			
Bone, joint, or muscle injuries or problems (includes dislocations, separations, sprains, broken bones, etc)?			
Neck injury, back injury, or back problems or surgery?			
Hip, knee, ankle, shoulder, wrist, elbow, problems or surgery?			
Hernia or kidney problem?			
Eye, ear, or significant dental problems or injuries?			
Menstrual irregularities? List date of last period:			
Skin problems, including recurrent rashes, infection, etc.?			
Any other important illness, injury, or medical condition?			
Do you: Wear glasses, contact lenses, dental bridges, etc.?			
Have full function of and presence of all paired organs, (i.e., eye, kidney, testicle, ovary, lung)?			
Take medication on a regular basis? Please list:			
Has any blood relative:			
Died suddenly or had a heart attack at less than age 50?			
Been diagnosed with Marfan syndrome?			
Has your athletic playing status ever been interrupted or limited because of illness or injury?			
Do you know of any medical reason that might limit your participation in sports?			
Immunization Verification:			NOTE: attach copies of documentation of required immunizations.
Date of last Tetanus _____ (verified by physician)			
Date of most recent Measles/Rubella _____			
Date of Hepatitis B series (required if under 19) 1 / 2 / 3 _____			

I certify that the above information is correct, and authorize the transfer of medical information to the SSU Athletic Trainer, team physician, and SSU Student Health Center:

*Athlete's signature: _____

Date: / /

*Reviewed by physician _____

Date: / /

A. LENGTH OF SSU ATHLETIC INSURANCE

(Form 1A)

Student athletes at Sonoma State University covered by SSU athletic insurance benefits are on a 2-year (104-week) pay out program. The first medical expense must be incurred within 90 days of the onset of a documented injury and insurance for covered injuries occurring during participation in intercollegiate athletics at SSU will terminate two calendar years from the date of the injury.

B. SSU ATHLETIC INSURANCE POLICY PROCEDURES

1. SSU athletic insurance is secondary to any personal insurance you may have. In seeking any medical care, you must follow your health care plan instructions. Verification of your insurance status (form 1B) must be on hand prior to participation and a resultant medical referral.
2. SSU athletic insurance is not a comprehensive athletic insurance policy. It does not cover degenerative conditions, medical illness or disease; i.e. arthritis, asthma, or diagnosed ongoing congenital heart conditions. Undiagnosed heart conditions with original onset occurring during covered athletic participation are covered benefits for initial injury care and testing. Follow up care for a diagnosed congenital heart condition is not a covered benefit. In the absence of primary personal health insurance, general medical coverage that is supplemental to Student Health Center services (i.e. emergencies, urgent after hours or out of area care hospitalizations, etc.) is described on the Web at www.csuhealthlink.com. This insurance may be obtained through this website, by contacting the Associated Students Office in the Student Union (707) 664-2815 or by calling the company directly at 1-800-853-5899.
3. SSU athletic insurance only covers accidental injury. An accidental injury is a sudden, unexpected, external or violent event that occurs independently of any other cause.
4. A re-injury of an injury sustained prior to the effective date of this policy is covered, provided the athlete was given a specific medical examination and clearance by the SSU team physician for such identified injury prior to participation.
5. A covered injury must be verified to a specific cause and occur during identified and supervised practice and game sessions. Personal, recreational, PE or injury outside of official practice/game participation are not covered incidents.
6. If you have primary insurance, you are responsible for submitting all provider bills to your insurance company.
7. If your insurance has a deductible or does not pay for full coverage, SSU secondary insurance will cover eligible unpaid expenses. In order for a claim to be processed, the following must be obtained:
 - a. An SSU insurance claim form
 - b. The first fully itemized and any subsequent visits not on the original bill from all providers
 - c. An explanation of benefits (EOB) for medical bills processed by your insurance company
8. Athletes are referred for medical care based on need. Referral does not imply secondary medical coverage.
9. All athletes must be referred through the athletic training room (ATR) with a medical referral card for non-emergency care. If you seek non-emergency medical or selectable treatment on your own or by a coach without proper referral notice through the ATR, **you will be responsible for the incurred expenses.**
10. All athlete referrals are to be made to the SSU team physician and where restricted by HMO or designated PCP care, pre-authorization from primary insurance must be obtained prior to non-emergency visits. Pre-authorization not granted by your insurance for out-of-area plan care must be honored, which means you would have to go home to receive off campus non-emergency care. Restricted out-of-area PCP care should be considered for local transfer (available from SSU Team physician) so that necessary off campus physician care will not be disrupted.
11. A WRITTEN CLEARANCE using the ATR referral card must be completed for doctor visits PRIOR TO RETURNING TO PRACTICE for an illness or injury that caused you to miss a practice.

ALL REQUESTED INFORMATION MUST BE PROVIDED TO START, RESUME, OR CONTINUE PARTICIPATION

C. PRESCRIPTION, OVER-THE-COUNTER MEDICATION AND SUPPLEMENT USE:

1. Personal prescription medication must be used by the person and the purpose for which it is prescribed and should not be given to anyone not named on the prescription. SHC and team physician are available and should be consulted for conditions where athletes believe medication is needed. **DO NOT SHARE MEDS!!**
2. Over-the-counter (OTC) medication in the ATR is limited to the following categories; anti-inflammatory, analgesic, decongestant, anti-histamine, anti-acid/gas, glucose and will be provided on an acute need, temporary (1-3 days) first aid basis only. **Please note:** any medication received from the ATR does not imply a medical diagnosis or constitute medical advice.
3. OTC medication from the ATR is provided in single-dose packets, which include the name of medication, dosage, instructions for use, warnings and precautions, expiration date, and lot number pre-printed on them. It is the athlete's responsibility to adhere to the package label information.
4. OTC medications from the ATR are provided as a courtesy upon request made to the certified athletic trainer or team physician and will be dispensed by athlete written consent. If you are ill, need medical advice, or need OTC medication on other than a temporary basis, you should contact the SSU Student Health Center (SHC), team physician or seek your own physician or pharmacy assistance.
5. Some prescriptions and OTC medications and some dietary supplements or energy food additives may contain substances banned by the NCAA. Steroids, Ephedra hi concentration of caffeinated drinks and some anti-asthma medications (Primatene and corticosteroids) are types of NCAA banned substances. Creatine usage can lead to muscle cramping, strains and kidney or renal complications and along with other supplement usage may be detrimental to your health and/or athletic performance and should not be consumed. In order to prevent unintended consequence, please consult with the Certified Athletic Trainer, team physician, SHC staff or obtain further educational information on NCAA banned substances and supplement warnings. Please refer to the NCAA website at www.ncaa.org/health-safety, or the Drug Free Sports Resource Exchange Center at www.drugfreesort.com/rec and enter Division II, password ncaa2, about any medications or supplements you are taking or thinking of taking.

D. TOBACCO AND BODY PIERCING:

1. Tobacco is also banned by the NCAA, can often lead to cancerous lesions that can be life threatening and is not to be used at any time.
2. Body piercing, especially associated with tongue has led to severe injury and airway complications. Along with other external area use, piercing ornaments and jewelry should be removed prior to all practices and competitions.

E. HYDRATION AND ELECTROLYTE CONSUMPTION:

1. For every pound of sweat loss during exercise, 15-23 oz. (2-3 cups) of fluid needs to be replaced. A one to two percent body weight loss difference (1.5-3 lbs. for 150lb athlete) between daily workouts can hinder performance and a 3-6% (4.5-9lbs for 150lb athlete) weight difference can lead to severe heat stress complications. As a general rule, same time daily weight differences need to be similar not exceeding 2-3 pounds.
2. Dehydration symptoms of headache or light headedness, dizziness, nausea with muscle cramping or a general feeling of medical malaise need to relayed to an ATC or coach and a remedy sought.

F. MEDICAL INFORMATION RELEASE:

1. Athlete medical information controlled by federal (FERPA and HIPPA) and state regulation will not be released for public information unless authorized in writing by the athlete.

I acknowledge a full understanding and willful compliance of the above information included in all sections of: A,B,C,D,E, and F.

Athlete's Name _____
Athlete's Signature _____ Date _____

PART I: PARENT(S) / GUARDIAN / ATHLETE

(Form 1B)

SSU athletic insurance is not comprehensive. It covers accidental injury; medical conditions are not covered. Accidental injury benefits are provided on a "secondary-excess basis" and personal insurance must be billed first. Athlete's seeking "specialty" medical care **MUST BE REFERRED** through the athletic training room. Personal physicians can be consulted for a second opinion authorized by the SSU team physician. I/we have reviewed all of the form 1A policies and medical procedures and with my signature below confirms my/our understanding and compliance. I certify that information given below is complete and correct.

Mother's Signature _____ Date _____ Father's Signature _____ Date _____
Athlete's Signature _____ Date _____ Guardian Signature _____ Date _____

PART II: ATHLETE

Date _____ Athlete's Name _____ Sport _____
Athlete's Address _____ City _____ State _____
Athlete's Local Phone # _____ SSN# _____

I or my spouse (circle) am / am not employed. If employed, give:

Athlete's / Spouse Employer _____ Phone # _____
Employer's Address: _____
Are you covered by personal health or spouse (circle) insurance? ___ Yes ___ No
Name of Insurance Company: _____ Policy # _____

PART III: PARENT/GUARDIAN - THE FOLLOWING SECTION MUST BE FULLY COMPLETED - REGARDLESS OF DEPENDANT COVERAGE

Father's Name _____ Social Security # _____
Father's Home Address _____ Phone # _____
City _____ State _____ Zip _____
Employer's Name _____ Phone # _____
Employer's Address _____
Name of your Insurance Company _____ Policy # _____
Claims Phone # _____ Type of Plan; ___ HMO ___ PPO ___ Other
IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? ___ Yes ___ No
Does Your Insurance Require: Second Opinion for Surgery? ___ Yes ___ No
Pre-authorization? ___ Yes ___ No Phone # _____

Mother's Name _____ Social Security # _____
Mother's Home Address _____ Phone # _____
City _____ State _____ Zip _____
Employer's Name _____ Phone # _____
Employer's Address _____
Name of your Insurance Company _____ Policy # _____
Claims Phone # _____ Type of Plan; ___ HMO ___ PPO ___ Other
IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? ___ Yes ___ No

Does Your Insurance Require:

Pre-authorization?

Second Opinion for Surgery? Yes No

Yes No Phone # _____

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I understand that as a student-athlete, my medical records and health information will be kept confidential in accordance with THE FAMILY EDUCATION RECORDS PRIVACY ACT (FERPA), the Buckley Amendment.

I, _____ hereby authorize the Sonoma State University Athletic
(Print name of student athlete)

Training staff, its Team and Student Health Center (SHC) physicians and staff to release my protected health information regarding any injury or illness during my physical training and participation in SSU Intercollegiate Athletic activities TO the SSUAD medical, coaching or administrative staffs, parents or legal guardian.

I understand that my protected health information will be used by the staff's mentioned above for the purpose of "continuity of care" and that my authorization/consent is not contingent in order to be eligible for participation in NCAA athletics.

This authorization/consent expires 380 days from the date of my signature below.

Print-Student Athlete Name

Date

Signature-Student-Athlete

Sport

Signature- Parent/Guardian if under 18 years of age

Date

PERSONAL & MEDICAL INFORMATION FORM

Name _____ Social Security # ____ - ____ - ____

Last First MI

Birth date _____ Age _____ School Phone () _____

Parent/Guardian Name _____ Phone () _____

Last First MI

Contact in Emergency _____ Phone () _____

Last First MI

MEDICAL INFORMATION:

1. Date of last tetanus shot? _____ 2. Glasses? Y / N Contacts? Y / N
 3. Do you have any Allergies? Y / N To what? _____
 4. Are you taking medication on a regular basis? Y / N List _____
 Insurance Co. _____ Policy # _____ Group # _____
 Insurance Co. Phone #(____) _____

Circle One:

List (HMO) Primary Care Physician OR (PPO) Medical Group OR Other

Name	Address	City/State	Zip
Physician or Group Phone Number (____) _____			

MEDICAL CONSENT AND ASSUMPTION OF RISK

I/we hereby grant permission to SONOMA STATE UNIVERSITY (SSU), its physicians and/or athletic trainers to render aid, treatment, medical or surgical care deemed reasonably necessary for my health and wellbeing.

I/we fully authorize the athletic trainers at the above-named institution, or institution where a visiting event or match is taking place, to render any first aid, preventative and rehabilitative or emergency treatment, deemed reasonably necessary to protect my health and wellbeing.

I/we additionally grant, when necessary for protecting the health and well being , permission for hospitalization, treatment or surgery at a competent and or accredited facility.

I/we realize that there are inherent risks in my sports participation. These risks include a full range of injury from minor to severe to catastrophic and I/we recognize that death, paralysis, or other serious permanent disability can result from my participation in this sports program. I further realize that the protective equipment, safety rules, coaching instruction, or the medical care I receive will not all guarantee my safety or prevent all injuries I might sustain. Therefore, I/we release SSU, its athletic trainers, coaches, and employees from liability for any and all damages or injuries sustained as a result of my sports participation.

The undersigned here with also understands that for any injury or illness requiring medical attention resulting in a missed practice or game, permission by the doctor or athletic trainer must be given in order to resume practice or play in games.

The medical information given is complete with my/our permission receiving stated medical care. I also assume the stated medical risks of injury related to my sport participation at SSU.

STUDENT-ATHLETES MUST SIGN BELOW. IF YOU ARE UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST ALSO SIGN BELOW

SIGN	DATE	SIGN	DATE
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

AUTHORIZATION TO CONSENT MEDICAL TREATMENT FOR MINORS

The undersigned parent / guardian of _____
Who is below the age of 18, and is or will soon be a regularly enrolled student at Sonoma State University (SSU), authorizes the medical staff of the SSU Health Center, SSU Athletic Training Room staff and / or other appropriate University personnel (i.e. public safety) acting under the administration authority of SSU to act as agents for the undersigned to consent to any diagnostic procedure (including X-Rays), to the administration of any medical or surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

I realize that the above minor must be a regularly enrolled student at SSU in order to receive health care at the Student Health Center (SHC) and may be referred to off campus facilities if:

1. the minor is not currently registered student of the California State University system*, 2.
2. if medical care is advisable during the hours that the SHC is closed, or
3. if hospitalization, long term care, complex diagnostic evaluation and treatment, specialty consultation or other medical services that are beyond the scope of the SHC are required.

I realize that individuals must make their own financial arrangements for off-campus health care.

Parent or guardian signature Date

Parent or guardian printed name

Street Address City / State Zip Code

Home Phone Number Work Phone Number

Cell Phone Number

* Student Health Center services are available only to regularly enrolled students who pay University registration fees. Fee waiver students and non-fee paying participants of High School Early Entry Program are not eligible for Student Health Center services.