John Jay College of Criminal Justice
Sports Medicine Department

John Jay College of Criminal Justice Student-Athletes:

Attached you will find important forms and information regarding your athletic participation at John Jay College of Criminal Justice. Please print all forms legibly. All of the information must be completed in full so that in the event you are injured, we can deliver the best treatment, make the proper referral, and provide the medical provider with necessary information. In addition, it is a sports medicine department requirement that we have a photocopy of your insurance card on file

John Jay College of Criminal Justice has a secondary athletic accident insurance policy. This policy provides secondary insurance coverage for injuries you may incur while participating in an intercollegiate sport. Please note the NCAA does not allow coverage for injuries or illnesses that are pre-existing in nature. Our policy does not cover the following situations and/or circumstances:

- Athletic injuries or illnesses that are pre-existing in nature
- Chronic or Overuse injuries
- Medical Illnesses such as Mononucleosis, Strep Throat, Influenza, etc.
- Athletic injuries that are not directly related to John Jay College intercollegiate sport participation
- Athletic injuries that are not directly reported to the Sports Medicine Staff in a timely manner

In addition, John Jay College will not be held responsible for any medical bills above and beyond the usual and customary cost as dictated by the insurance industry. Please understand that most universities operate under the same regulations.

In the event you sustain an injury which is eligible for secondary insurance coverage under the John Jay policy, the following steps will occur:

1) We file an injury report with our insurance company indicating a legitimate claim may be forthcoming.
2) You or your parents/legal guardians are responsible for submitting any bills to your primary insurance plan if the medical provider does not do so.
3) Once bills have been submitted, your insurance carrier will send you or your parents an Explanation of Benefits (EOB) showing what has been paid to the medical provider. Please forward a copy of this EOB and any bills to the attention of the Head Athletic Trainer in the sports medicine department.

The insurance agency will make requests directly to you or your parents/legal guardians for any information needed to process the claim. At no time will the school be responsible for securing the needed information.

Lastly, please note that if your primary insurance coverage is through an HMO or PPO, you must see a physician within your network or follow proper procedures required by your plan in order for your insurance and the university's insurance to satisfactorily complete its portion of the claim. Failure to follow the proper procedures may nullify benefits.

I HAVE READ AND UNDERSTAND THE INFORMATION STATED ABOVE

Student-Athlete's Signature: _____ Date: _____

John Jay College of Criminal Justice

Sports Medicine Department

Personal Information

Name:_____ **Date:**_____
Social Security #:_____ **Date of Birth:**_____
Sport:_____ **Year in School** (please circle one)**:** FR / SO/ JR / SR

Address: _____
City: _____
State, Zip: _____
Phone #: _____
Cell #: _____
E-Mail: _____

Person to notify in the event of an EMERGENCY
Name:_____ **Relation:**_____

Daytime Phone:_____ **Evening Phone:**_____

Insurance Information

I am covered under the following person's insurance policy:
□ Myself * □ Spouse* □ Mother □ Father □ No Coverage
*If covered by your own or your spouses insurance please place info on the lines provided for parents/guardians.

Mother/Guardian Information		Father/Guardian Information
_____	Social Security #	_____
_____	Date of birth	_____
_____	Address	_____
_____	City, State, Zip	_____
_____	**Insurance Company**	_____
_____	**Address**	_____
_____	**City, State, Zip**	_____
_____	**Group #**	_____
_____	**Policy #**	_____
_____	**Phone #**	_____

□ Yes □ No	Is this plan an HMO or PPO?	□ Yes □ No
□ Yes □ No	Is pre-authorization required to obtain treatment?	□ Yes □ No
□ Yes □ No	Is a second opinion required before surgery?	□ Yes □ No

In signing this document, I certify that the answers to the above questions are correct. I understand that is my responsibility to notify the appropriate departments if any of the information should change over the course of the year.

Signature of Athlete: _____ Date:_____

Signature of Guardian: _____ Date: _____
(Required if Athlete is a minor)

John Jay College of Criminal Justice

Sports Medicine Department

Release of Records Authorization

Send Info To: Theresa D. Acosta MS, ATC
Head Athletic Trainer / Athletic Department
John Jay College of Criminal Justice
899 10th Avenue
New York, NY 10019-1069
Office: (212) 237-8324
Fax: (212) 237-8474
E-mail: tacosta@jjay.cuny.edu

I, _____, hereby authorize the release of the following information to the John Jay College of Criminal Justice Sports Medicine Department.

(Please place your initials on the appropriate lines)

_____ Initial evaluations
_____ Progress Notes
_____ Consultation reports
_____ Treatment summary
_____ Diagnostic test results
_____ All information
_____ Psychological reports
_____ History/Physical exam
_____ Correspondence notes
_____ Entire medical record
_____ Billing records
_____ Other

I further authorize John Jay College of Criminal Justice Sports Medicine Department and its designated agents to discuss or distribute this information as needed.

I understand that I sign this form voluntarily and that I may change my mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This consent form will expire (1) one year following the date signed.

Signature of Athlete: _____ Date: _____

Signature of Guardian: _____ Date: _____
(Required if Athlete is a minor)

Signature of Athletic Trainer: _____ Date: _____

John Jay College of Criminal Justice

Sports Medicine Department

Medical Information Waiver

I, _____, hereby give permission to the medical staff of John Jay College to release and discuss medical conditions that may occur through participation in athletics with John Jay College to the following people.

(Please give consent by placing your initials on the appropriate lines)

_____ Director of Athletics

_____ Coaching Staff

_____ Opposing team trainer

_____ Parent, Guardian or Spouse

_____ Insurance Company

_____ CUNY Conference Administrators

I understand that the information, or some portion thereof, that may be disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This authorization form will expire (1) one year following the date signed.

Signature of Athlete: _____ Date: _____

Signature of Guardian: _____ Date: _____
(Required if Athlete is a minor)

Signature of Athletic Trainer: _____ Date: _____

John Jay College of Criminal Justice

Sports Medicine Department

Assumption of Risk and Medical Consent

I, _____, verify that I have been informed that I may be injured while participating in any intercollegiate athletic practice or competition. I understand that it is possible that I may sustain an injury which may result in permanent disability, paralysis, or possibly death. In addition, I understand that an injury to any of my body joints (ankle, knee, hip, spine, shoulder, etc.) may result in disfigurement, loss of movement, strength, or feeling which may last my entire lifetime.

I understand that it is my responsibility to adhere to all the rules and regulations of my chosen sport. I understand that any infraction of these rules and regulations may result in injury to my opponent or me. I also understand that no modification of protective equipment or uniform should be made. In addition, I understand that it is my responsibility to report faulty or poor fitting equipment immediately to the coach, equipment manager, or athletic trainer.

I understand that all injuries and illnesses are to be reported to the athletic trainer. I understand that I am responsible for the follow-up medical care and treatment of my injuries under the supervision of the sports medicine staff.

I hereby grant permission to John Jay College of Criminal Justice Sports Medicine Staff, team physicians, and/or their consulting physicians to render any medical treatment or surgical care they deem reasonably necessary to my health and well-being. In the event that hospitalization is required, I freely give my permission for hospitalization at an accredited hospital.

Consequently, I hereby authorize John Jay College of Criminal Justice Sports Medicine Staff who are under the direct supervision of a board certified physician to render any preventative treatment, first aid, rehabilitation, or emergency treatment that they deem reasonable and necessary to my health and well-being.

I understand that the information, or some portion thereof, that may be disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I accept these risks of athletic participation in _____ (Sport) and herby give my consent for medical treatment.

Signature of Athlete: _____ Date: _____

Signature of Guardian: _____ Date: _____
(Required if Athlete is a minor)

Signature of Athletic Trainer: _____ Date: _____

John Jay College of Criminal Justice

Sports Medicine Department

Medical History

The information provided remains confidential within the John Jay College of Criminal Justice Athletic Department in a *secured* medical file in the Sports Medicine Office.

Name:_____ **Date:**_____
Sport:_____ **Year in School:**_____
Social Security #:_____ **Date of Birth:**_____
Home Phone Number: _____ **Cell Phone Number:** _____

Have Any Blood Relatives Ever Had:
(PLEASE CHECK ALL THAT APPLY AND LIST WHICH RELATIVE)

Blood Diseases (Sickle Cell, Leukemia)	
Cancer	
Diabetes	
Drug and/or Alcohol Dependency	
Epilepsy	
Gout	
Heart Disease	
Hemophilia	
High Blood Pressure	
Mental Disorders	
Stroke	
Sudden Death (Before Age 55)	
Tuberculosis	

GENERAL MEDICAL HEALTH HISTORY
Have you EVER had or been diagnosed with the following medical conditions?
(PLEASE CHECK ALL THAT APPLY)

Abnormal Bruising		Cancer		Hernia	
Abnormal Bleeding		Concussion		Herpes (Genital)	
Air or Car Sickness		Constipation (Frequent)		Herpes (Oral)	
Anemia		Diabetes		High Blood Pressure	
Appendicitis		Eating Disorder		HIV/AIDS	
Arthritis		Elevated Cholesterol		Joint Inflammations	
Asthma		Gastrointestinal Bleed		Kidney Problems	
Birth Defects		Goiter, Thyroid Disease		Loss of Memory	
Bladder Infections		Headaches (Frequent)		Meningitis	
Blood in Urine		Hearing Defect/Loss		Migraine Headaches	
Blood Disease		Heart Trouble/Murmur		Mononucleosis	
Blood Clots		Hemorrhoids		Mumps	
Bronchitis		Hepatitis		Muscular Disease	

Nervous Stomach	
Nose Fracture	
Pneumonia	
Respiratory Infections	
Ruptured Organs	
Seizure Disorder/Epilepsy	

Sickle Cell Anemia/Trait	
Shingles	
Skin Disorders	
Tuberculosis	
Tumor, Cyst	
Ulcer	

Urinary Infections	
Chicken Pox	
Other	

Do you CURRENTLY have any of the following SYMPTOMS or PROBLEMS? (PLEASE CHECK ALL THAT APPLY)

Frequent Headaches	
Recurring Coughing	
Frequent Diarrhea	
Visual Changes	
Poor Concentration	
Chest Pain	
Rectal Bleeding	
Ringing in Ears	

Abdominal Pain	
Loss of Energy	
Sore Throat	
Muscle Cramps	
Anxious Feelings	
Trouble Sleeping	
Sinus Congestion	
Frequent Nausea	

Loss of Appetite	
Increased Appetite	
Excessive Worry	
Breathing Difficulty	
Frequent Vomiting	

ALLERGIES - Are you allergic to...? (PLEASE CHECK ALL THAT APPLY)

Anti-Inflammatories	
Aspirin	
Codeine	
Cortisone	
Hay Fever	
Insect Bites/Stings	
Nail Polish or Cosmetics	
Novocain/Anesthetics	

Penicillin	
Sulfa	
Tetanus Antitoxin or Serums	
Any Foods:	
Any Other Drugs:	
Other:	

PSYCHOLOGICAL/NEUROLOGICAL
Have you ever been treated for , diagnosed, or sought medical help for the following conditions? (PLEASE CHECK ALL THAT APPLY)

Alcohol Abuse/Addition	
Anorexia	
Anxiety Disorder	
ADD	
Bipolar Disorder	
Bulimia	
Chemical Dependencies	
Depression	
Disorderly Eating	
Drug Abuse/Addiction	
Dyslexia	
Epilepsy	

Gambling Addiction	
Learning Disabilities	
Narcolepsy	
Obsessive Compulsive Disorder	
Psychological Counseling	
Schizophrenia	
Spina Bifida	
Tourette's Syndrome	
Other:	

INTERNAL

Were you born with a complete and functional pair of organs (eyes, kidneys, ovaries/testicles, lungs)? **Yes** **No**

If not, which organs were involved? _____

Have you ever had surgery to repair or remove any organ (hernia, tonsils, appendix, spleen, etc.)? **Yes** **No**

Please list all surgeries:

_____

_____

CARDIAC - Have you ever. .

Felt dizzy, light-headed or passed out during or after exercise?	**YES**	**NO**
Had chest pain while exercising?	**YES**	**NO**
Had an irregular heart beat or heart palpitations?	**YES**	**NO**
Been told you have a heart murmur?	**YES**	**NO**
Been seen by a heart specialist (cardiologist)?	**YES**	**NO**
If yes? Who: Date:		
Had an echo-cardiogram (EKG)?	**YES**	**NO**
Had a heart stress test?	**YES**	**NO**

VISION

Have you ever been to an eye doctor?	**YES**	**NO**
Date of last visit: _____		
Do you wear glasses now?	**YES**	**NO**
Do you wear contact lenses?	**YES**	**NO**
Will you wear contact lenses/glasses to participate?	**YES**	**NO**
Have you ever had an eye injury?	**YES**	**NO**

DENTAL - Do you now have or have you experienced any of the following?

Do you have a bridge or false teeth?	**YES**	**NO**
Fractured a tooth?	**YES**	**NO**
Had a tooth knocked out?	**YES**	**NO**
Do you wear a mouth protector?	**YES**	**NO**
Do you wear orthodontic appliances?	**YES**	**NO**

HEAT - Have you ever experienced any of the following?

Trouble with dehydration	**YES**	**NO**
Heat Stroke	**YES**	**NO**
Heat Cramps (Due to fluid loss)	**YES**	**NO**
Heat Intolerance	**YES**	**NO**

DRUG, FOOD SUPPLEMENTS, AND MISCELLANEOUS AGENTS
(Place the appropriate letter, according to YOUR use of the following items. in the space provided)

N - Never **R** – Rarely **O** – Occasionally **F** - Frequently

Alcoholic Beverages	
Antihistamines	
Anti-Inflammatories	
Caffeine	
Diet Pills	

Laxatives	
Sleeping Pills	
Tobacco	
Vitamins	
Other:	

LIST ANY MEDICATIONS OR SUPPLEMENTS YOU TAKE ON A REGULAR BASIS

_____

_____

DIETARY HABITS

Have you ever been treated for anemia?	**YES**	**NO**
Have you ever been treated for an eating disorder?	**YES**	**NO**
If yes, what? _____		
Are you unhappy with your weight?	**YES**	**NO**
If yes, what would you like to weigh?_____		
Do you feel pressured to keep your weight low?	**YES**	**NO**
Have you ever tried to control your weight by any of the Following methods? vomiting, laxatives, diuretics, diet pills, fasting?	**YES**	**NO**
Are you a vegetarian?	**YES**	**NO**
Are there certain food groups you refuse to eat?	**YES**	**NO**
If yes, what? _____		
Do you have any questions about healthy weight control?	**YES**	**NO**

ORTHOPAEDIC HISTORY QUESTIONNAIRE
Have you ever injured or consulted a Doctor about an injury to the following body parts? (PLEASE CHECK ALL THAT APPLY)

Head	
Neck	
Spine	
Chest	
Back	
Low Back	
R - Shoulder	
L - Shoulder	
R - Upper Arm	
L - Upper Arm	
R - Elbow	
L - Elbow	
R - Forearm	
L - Forearm	
R - Wrist	
L - Wrist	
R - Hand	

L - Hand	
R - Fingers	
L - Fingers	
Hip & Pelvis	
R - Thigh	
L - Thigh	
R - Knee	
L - Knee	
R - Lower Leg	
L - Lower Leg	
R - Ankle	
L - Ankle	
R - Foot	
L - Foot	
R - Toes	
L - Toes	

Have you had or do you have any other medical problems or injuries not listed on this form?	**YES**	**NO**
Are currently receiving medical treatment for these conditions?	**YES**	**NO**
Is there any reason that you are not able to participate in athletics?	**YES**	**NO**
Has a doctor ever advised you not to participate in athletics?	**YES**	**NO**
Do you wish to discuss any condition or problem with a physician or athletic trainer?	**YES**	**NO**

If any of the last five questions above were answered with **YES**, please explain below:

_____

_____

WOMEN'S HEALTH HISTORY ***(FOR FEMALE ATHLETES ONL)***

Is your menstrual cycle regular?	**YES**	**NO**
Date of last period: _____		
Have you ever gone for more than 2 months without having a menstrual cycle?	**YES**	**NO**
If yes, for how long? _____		
Is heavy bleeding ever a problem?	**YES**	**NO**
Do you ever have bleeding between periods?	**YES**	**NO**
Are cramps a frequent problem during your period?	**YES**	**NO**
Past pregnancies/births?	**YES**	**NO**
Are you on birth control medication or hormones?	**YES**	**NO**
If yes, what brand name? How Long? _____		

The undersigned,

- Understands that any medical expense incurred due to the above pre-existing conditions and not directly attributable to athletic participation at John Jay College of Criminal Justice is their personal medical and financial responsibility.

- Understands that the athletic medical insurance here at John Jay College of Criminal Justice is only secondary coverage, which will cover the remaining balance on an athletic related injury only.

- Understands that it is his/her responsibility to report all injuries/illnesses to an athletic trainer as soon as possible.

- Understands that he or she must refrain from practice while ill or injured, as per athletic trainer or physician until he or she is discharged from treatment or is given permission to return to participation by the attending athletic trainer or physician.

- Understands that having passed a physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

- Certifies that the answers above are correct and true.

- Understands that it is John Jay College of Criminal Justice Athletic Department's Policy to allow the Sports Medicine Staff and its designated agents to inform and disclose my health and medical information to my Parent(s)/Legal Guardian(s), John Jay Coaches & Administrative Staff, the University Athletic department's Secondary Athletic Accident Insurance Company, and either the Parents'/Legal guardians' or my own medical insurance company.

Signature of Athlete: _____ Date: _____

Signature of Guardian: _____ Date: _____
(Required if Athlete is a minor)

Signature of Athletic Trainer: _____ Date: _____

John Jay College of Criminal Justice

Sports Medicine Department

Physical Form

The information provided remains confidential within the John Jay College of Criminal Justice Athletic Department in a *secured* medical file in the Sports Medicine Office.

Name:_____ **Date:**_____
Sport:_____ **Year in School:**_____
Social Security #:_____ **Date of Birth:**_____
Home Phone Number:_____ **Cell Phone Number:**_____

Height:_____ Weight:_____ B.P.:_____ HR:_____

History of Asthma: **YES** **NO** Glasses: **YES** **NO** Contacts: **YES** **NO**

Drug Allergies: _____

General Athletic Physical

Body Part	Normal	Abnormal	Comments
Head			
Eyes			
Ears			
Nose			
Throat			
Neck			
Thorax / Lungs			
Heart			
Abdomen			
Extremities			
Neurological			
Skin			

Physicians Comments: _____
_____
_____
_____

Is this patient physically capable of competing in Intercollegiate Athletics? **YES** **NO**

_____ _____
Physician's Name Date

_____ _____
Physician's Signature Office Phone Number

Name:_____ **Sport:**_____

Orthopedic Physical

Body Part	Normal	Abnormal	Comments
Neck			
Spine			
Shoulder			
Elbow			
Wrist			
Hand			
Chest			
Back			
Hip / Pelvis			
Thigh			
Knee			
Lower leg			
Ankle			
Foot			

Physicians Comments: _____

Is this patient physically capable of competing in Intercollegiate Athletics? **YES** **NO**

Physician's Name

Date

Physician's Signature

Office Phone Number

Physician's Address

Fax Phone Number