

Dear Returning Student Athlete and Parents,

On behalf of Northeastern University Sports Medicine Staff, we would like to welcome you back to Northeastern University. In order to be prepared for your return to campus, we ask that you complete all forms pertaining to your year of athletic eligibility. Please return those forms in an addressed stamped envelope to the following address:

Northeastern University
Sports Medicine Department
Attention: Medical Clearance
360 Huntington Ave.
219 Cabot Athletic Center
Boston MA, 02115

These forms will provide us with the pertinent information related to your medical history, which will allow for a more thorough and efficient physical examination. Please answer all the questions as fully and honestly as possible. Your health and safety are our primary concerns. All information will be handled in a confidential manner. The enclosed forms are as follows:

(Check box when completed)

- 1. Read and Understand Northeastern University Athletic Medical Insurance Coverage.
- 2. Completed Health Insurance Information for 2008-2009 Academic Year
Affixed copy of current insurance card. (front and back)
- 3. Completed with son/daughter Northeastern University Medical History & Pre-Participation Physical Examination Form (Returners)
- 4. Completed Northeastern University Department of Athletics FERPA Authorization for Release of Health Information.
- 5. Completed NCAA Drug-Testing Consent – Division I. (signature page only)
- 6. Completed Assumption of Risk. Signed and Dated.
- 7. Enclosed all Signed documents into an addressed envelope and mailed by indicated date below.

Please return the completed forms by the dates listed below to allow us enough time to get your medical file prepared for your team's physical examination.

Fall Sports/If your report date is in August return forms by: **July 1, 2008**
Winter, Spring Sports/Return forms by: **August 15, 2008**

All Winter and Spring Sport Athletes are expected to check in on September 8, 2008.

You will not be given a physical examination or be able to participate until these forms are completed and returned. If you have any questions, please feel free to contact us at (617) 373- 8221.

Once again, welcome back to Northeastern University, and we look forward to seeing you again this fall.

Sincerely,

Northeastern University Sports Medicine Staff

Northeastern University Sports Medicine
Policy on Student-Athlete Insurance 2008-2009

Despite our very best preventative efforts athletic injuries will occur, many of which will require specialty medical services outside of the Sports Medicine department and the University Health and Counseling Service. It is important that you fully understand the policies regarding medical insurance coverage for athletic injuries.

All Northeastern University students are required to have a health insurance plan based in the United States (by Massachusetts law), and are automatically enrolled in the NUSHP plan upon registration at Northeastern University. You are however able to opt out of the NUSHP online at myneu.neu.edu, but only if you are enrolled in a comparable American based plan. International based travel policies are unacceptable. If you have a comparable insurance policy and do not wish to be enrolled in the NUSHP plan you must follow the proper steps to opt out it by the appropriate time **or** you will be billed for its cost. The NUSHP policy is currently through Blue Cross/Blue Shield of Massachusetts.

Northeastern University's Athletics and Sports Medicine Department strongly urges all student-athletes and their families to closely examine the access to care and benefits associated with an on-campus healthcare plan compared to their personal insurance plans, especially for out-of-state athletes. Visit www.bluecrossma.com/nushp to learn more about the NUSHP policy.

All medical expenses incurred for the treatment of illness or injuries are the responsibility of the student-athlete, regardless of how or where an injury occurs. The Athletic Department however, does have a secondary "athletic accident" insurance policy through NAHGA, underwritten by AIG. This policy requires us to submit claims for each individual athletic related injury and is designed to help cover medical expenses that your primary insurance does not. Claims must be for injuries that occur while a student-athlete is engaged in a NU athletic workout/practice/game. Illnesses and injuries from non- NU athletics events are not covered. For a more detailed description of the NAHGA plan, contact a member of the Sports Medicine staff.

The student-athlete is responsible for following proper insurance procedures. Northeastern University Sports Medicine does not pay medical bills, but we can help facilitate the proper procedure so bills do get paid.

Please follow the outlined steps when utilizing your primary insurance and the NAHGA policy after an athletic related injury:

1. When you become injured and a bill is generated (i.e. you see a doctor, get X-rays, etc) be aware of you primary insurance company's rules.
 - If an authorization or referral is required beforehand, get it – we can help.
 - Always have your insurance card available – present it to providers.
2. Be sure to fill out a NAHGA claim with a member of the staff as soon as possible.
3. If you have to pay anything up front (co-pays) for appointments or medications; keep receipts.
4. Look in the mail for "itemized bills" and "explanation of benefits"
 - Itemized bills have specific dates and codes on them for services – these are from providers.
 - Explanation of benefits (EOBs) are statements of what your primary insurance companies will pay to providers.
 - When you get these, bring them in to the sports medicine department. We will show you how to submit them with a claim form to NAHGA for payment.
 - Keep all correspondence from your insurance company and providers.

As always, if you have any questions, please ask a member of the Sports Medicine Staff. Please be advised that this information is our best current understanding of the process, and may change without notice.



Health Insurance Information for 2008-2009 Academic Year



I have read and understand the attached medical insurance procedure for student-athletes. This form must be signed and returned prior to clearance for athletic participation for your son/daughter. _____ Date: _____

Athlete's Name _____
Last First MI

M / F
(Circle)

Athlete's Home Address _____
City State Zip Code

Home Phone Number _____ Cell phone _____

Athlete's SS# - - _____ NU # _____

Sport(s) _____ Athlete's DOB ____ / ____ / ____

Does your insurance plan have a deductible? How much?

Does your insurance plan require a co-pay for services and/or prescriptions?

Complete Name of Primary Insurance Company _____

Insurance Address _____

Policy Holder's Name _____
Last First MI

Policy Holder's Address _____
City State Zip Code

Policy Holder's SS# - - _____ Policy Holder's DOB ____ / ____ / ____

Does this insurance company require pre-certification for the following services?
____ X-rays
____ MRI
____ Hospital Admission
____ Consultation outside of Network
____ Other: please list

Please copy the front and back of your primary insurance card and affix it below.

Front	Back
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ONLY COMPLETE THIS PAGE IF YOU WISH TO UTILIZE OR HAVE A SECONDARY INSURANCE POLICY

Complete Name of Secondary Insurance Company (if applicable) _____

Insurance Address _____

Policy Holder's Name _____
 Last First MI

Policy Holder's Address _____
 Number Street

 City State Zip Code

Policy Holder's SS# ____ - ____ - ____ Policy Holder's DOB ____ / ____ / ____ .

Does your insurance plan have a deductible? How much? _____
Does your insurance plan require a co-pay for services and/or prescriptions?
Does this insurance company require pre-certification for the following services? ____ X-rays ____ MRI ____ Hospital Admission ____ Consultation outside of Network ____ Other: please list

Please copy the front and back of your secondary insurance card and affix it below.

Front	Back
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MEDICAL HISTORY & PRE-PARTICIPATION
PHYSICAL EXAMINATION FORM

DATE: ____/____/____
Month Day Year

Athlete's Name: _____ Sports(s): _____
(Last) (First) (Middle) (Nickname)

Social Security No: ____/____/____ Date of Birth: ____/____/____
Month Day Year Age Sex Race (optional)

Student No: _____ Athletic Classification Fr. So. Middler Jr. Sr.
(NU assigned, Not Social Security No.)

e-Mail Address(es): _____

Local Apartment, Address, Dormitory, etc. _____

Cell Phone: _____

Permanent Address: _____

Home Phone: _____ Other Phone: _____

I. Father's or Guardian's Name: _____

Address: _____

(City) (State) (Zip)

e-Mail: _____

Home Phone: (_____) _____

Business Phone: (_____) _____

Cell Phone: (_____) _____

II. Mother's or Guardian's Name: _____

Address: _____

(City) (State) (Zip)

e-Mail: _____

Home Phone: (_____) _____

Business Phone: (_____) _____

Cell Phone: (_____) _____

III. In case of an emergency when parent/guardian cannot be reached contact: _____ Relationship: _____

Address: _____ (City) (State) (Zip)

Home Phone: (_____) _____ Business Phone: (_____) _____

Cell Phone (_____) _____ e-Mail: _____

IV. Name of family physician: _____ Business Phone (_____) _____

Address: _____ (City) (State) (Zip)

INTERIM MEDICAL HISTORY

1. Have you had any serious illness, disease, injury, operation, mental illness, infection, accident, or any other significant medical condition during the past year (12 months)? If yes, please explain.	YES	NO
2. Have you been hospitalized or examined by a physician other than a Northeastern University Sports Medicine physician for any type of medical condition during the past year (12 months)? If yes, for what reason?	YES	NO
3. Did you have any medical conditions or injuries that required surgery in the past year (12 months)? If yes, please explain surgery, including surgeon's name, date and location.	YES	NO
4. Are you currently taking any prescription medication? If so, for what purpose? Please list name and dosage of medication.	YES	NO
5. Have you had a concussion during the past year (12 months) that was not evaluated by either a Northeastern University Certified Athletic Trainer or a Northeastern University Sports Medicine physician? If yes, give an explanation, including dates and location.	YES	NO
6. Have you had any immediate relative die suddenly or be diagnosed with cancer in the past year (12 months)? If so, who was the relative and please describe the situation.	YES	NO
7. During the past year (twelve months) have you had any type of problem with tolerance to exercise (shortness of breath, fainting)? If yes, please give a brief explanation.	YES	NO
8. Do you know or have you ever had any heart problems (rapid heart beat, chest pain, murmur)? Please explain situation.	YES	NO
9. Do you wear contacts or glasses?	YES	NO
10. Are you currently injured or ill?	YES	NO

Complete the chart below giving details in the space provided if you sustained injuries or underwent testing or surgery during the past year (12 months).

HEART	YES	NO			
HEAD/FACE	YES	NO			
NECK	YES	NO	R	L	
SHOULDER	YES	NO	R	L	
ARM	YES	NO	R	L	
ELBOW	YES	NO	R	L	
FOREARM	YES	NO	R	L	
WRIST	YES	NO	R	L	
HAND	YES	NO	R	L	
FINGERS	YES	NO	R	L	
CHEST	YES	NO	R	L	
SPINE	YES	NO	R	L	
ABDOMEN	YES	NO			
PELVIS	YES	NO	R	L	
HIP	YES	NO	R	L	
THIGH	YES	NO	R	L	
KNEE	YES	NO	R	L	
LEG	YES	NO	R	L	
ANKLE	YES	NO	R	L	
FOOT	YES	NO	R	L	
OES	YES	NO	R	L	

GENERAL MEDICAL ALLERGIES: Please answer as to whether you are allergic to the following items.

Aspirin	YES	NO	Penicillin	YES	NO	Tetanus antitoxin or serums	YES	NO	Bee stings	YES	NO
Codeine	YES	NO	Erythromycin	YES	NO	Novocaine or other anesthetics	YES	NO	Fire ant bites	YES	NO
Sulfa Drugs	YES	NO	Ibuprofen	YES	NO	Hay Fever – dust/mold/pollen/grass	YES	NO	Wasps stings	YES	NO
Iodine	YES	NO	Acetaminophen	YES	NO	Oral Anti-inflammatory medication	YES	NO	Latex	YES	NO
1. Are you allergic to any other drug, medications, foods, plants, insects, etc. not listed above? If yes, please list those allergies here:										YES	NO
2. Have you ever had any reaction to Serum Drugs? If yes, please list the drugs and related details here:										YES	NO
3. Do you carry any type medication to control allergic reactions? If yes, please list the drugs and related details here:										YES	NO

NUTRITION, DRUGS, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS:

Check the appropriate space according to your use of the following products:

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY
Alcoholic Beverages				
Chewing Tobacco, Snuff, or Smokeless Tobacco				
Cigarettes, Cigars, or Pipe				
Vitamins				
Sleeping Pills				
Diet Pills				
Stimulants (Benzedrine, Amphetamines, etc.)				
Anabolic Steroids (growth stimulants)				
Amino Acids				
Creatine phosphate				
Decongestants				
Antihistamines				
Ephedrine				
Any other diet, nutritional or performance enhancing drug Please list:				

EATING BEHAVIORS:

1. Have you ever had a problem with food bingeing? If yes, when?	YES	NO
2. Has it ever been suggested or have you ever been diagnosed as being anorexic? If yes, when?	YES	NO
3. Have you ever been diagnosed as bulimic or having bulimia? If yes, when?	YES	NO
4. Do you sometimes or often induce vomiting after eating?	YES	NO
5. Have you or do you take laxatives to prevent being overweight?	YES	NO
6. Do you regularly lose or gain weight to meet weight requirements for your sport?	YES	NO
7. What is your highest weight in the past year? _____ Lowest weight? _____ What do you consider your ideal weight? _____		
8. Do you want to weigh more or less than you do now? _____		

If you have any additional conditions, problems, or comments that have not been addressed thoroughly in the above questionnaire, please use the space below to inform us so we may be able to better serve you with our best medical care.

All statements and answers in the above medical history questionnaire are true and completely represent my current health status to the best of my knowledge. I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this information is to help determine my fitness to participate in athletics, and to aid in the treatment and diagnosis of future injuries/illnesses that I may incur.	
SPORT(S): _____	PRINTED NAME OF ATHLETE: _____ (Last) (First) (Middle)
DATE: _____	SIGNATURE OF ATHLETE: _____

PLEASE READ THE FOLLOWING STATEMENTS THOROUGHLY AND SIGN

Statement: The National Collegiate Athletic Association's (NCAA) policies recommend that all student-athletes have a qualifying medical evaluation upon their initial entrance into an institution's intercollegiate athletic program. Northeastern University adheres to the NCAA policy. Further evaluation (subsequent to the initial qualifying exam) may be necessary in specific cases. A pre-participation history update will be performed annually and physical examination if indicated.

The undersigned here within,

- A. Understands that I must refrain from practice or play while ill or injured whether or not receiving treatment until I am discharged from treatment or given permission by the health care provider to restart participation despite continuing treatment.
- B. Understands that passing the physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me at the time of said exam.
- C. Acknowledges that ALL questions on this form have been answered completely and truthfully to the best of my knowledge.

Student-Athlete

Print

Signature

Date

Witness

Print

Signature

Date

TEAM PHYSICIAN CLEARANCE

As a current or prospective student-athlete at Northeastern University, I understand and agree to the following statement:

The Athletic Department of Northeastern University has a designated "Team Physician(s)". The physician has final approval or disapproval of my participation in intercollegiate athletics at Northeastern University. This includes, but is not limited to the following: pre-participation exam results and illness or injury prior to, during and post season. This decision may be in lieu of or in addition to recommendations by other physicians.

Printed name of Student-Athlete: _____

Signature of Student Athlete: _____ **Date:** _____

As the parent/guardian of the above-named athlete, I agree to the "Team Physician Clearance" statement:

Parent/Guardian signature (if student is a minor): _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF MEDICAL/PERSONAL INFORMATION:

I, _____, authorize Northeastern University and its employees and representatives to release pertinent personal and insurance information to any interested medical care provider and the coach of my sport. This information may need to be provided to interested persons in the event that I require medical care. This information may include, but is not limited to: my name, date of birth, social security number, insurance information, parent's telephone numbers, school and home addresses and emergency contacts.

I also authorize Northeastern University and any physician, certified athletic trainer or other health care provider retained by Northeastern University to release and discuss with the coach of my athletic team, the Northeastern University athletic administration or any interested health care provider, information concerning my past and present general health, provided that Northeastern University or any such health care provider has determined in its, his or her sole discretion that such information may be relevant to my ability to participate, or continue to participate, in any Northeastern University athletic program.

For good and valuable consideration, the receipt of which is hereby acknowledged, I release Northeastern University (including its offices, trustees, employees, agents and representatives) from any and all claims and liability arising from the release by Northeastern University or my medical records or other personal information in accordance with the terms of the foregoing authorization.

Student-Athlete signature: _____ **Date:** _____

I, _____, the parent/guardian (if student is a minor) of the above-named student-athlete agree to the "Authorization for release of medical/personal information" for my son/daughter.

Parent/guardian signature (if student is a minor): _____ **Date:** _____

Authorization For Release Of Medical Information

I hereby authorize the Northeastern University Sports Medicine Staff to access my medical records at the University Health and Counseling Services in circumstances where the records pertain to and/or affect my intercollegiate athletic participation status.

Student-Athlete's Name (Print)

Student-Athlete's Signature (Parent/Guardian if minor)

Date

ID Number/Social Security Number

Date of Birth

Assumption of Risk

Injury is an inherent aspect of sport. I understand that through my participation in the intercollegiate athletic program at Northeastern University I am subject to the possibility of injury, and also understand that by my participation, I accept the risk of possible injury.

I understand that those who are responsible for the conduct of my sport have taken reasonable precautions to minimize such risks.

This statement will remain in effect until such time as it is revoked in writing.

Printed Name

Signature

Parent/Guardian Signature if under 18

Date

NORTHEASTERN UNIVERSITY
DEPARTMENT OF ATHLETICS
FERPA Authorization for Release of Health Information for Varsity Intercollegiate Athletes

Name (Please Print)

Sport

Date of Birth

Social Security Number

TO: NORTHEASTERN UNIVERSITY ATHLETIC TRAINERS, PHYSICIANS, STRENGTH COACHES, SPORTS DIETICIANS AND OTHER RELATED PERSONNEL:

You are hereby authorized and requested to disclose information and records pertaining to my physical health or condition, whether past, present or future, including all physicals, physicians' records, athletic trainers' records, diagnoses, treatment information, histories, and prognoses, and including information and records pertaining to any and all injuries or illnesses to (i) Northeastern University Department of Athletics and its personnel (including coaches of my sport) who the University, in good faith, determines have a legitimate "need to know" and/or (ii) Northeastern University's team physicians; but only disclosing such information to the media as it relates to my ability to participate in my sport.

The purpose of this authorization is (i) to assist coaches and other personnel within the Department of Athletics in evaluating my fitness as it pertains to my ability to participate in my sport; (ii) to allow personnel within the Department of Athletics to assist me with respect to my athletic grant-in-aid or with respect to my academic progress; (iii) to assist Northeastern University's team physicians in providing medical care to me; (iv) to meet the requirements of insurers or health plans when such insurers require such information before paying for your health care services; and/or (v) to allow athletic training students and student physicians in training to participate in my medical care or to contribute to their educational training.

I hereby agree that the information that is used or disclosed pursuant to this Authorization may be redisclosed by the receiving entity. For example, information given to the media about my physical ability to play my sport will, in all likelihood, be redisclosed to their audience. By signing below, I specifically authorize and consent to all such redisclosures.

I understand that the information referenced above is protected by law and may not be disclosed without my consent. By signing this form, I certify that I agree to the disclosure of the records referenced above.

A copy of this authorization shall be considered as effective and valid as the original.

Student-Athlete Signature

Signature of Parent/Guardian if Student-Athlete
is Under 18 Years of Age

DATE: _____

DATE: _____