Walk-On/Try-Out

Pre-Participation Medical Paperwork

Georgia State University Athletic Department

Students wishing to try out for a GSU team must review and complete the paperwork found in this packet. After completion of the entire packet, the forms can be mailed to the address below or submitted directly to the Sports Medicine office/Athletic Training Room in the GSU Sports Arena. **Student-athletes are not permitted to participate until the completed packet is received.** Please also read and review our policies and insurance information found on the Sports Medicine web page (www.GeorgiaStateSports.com), and acknowledge they have been read on the Authorization form.

PLEASE READ: ***THE TWO MOST COMMON REASONS FOR DELAYS IN MEDICAL CLEARANCE***

- **Failure to have the physical signed by a PHYSICIAN (with MD or DO credential). Physicals signed only by a physician assistant (PA) or nurse practitioner (NP/LNP) will not be accepted. Do not go to a drug store minute clinic for a physical. We recommend you see your primary care physician for a physical. If you do not have a primary care physician, the GSU Student Health Center or Urgent Care at Peachtree (www.urgentcareatpeachtree.com) are potential options.**
- **Failure to provide proof of current personal medical insurance. You must have current, active personal medical insurance in order to be cleared for and maintain participation with GSU athletic teams.**

Medical Forms Check-list:

_____ Immunizations Form
_____ Pre-Participation Physical Exam Form
_____ Sports Medicine Medical Authorization, Assumption of Risk & Disclosure of Health Information
_____ Drug Testing Consent Form
_____ Health Insurance & Emergency Contact Form
_____ Insurance Card Copy (front & back of card please)
_____ Authorization/Consent for Release of Protected Health Information

We look forward to working with you and hope that your year is injury free. Contact us any time with any questions.

Sincerely,

Georgia State Sports Medicine Staff
(404) 413-4040

Completed forms must be **submitted in person** to the Athletic Training Room in the GSU Sports Arena

Immunizations Form

Georgia State University Athletic Department

Included with this packet is a Georgia State University Certificate of Immunization. All new students must submit this form upon enrolling at Georgia State University. Please send this form to the Sports Medicine office with all other medical paperwork.

Please note:

- New students are responsible for submitting immunization records to the GSU Health Clinic per standard GSU admissions policy.
- Currently enrolled students may request a copy of their immunization records from the GSU Health Clinic to submit with this paperwork.

Please review the following special notes in regards to this form:

- If this form is **not submitted**, a hold will be placed on the student's account and he or she will not be able to enroll for spring semester classes. The hold will be removed when the form is submitted.
- If the form is submitted **but is not complete**, a hold will be placed on the student's account and he or she will not be able to enroll for spring semester classes. The student must complete any missing immunization requirements before the hold is removed. Immunizations are typically more expensive and may not be covered by insurance if performed through the GSU Health Clinic or a doctor other than the student's primary care provider.
- The form must be signed and stamped by a health care provider verifying the immunization information.
- Please review the form for completeness before submitting. We strongly recommend making sure all immunization requirements are met before you submit the form.
- Common immunization form mistakes or omissions include:
    - ❖ Incomplete or omitted Varicella ("chicken pox") verification
    - ❖ Most recent Tetanus-Diphtheria shot not completed within last 10 years
    - ❖ Incomplete Hepatitis B vaccination

Please note, the Georgia State University Athletic Department will not be responsible for any costs associated with immunizations.

Please contact the GSU Student Health Clinic at 404-413-1930 with any questions about this form or about immunization requirements.

Georgia State University
REQUIRED CERTIFICATE OF IMMUNIZATION
Last revised: 6.21.2012

Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID: _____ **Nation of Birth:**_____

Name: _____ Date of Birth: _____/_____/_____
Last First Middle

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Your age on the 1st day of class at GSU: _____ term of enrollment (circle one): Spring Sum Fall 20_____

Student Signature_____ Phone #:_____

IMMUNIZATION INFORMATION (See the reverse of this form for specific immunization requirements)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY		DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE (copy of lab report REQUIRED)
MMR 1	/ /	/ /			
Measles 1	/ /	/ /			/ /
Mumps 1	/ /	/ /			/ /
Rubella 1	/ /	/ /			/ /
Varicella 3	/ /	/ /		Date of Disease / /	/ /
Tetanus-Diphtheria Pertussis(Whooping Cough) 4	Tdap / /	Td 4 / /			
Hepatitis B 2	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal	/ /	MCV4 booster 8 / /			Required for newly admitted freshmen or matriculated students planning to reside in university managed campus housing. 8—MCV4 Booster only necessary if younger than 21years & initial MCV4 dose was received before age 16 years

1—Not required if born before 1957. 2—Only required of students who are 18 years of age or younger at time of expected matriculation.
3—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. 4-- Td booster only necessary if ≥ 10 years since Tdap dose

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

☐ This student is exempt from the above immunizations on the ground of permanent medical contraindication.

☐ This student is temporarily exempt from the above immunization until _____

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature: _____

Address: _____

_____

Phone: _____ Date: _____/_____/_____

Medical Office Stamp:

EXEMPTIONS

Check the appropriate box, sign, & date if you are claiming exemption of the immunization requirement for one of the following reasons:

☐ I affirm that Immunization as required by the University System of Georgia is in conflict with my religious beliefs. I understand that I am subject to exclusion in the event of an outbreak of a disease for which immunization is required.

☐ Military exemption –students who were active military within past 2 yrs, must show proof of active military service.

☐ I declare that I will be enrolling in ONLY courses offered by distance learning. I understand that if I register for a course that is offered on-campus or at a campus managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature: _____ Date: _____/_____/_____ **semester and year----------**

Address: 141 Piedmont Ave., Ste. D, Atlanta GA 30303 phone: 404.413.1940 Fax: 404.413.1955

Pre-Participation Physical Exam Form

Georgia State University Athletic Department

The Pre-Participation Physical Exam Form must be completed and submitted before a student-athlete is allowed to participate in a Georgia State athletic program.

The form is comprised of two sections: the History Form and the Physical Examination Form.

1. The History Form is comprised of several questions asking about previous injuries, illnesses, and other medical conditions. It should be completed carefully and completely by the student-athlete and his or her parent(s)/guardians(s). Please be sure all "YES" answers are explained in the space provided. Both the student-athlete and parent sign at the bottom of the page.
2. The Physical Examination Form ***MUST be completed by a physician (with a MD or DO credential per NCAA rules)*** after the physician completes a medical exam. The physician will then indicate participation status, sign the form, and include any other recommendations. ***Please note, physical exams performed by any medical professional other than an MD or DO will not be accepted.*** A prior physical exam may be submitted if it was conducted within 6 months of the activity start date and if it explicitly states the student-athlete is cleared for athletic participation.

Sickle Cell Trait

The NCAA has recently passed legislation regarding student-athletes and sickle cell trait. Having sickle cell trait is not a barrier to outstanding athletic performance, and those with the trait are not excluded from athletic participation. During intense exercise, though, student-athletes with sickle cell trait have experienced significant physical distress, collapsed, and even died. Knowing who has sickle cell trait allows recommended precautions to be put in place. Please see the Fact Sheet at the end of this packet or go to www.ncaa.org for more information.

A student wishing to try-out or walk-on to a GSU athletic team must provide documented evidence of a prior sickle cell trait test (like a copy of the laboratory test report). The documented evidence must be submitted with all other medical paperwork. Students may also sign a waiver declining the test. Most states screen for sickle cell trait at birth, so record of testing may be obtained by calling the doctor who first saw the student-athlete at birth, his/her pediatrician, or his/her primary care physician. A student-athlete may request a sickle cell screening through his/her physician or at the GSU Student Health Center.

NCAA Banned Drug and Medical Exceptions Policy

The NCAA bans certain drugs because they may cause harm to student-athletes and/or create and unfair advantage in competition. Medications used in the management of ***Attention Deficit Hyperactivity Disorder (ADHD)*** often are classified as stimulants and are included in this ban. The NCAA does grant medical exceptions to this policy, but requires specific documentation outlining the diagnosis and treatment plan for student-athletes who use prescribed stimulants for the management of ADHD.

If you (the student-athlete) or your son/daughter uses medication for ADHD, please contact Jessica Peters at 404-413-4038, to ensure proper documentation is obtained. As with all medical information, strict confidentiality will be maintained.

More information about this NCAA policy can be found at www.ncaa.org and searching "ADHD".

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Georgia State University Department of Athletics

Sports Medicine Medical Authorization, Assumption of Risk & Disclosure of Health Information

Student-Athlete Name	Sport(s)	PantherCard ID No. (If Applicable)

FOR AND IN CONSIDERATION of the opportunity to utilize participate in intercollegiate athletics at Georgia State University ("University"), and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, student-athlete ("Undersigned") does hereby agree to the following:

Sports Medicine Services. The Undersigned understands that the University's Department of Athletics' sports medicine staff's primary focus is preventing injury as well as treating and rehabilitation of injuries. The Undersigned further understands that the sports medicine staff will develop a rehabilitation program to fit a student-athlete's needs for a quick recovery and are assigned to attend practices and competitions with priority given to in-season, collision or high-risk sports. Physicians do not attend all practices and competitions, but are immediately available via cell phones and pagers. The Undersigned understands and agrees that if he/she experiences an injury/illness that it is his/her responsibility to inform promptly the University's Department of Athletics' sports medicine staff. The sports medicine staff will assess the immediate needs and give authorization to receive medical care from one of the following: team physicians, health services, or outside physicians. No one else within the Department of Athletics is authorized to authorize any type of care or referral. The Undersigned is responsible to report back to the sports medicine staff with information regarding any doctor's visits and follow-up care. The Undersigned expressly understands that failure to comply with such requirements will result in being withheld from participation in intercollegiate athletics.

Student-Athlete Initial: _____

Assumption of Risk. The Undersigned acknowledges the existence of risk in connection with his/her participation in intercollegiate athletics, including, but not limited to, training, trying out, practicing, competing, or traveling, at the University (collectively, "Intercollegiate Athletics"). Participation by the Undersigned in the Intercollegiate Athletics is purely voluntary and the Undersigned elects to participate with full knowledge of the risks of injury, illness or damage to property. The specific risks vary from one activity to another, but potential risk include, but are not limited to: scratches, cuts, splinters, bruises, sprains, dislocations, broken bones, torn muscles, torn ligaments, joint or back injuries, nerve damage, eye injuries or loss of sight, heat stroke or exhaustion, heart attacks, strokes, concussions, brain or spinal cord injuries, temporary or permanent paralysis, loss of bodily functions, drowning, or even death. These risks may result from the Undersigned's participation in Intercollegiate Athletics, from the acts of others, or from the unavailability of emergency medical care.

Student-Athlete Initial: _____

Disclosure of Health Information. The Undersigned authorizes the University, and its employees and representatives, to release pertinent personal and insurance information to any interested medical care provider and the coach of the Undersigned's sport. This information may need to be provided to interested persons in the event that the Undersigned requires medical care. This information may include, but is not limited to: the Undersigned's name, date of birth, social security number, insurance information, parent's telephone numbers, school and home addresses and emergency contacts. The Undersigned also authorizes the University and any physician, certified athletic trainer or other health care provider retained by the University to release and discuss with the coach of the Undersigned's athletic team, University athletic administration or any interested health care provider, information concerning the Undersigned's past and present general health, provided that the University or any such health care provider has determined in its, his or her sole discretion that such information may be relevant to the Undersigned's ability to participate, or continue to participate, in any University athletic program.

Student-Athlete Initial: _____

Medical Care. The Undersigned expressly authorizes the University's Department of Athletics' staff, including, but not limited to, sports medicine staff, to evaluate and treat any injury/illness that occurs during the Undersigned's participation in intercollegiate athletics and/or to seek emergency medical, rescue, or evacuation services for him/her should he/she become injured or ill. The Undersigned understands that he/she may be attended to by such staff until appropriate medical care is available. The Undersigned further authorizes such staff to communicate with athletic department officials and coaching staff regarding their findings and recommendations.

Student-Athlete Initial: _____

Waiver/Indemnify and Defend. The Undersigned hereby releases, waives, discharges, indemnifies, covenants not to sue, and agrees to hold harmless for any and all purposes the Board of Regents of the University System of Georgia ("Board") and the Board of Regents of the University System of Georgia by and on behalf of Georgia State University (hereinafter referred to as the "University"), and their employees, officers, members or agents (hereinafter collectively referred to as the "Releasees") from any and all liability, claims, demands, causes of action, suits, losses, damages, property damage, property loss or theft, costs (including court costs and attorneys' fees) or injury, including death, that may be sustained by the Undersigned while participating in activities associated with Intercollegiate Athletics or that may occur from the release of the Undersigned's medical records or other personal information in accordance with the terms of the authorization set forth in this Agreement, whether caused by the negligence of the Releasees or otherwise. The Undersigned understands and intends that this Assumption of Risk and Release is binding upon the Undersigned and his/her heirs, executors, administrators, assigns, estate, and all members of his/her family.

Student-Athlete Initial: _____

Severability. The Undersigned expressly agrees that this Agreement is intended to be as broad and inclusive as permitted by the law of the State of Georgia and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgement of Understanding. The Undersigned has read, understands and accepts the terms and conditions stated herein, and **understands that he/she is giving up substantial rights, including the right to sue Georgia State University or the Board of Regents of the University System of Georgia, or any of their officers, agents, servants, or employees**. The Undersigned acknowledges that he/she is signing the agreement freely and voluntarily, and **intends by his/her signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law. The Undersigned further understands that acceptance of this Agreement by Georgia State University and the Board of Regents of the University System of Georgia shall not constitute a waiver, in whole or in part, of sovereign immunity.

_____

Student-Athlete Signature Date

_____

Name of Student-Athlete's Parent/Guardian (if under 18) Parent/Guardian Signature Date

DRUG TESTING CONSENT

Georgia State University Athletic Department

I hereby consent to and authorize Georgia State University, or any entity or person authorized by or acting on its behalf, to conduct, at reasonable times during the academic year, a standardized drug screening urine test. I understand that pursuant to Federal, state, and municipal laws, now or hereafter in force, you will permit me to review my drug test results at reasonable times following your receipt of such results. I further understand that any drug test results shall remain confidential and will not be released without my written authorization except for the purposes of evaluation and treatment and except that I agree that the results of my test will be shared with the Director of Sports Medicine, the Director of Athletics, my Coaches and other University personnel who need to know for eligibility or financial aid purposes. I further consent to and authorize Georgia State Athletics to disclose my drug tests and treatment records to my family if deemed appropriate by the medical team or in the event of an emergency medical situation

The complete Drug Testing Policy can be found in the Sports Medicine section of the GSU Athletics website (www.GeorgiaStateSports.com).

_____ _____

Student-Athlete – print Student athlete – signature

_____ _____

Date (month / day / year) Sport

I have read the above information and agree to the participation of my son/daughter in the athletics department's drug testing program.

_____ _____

Parent/Guardian – print Parent/Guardian - signature
(If student is under the age of 18)

_____ _____

Date (month / day / year) Relationship to student-athlete

Health Insurance & Emergency Contact Information

Please complete all sections

Georgia State University Athletics Department's accident policy only provides insurance coverage for student-athlete injuries that occur while participating in the play or practice of intercollegiate sports. This policy is considered EXCESS or SECONDARY to any other collectible group insurance benefits. This simply means that any claims must FIRST be filed with any other valid and collectible group insurance policy under which the athlete is covered. Only after the student-athlete's PRIMARY carrier has exhausted all available benefits will our athletic insurance company consider the payment of remaining balances. The University's athletic policy covers athletic injuries only and is not a substitute for comprehensive medical coverage, so please do not cancel coverage presently in force. *Georgia State University does not have the option of waiving the requirement to file with your primary group insurance company.*

Student-Athlete Information

Name: _____ Sport(s):_____ Date of Birth: _____ / _____ / _____

Panther ID# _____ - _____ - _____ Year in School: First Year Sophomore Junior Senior 5th Year

Permanent Home Address: _____City, State, Zip:_____

Cell Phone Number:_____ Email Address:_____

Medication Allergies: _____ Current Medications: _____

Emergency Contact Information

Primary Contact Name: _____Relationship:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Secondary Contact Name: _____Relationship:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Insurance Information

Students wishing to try-out MUST show proof of medical insurance*

Primary Insurance Company: _____Group # or Name: _____Policy #:_____

☐ HMO ☐ PPO ☐ POS ☐ Other Insurance Company Phone: _____Pre-certification required? ☐ Yes ☐ No

Claims Mailing Address: _____City, State, Zip:_____

Name of Insured: _____Relationship to Student: ☐ Father ☐ Mother ☐ Self ☐ Other: _____

Insured Person's Date of Birth:_____/_____/_____ Phone:_____ Email:_____

Employer _____Employer Address:_____

Is the student-athlete covered under any additional insurance policies? ☐ Yes ☐ No
Does the student-athlete have a separate prescription card? ☐ Yes ☐ No
Does the student-athlete have dental insurance? ☐ Yes ☐ No
Does the student-athlete have vision insurance? ☐ Yes ☐ No

If "yes" to any of the above questions, please provide a copy of the insurance card on the included "Copy of Insurance Card(s)" Form

****Please inform the Sports Medicine office of any insurance changes during the course of the year****

Authorization to File Under Primary Policy (Please Check One)

☐ I hereby authorize a claim to be filed on behalf under the above medical policy in the event an athletic injury is sustained
☐ I am NOT covered under a group insurance plan.

Authorization to Obtain Information (Please Sign and Date)

To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; group policyholders; insurance support organizations; and other persons who have information about the patient. I permit the release of any medical information about me to GSU accident insurance carrier. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The company will use this information to find out if any claim is eligible. A copy of this authorization will be valid as this one. I certify that the above information given by me is true and correct to the best of my knowledge.

Signature of Student-Athlete: _____ Date: _____/____/_____

Signature of Parent/Guardian: _____ Date: _____/____/_____
(If student is under the age of 18) (month / day / year)

Rev. 04/11

Copy of Insurance Card(s)

Georgia State University Athletic Department

Student-athlete name: _____ Sport (s): _____

Primary Insurance Card:

Copy front of card here

Copy back of card here

Additional Cards (if applicable):

Card type: □ Additional Insurance □ Prescription □ Dental □Vision

Copy front of card here

Copy back of card here

Card type: □ Additional Insurance □ Prescription □ Dental □Vision

Copy front of card here

Copy back of card here

STATE OF GEORGIA
COUNTY OF FULTON

Student-Athlete Authorization/ Consent for Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Georgia State University and the Georgia State University Athletic Association to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in inter-collegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, athletic and/or university administrators, chaplains and/or clergy members, NCAA Injury Surveillance System, sports information staff and members of the media.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an intercollegiate athlete for Georgia State University. I understand that my protected health information is protected by federal regulations under either the Health Information portability and Accountability act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or FERP.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Director of Sports Medicine, but if I do, it will not have any effect on actions Georgia State University or Georgia State University Athletic Association took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires six (6) years from the date it is signed.

_____	_____	_____
Name of Student-Athlete (print or type)	Signature of Student-Athlete	Date
_____	_____	
Panther ID# of Student-Athlete	Date of Birth of Student-Athlete	
_____		_____
Signature of Parent/Legal Guardian (if student-athlete is under 18 years of age)		Date