NAME	SPORT	GTID#:

I verify that I have read, understand and will comply with the Georgia Tech Sports Medicine Injury, Illness, and Medical Procedures listed below.

Signature _____ Date _____

GEORGIA TECH SPORTS MEDICINE
INJURY, ILLNESS, AND MEDICAL PROCEDURES

Intercollegiate Athletic Medical Eligibility

- All physical examinations are scheduled through the athletic training staff. All prospective student athletes must pass a physical examination given by the Georgia Tech Team Physician or his/her designee before being permitted to participate in athletic activity for Georgia Tech. The physical examination is effective for the duration of the academic year.
- A complete medical history must be provided to the athletic trainer or team physician before the physical exam. Failure to report conditions may result in disqualification from intercollegiate activity or delayed clearance to participate in intercollegiate activity. All team candidates may lose their clearance status if the following are not completed: 1) Signed Assumption of Risk, Release of Medical Information and under age 18 waiver, 2) submitted primary insurance information, and 3) Submitted additional medical information as requested by the team physician.
- The Team Physician may re-examine any student-athlete and change the student-athlete's status at any time should the situation warrant.
- Candidates with special conditions may be referred to specialists for examination. Failure to report special conditions will release Georgia Tech from any liability in the event of another injury caused by or related to the unreported condition. Any tests (x-rays included) or referral to specialists to conclude a student-athlete's physical examination may be the financial responsibility of the student-athlete and his/her family.
- Loss of one of the paired organs (e.g. kidney, eye) or any other condition that is determined by the team physician to be detrimental to the student-athlete's health and well-being may disqualify a candidate from participation in intercollegiate athletics.

Medical Treatment

- An Athletic Trainer will receive, examine and evaluate signs and symptoms presented in order to provide the needed healthcare or, refer to a physician as necessary.
- The Sports Medicine Department works in conjunction with the Georgia Tech Stamps Health Services to assist with the needs of the student-athletes.
- In case of an emergency or medical problem occurring outside of the normal athletic training room hours, contact an Athletic Trainer for assistance or advice immediately. If there is a true emergency or life-threatening situation, dial 911. These problems should be immediately referred to the local hospital.
- All treatments and appointments will be directed by the team physician and supervised by an Athletic Trainer.
- It is the policy of Georgia Tech Sports Medicine that outside medical treatment for non-athletically related injuries or illnesses will not be covered.
- The Sports Medicine Staff must be informed of all referrals prior to the appointment. When applicable, student-athletes may request to have a second opinion. The Sports Medicine Staff will coordinate and pay for the second opinion with a designated physician. However student-athletes who choose to seek outside treatment or referrals on their own, without prior approval, may be responsible for the full cost of services.
- Athletic training room policies are as follows:
    - The Sports Medicine Staff is here to provide quality care for our student-athletes. Proper conduct is expected.
    - The athletic training room is a co-educational facility. Athletes are asked to wear shorts, shirt and sports bra (females only).
    - Report all injuries and illnesses to your team Athletic Trainer or to an Athletic Trainer in the athletic training room.
    - Be on time for all treatments. Failure to keep appointments will be interpreted as indifference and lack of desire to return quickly to full activity. Reports of tardiness and such indifference will be reported to your head coach.
    - All equipment will be operated by the Sports Medicine Staff. NO ONE is to self-administer treatment. All equipment and supplies must remain in the athletic training room unless expressly permitted otherwise by an Athletic Trainer.
    - Records of treatment attendance are open to all coaches for review.
    - All athletes must shower after practice/workouts before receiving treatment.
    - GTAA Policy is that student-athletes will not consume any dietary supplement that is not given to him/her by the sports medicine department or the sports nutrition department.

NAME	SPORT	GTID#

GEORGIA TECH ATHLETIC TRAINING & SPORTS MEDICINE
WAIVER, ACKNOWLEDGEMENTS AND DISCLOSURE POLICY

1. Under Age 18 Medical Waiver (if applicable)

I, the parent/guardian of (print name/sport)_____ do hereby authorize the Georgia Tech Athletic Training and Sports Medicine Staff, Georgia Tech Stamps Health Services, and other healthcare providers or hospitals to provide treatment and other medical services that are deemed medically necessary.

I have read each of the documents and forms that my student athlete has initialed or signed as a part of the PPE process. I understand the policies of the Georgia Tech Sports Medicine Department and I acknowledge that all information provided is accurate and up-to-date.

_____Date _____Parent/Guardian Signature
_____ Relationship to Student-Athlete _____Parent/Guardian Primary Contact Number

---

2. Consent for Care Authorization

Permission is hereby granted to the Georgia Tech Athletic Training and Sports Medicine Staff, designated physician, or other medical personnel to proceed with medical or surgical treatment, X-ray examination or other diagnostic imaging, therapy/rehabilitation, mental health evaluation/treatment and/or other medical treatment deemed necessary.

Furthermore, I understand that failure to be compliant with any medial plan of care, as deemed necessary by a Georgia Tech Team Physician and/or member of the Georgia Tech Athletic Training and Sports Medicine Staff, can result in my medical disqualification from all intercollegiate athletic activities.

In the event of serious injury or illness, I understand that an attempt will be made by the appropriate sports medicine personnel and/or athletic department administration to contact my parents or legal guardian. If medical personnel are not able to communicate with the responsible party, the treatment necessary for my health will be provided.

_____ Student-Athlete Signature

3. Concussion Statement

I acknowledge that I have read and understand the NCAA Concussion Fact Sheet. I fully understand and accept my responsibility to report all injuries and illness to the Georgia Tech Athletic Training and Sports Medicine Staff including signs and symptoms of concussions.

_____ Student-Athlete Signature

4. Authorization For Medical Release of Information

I hereby authorize the Georgia Tech Athletic Training and Sports Medicine Department and/or designated physician to release all information with respect to my past, present, and future physical status as may be requested by professional or medical organizations, parents/guardians, media, and professional or amateur organizations.

I understand the GTAA Sports Medicine Department is permitted to disclose information for purposes of payment, health care, treatment, participation status, or as required by law.

Furthermore, I hereby give Georgia Tech Stamps Health Services or designated provider permission to release any/all requested medical records to Georgia Tech Sports Medicine Department if needed for payment, health care, treatment, participation status, or as required by law, of any incurred charges for services rendered at Georgia Tech Stamps Health Services. This release is valid for 1 year from date signed.

_____Student-Athlete Signature

NAME	SPORT	GTID#

GEORGIA TECH SPORTS MEDICINE
ACCEPTANCE OF RISK, MEDICAL CLEARANCE, AND SCREENING

Please initial in the space provided acknowledging that you have read and understand the risks, expectations and requirements of student-athletes who compete in intercollegiate athletics at Georgia Tech.

1. **Acceptance of Risk** **Student-Athlete Initial**_____
   There are inherent risks associated with participation in intercollegiate athletics that include but are not limited to death, severe neck and spinal injuries, which may cause complete or partial paralysis, brain damage, severe internal injury, severe injury to bones, joints, ligaments, muscles tendons, and other aspects of the musculoskeletal system. Additionally, there are risks associated with concussions, eye trauma or injury, environmental conditions such as heat or cold illness and dermatologic conditions. It is understood that such injuries may result in serious impairment of future abilities to engage in activities of normal daily living.

2. **Athletic Medical Clearance** **Student-Athlete Initial**_____
   All student-athletes must complete and pass a pre-participation physical examination (PPE) scheduled and administered through the sports medicine staff, Georgia Tech Sports Medicine team physician or his designee. The PPE, which is effective for the duration of the academic year, will be arranged after preliminary academic eligibility has been provided to the athletic administration. At any time the team physician may re-examine the student-athlete and change his or her status should the situation warrant.

3. **Medical Treatment** **Student-Athlete Initial**_____
   In accordance with NCAA rules, Georgia Tech Sports Medicine Department may provide a student-athlete's medical expenses resulting from any injury or illness regardless of whether the injury or illness occurs during the academic year or summer period. It is the policy of the Georgia Tech Sports Medicine to provide student-athlete medical expenses for those injuries or illness that are the result of athletic practice or competition. The Georgia Tech Sports Medicine Department will not provide medical expenses for illness or injury resulting outside your collegiate sport.

   Student-athletes must report injuries/illnesses occurring as a result of practice/competition to the athletic trainer. The Georgia Tech Sports Medicine Department or Athletics Department will not be responsible for payment of charges resulting from injuries/illness not reported.

4. **Sickle Cell Trait Screening** **Student-Athlete Initial**_____
   In accordance with NCAA mandates, ALL student-athletes must be tested for sickle cell trait prior to any athletics participation. I acknowledge that I have read and understand the NCAA Sickle Cell Trait Fact Sheet and will either 1. Provide proof of sickle cell testing performed at birth, or 2. Return results of a recent lab screening (blood test), along with medical forms. I understand that there are NO exceptions to this policy and that failure to provide results may result in delayed athletic medical clearance.

5. **Insurance** **Student-Athlete Initial**_____
   Neither Georgia Tech Sports Medicine Department nor Georgia Tech Athletics are primary insurance providers. It is the policy of the Georgia Tech Sports Medicine Department that all student-athletes submit primary and secondary insurance information. If an injury occurs, your insurance information will be submitted to the prospective provider. The provider will then file with your personal group insurance. The Georgia Tech Athletics secondary insurance or the Sports Medicine Department will pay the difference and you will incur no cost for an intercollegiate injury. This should not affect your policy premium and in many cases will help you meet your existing deductibles.

6. **Georgia Tech Sports Medicine Policies and Procedures** **Student-Athlete Initial**_____
   I have read and understand all Georgia Tech AT-SM policies and procedures. I further understand that the Georgia Tech Sports Medicine Department, specifically the Director of Sports Medicine and/or athletics administrators reserves the right to use discretion regarding student-athlete well-fare decisions on a case by case basis.

GEORGIA TECH SPORTS MEDICINE
INITIAL MEDICAL HISTORY
(INCOMING STUDENT-ATHLETE)

Please Print Legibly

Name:		**Sport:**	**GTID#:**
Sex: ☐ **M** ☐ **F**	**Birth Date (MM/DD/Year)**	**Age:**	**SS#:**
Race: ☐ **Caucasian** ☐ **Afro-American** ☐ **Asian/Pacific** ☐ **Alaskan/Indian** ☐ **Hispanic** ☐ **Other**_____			
Class: ☐ **FR** ☐ **SO** ☐ **JR** ☐ **SR** ☐ **5th**		**Athlete Cellphone #**	
Home Address:		**City/State/Zip:**	
Home Phone #:		**Athlete Email:**	
Parent/Guardian Name:		**Relationship to Athlete:**	
Parent/Guardian Home Address (if different from above):			
City/State/Zip:		**Parent/Guardian Primary Email Address**	
Parent/Guardian Primary Contact #: ☐**Mobile** ☐ **Home**		**Parent/Guardian Secondary Contact #:** ☐ **Mobile** ☐ **Home**	

GENERAL MEDICAL HISTORY (If YES, explain)	**YES**	**NO**
ARE YOU ALLERGIC TO ANY MEDICATIONS? If "YES", list medications		
ARE YOU ALLERGIC TO FOOD OR OTHER ITEMS? IF "YES", list items		
Asthma: If "YES", List Medication and Usage		
Diabetes:		
Epilepsy:		
Fainting Spells:		
Frequent Nose Bleeds:		
Heart Trouble-personal history:		
Rheumatic Fever:		
Hepatitis:		
Mononucleosis:		
Mental Illness/Nervous disorder:		
Anxiety:		
Eating Disorder:		
Prior or present substance abuse/counseling:		
Loss of pair organ:		
Pregnancy:		
Environmental Illness: (example: heat or cold illness)		
Family History: Sudden Death: (list family member below)		

ORTHOPAEDIC HISTORY (If YES, explain)	**YES**	**NO**
Hand/Fingers:		
Wrists:		
Arms:		
Elbows:		
Shoulder/Clavicle/Chest:		
Pelvis/Hips/Groin:		
Thigh(s)/Upper Leg:		
Knee(s):		
Lower Leg(s):		
Ankle(s):		
Feet/Toes:		
Spine/Back:		
Head/Neck:		
History of Stress Fractures:		
Concussions:		
If "YES" to concussions, list the # of incidences, dates & return to play		

Sickle Cell Trait Screening (attach screening results) ☐**Positive** ☐**Negative** ☐ **Unknown**

Have you had an eye injury? ☐ YES ☐ NO List injury and date	List serious illnesses, syndromes diseases or previous surgeries (explain)
Do you wear: ☐ Glasses ☐ Contacts Glasses: ☐ Reading ☐ Athletics Contacts: ☐ Hard ☐ Soft	List current medications (explain use)
Date of recent tetanus shot	Do you have body piercings? ☐ YES ☐ NO If "YES" list location(s)

READ BELOW AND SIGN

I verify that all of the above information is accurate and complete. I understand that failure to disclose previous medical conditions may result in removal from the team and/or loss of athletic-related financial aid. Also, I understand that the Georgia Tech Sports Medicine Department is not responsible for expenses related to pre-existing conditions that are not a direct result or occurred during athletic participation.

Signature of Athlete:	Date:
Signature of Parent/Guardian: (if S-A under age 18)	Date:

GEORGIA TECH SPORTS MEDICINE
CARDIOVASCULAR HEALTH QUESTIONNAIRE

NAME	SPORT	GTID#

Directions: Check (☑) the appropriate box and provide explain or list where applicable

FAMILY HEALTH

1. Has anyone in your family ever died suddenly before the age 55? ☐ YES ☐ NO
2. Has anyone in your family ever had a heart attack before the age of 55? ☐ YES ☐ NO
3. Have you or any relative been diagnosed as having Marfan's Syndrome? ☐ YES ☐ NO
4. Have you or any relative been diagnosed as having hypertrophic cardiomyopathy (HCM) or IHSS? ☐ YES ☐ NO

PERSONAL HEALTH

1. Have you ever fainted or "passed out" during exercise? ☐ YES ☐ NO

   Explain episode _____

2. Have you experienced chest pain, tightness, pressure or any discomfort during exercise? ☐ YES ☐ NO
3. Have you ever been told that you have high blood pressure? ☐ YES ☐ NO
4. Have you ever been told that you have a heart murmur? ☐ YES ☐ NO
5. Have your ever been told that you have a "heart problem"? ☐ YES ☐ NO
6. Does your heart ever beat fast or skip a lot of beats? ☐ YES ☐ NO
7. Have your ever been restricted from sports competition? ☐ YES ☐ NO

   Explain _____

8. Have you ever been hospitalized for any non-orthopaedic reason? ☐ YES ☐ NO

   Explain _____

9. List any/all supplements, herbs or proteins that you take, other than vitamins. ☐ YES ☐ NO

   List _____

I verify that all of the above information is accurate and up to date. I understand that failure to disclose previous medical conditions may result in removal from the team and/or loss of athletic financial aid. Also, I understand that the Georgia Tech Sports Medicine Department is not responsible for expenses related to previous conditions.

Name (signature) _____ Date _____

Parent/Guardian (signature) _____ Date _____

GEORGIA TECH SPORTS MEDICINE
WOMEN'S HEALTH QUESTIONNAIRE

NAME	SPORT	GTID#

Directions: Check (☑) the appropriate box and provide explain or list where applicable

MENSES

1. Age of first menstrual cycle _____ years old
2. Duration of menstrual cycle _____ days
3. Is your menstrual cycle regular? (regular=one per month) ☐ YES ☐ NO

   Explain (if not regular) _____

4. Are you currently taking birth control medication ☐ YES ☐ NO

   List birth control medication: _____

5. Do you ever experience the following during or in between your menstrual cycle? (check all that apply)

☐ Heavy Bleeding ☐ Severe Cramping ☐ Spotting ☐ Pain ☐ Discharge

OB/GYN

1. Have you ever had a gynecological exam? ☐ YES ☐ NO

   Date: _____

2. Have you ever had a pap smear? ☐ YES ☐ NO

   Date: _____

3. Have you ever had an abnormal pap smear? ☐ YES ☐ NO

   Date: _____

MEDICAL HISTORY

1. Have you ever been diagnosed with a stress fracture(s) ☐ YES ☐ NO

   Explain (include location of stress fracture, date, time missed from activity) _____

2. Have you ever been diagnosed with anemia? ☐ YES ☐ NO

   Explain (include information about diagnosis, medications, current condition) _____

NUTRITIONAL HISTORY

Do you consider yourself a vegetarian? ☐ YES ☐ NO

Do you take any supplements? (examples: multi-vitamins, calcium, iron, etc.)

List: _____

MEDICAL INSURANCE AND AUTHORIZATION FORM

STUDENT-ATHLETE INFORMATION

Athlete Legal Name_____	Sport _____
Social Security Number _____	Date of Birth _____
Email_____	Cell Phone _____

PARENT/GUARDIAN EMERGENCY & CONTACT INFORMATION

Father/Guardian_____	Mother/Guardian_____
Home Address_____	Home Address_____
City/State/Zip_____	City/State/Zip_____
Home Phone # (AC) _____	Home Phone # (AC) _____
Cell Phone # (AC) _____	Cell Phone # (AC) _____
Employer _____	Employer _____
Work Phone # (AC) _____	Work Phone # (AC) _____
Email_____	Email_____

PRIMARY INSURANCE INFORMATION

Policyholder's Name_____	Type of plan: HMO PPO POS Other_____
SS# _____ DOB_____	Coverage: Medical Pharmacy Dental Mental
Relationship to Athlete_____	
---	---
Please affix legible copy of Primary insurance card here (FRONT)	Please affix legible copy of Primary insurance card here (BACK)

_____**My son/daughter does <u>NOT</u> have medical insurance coverage.**

_____
Signature of Parent/Legal Guardian Date

AUTHORIZATION AND RELEASE OF INFORMATION STATEMENT

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief, the information contained is complete and correct as herein given. I hereby authorize the Georgia Tech Athletic Association to file a claim under the group medical policy or policies shown above on my/our behalf for an athletic injury I sustained. I authorize that amounts payable under this policy, for an athletically related injury, be paid directly to the medical provider or to the Georgia Tech Athletic Association.

Furthermore, I authorize and direct any physicians or medical facilities, insurance company, or other organization, institution or person, providing treatment, to disclose and release to government agencies, insurance carriers, Georgia Tech Athletic Association or others who are financially liable for my hospitalization and medical care, all information needed for payment to such providers. Additionally, I permit the aforementioned representatives to examine and make copies of all records relating to such care and treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Guardian Date

A FRONT AND BACK COPY OF YOUR INSURANCE CARD(s) MUST BE PROVIDED WITH THIS FORM

<u>Parents/Guardians please complete along with copies of insurance cards and return to</u>:
Gina Thompson, Athletic Insurance Coordinator (AIC), 150 Bobby Dodd Way NW, Atlanta, GA 30332-0455
Phone: 404-385-2960 Fax: 404-894-0695 Email: gthompson@athletics.gatech.edu

Rev. 6/2015

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
and Treatment with Banned Stimulant Medication

- Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
- Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting).

To be completed by the Institution:

Institution Name:_____

Institutional Representative Submitting Form:
Name_____
Title_____
Email_____
Phone_____

Student-Athlete Name_____
Student-Athlete Date of Birth_____

To be completed by the Student-Athlete's Physician:

Current Treating Physician (print name):_____
Specialty:_____
Office address_____
Physician signature:_____ Date_____

Check off that documentation representing each of the items below is attached to this report

- o Diagnosis.
- o Medication(s) and dosage.
- o Blood pressure and pulse readings and comments.
- o Note that alternative non-banned medications have been considered, and comments.
- o Follow-up orders.
- o Date of clinical evaluation: _____
- o **Attach written report summary of comprehensive clinical evaluation. Please note that this includes the original clinical notes of the diagnostic evaluation.**
  The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores.
  The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.