# Try-Out Emergency Notification / Health Insurance Form

**Please Print**

Athlete's Name: ______________________ Sport: ____________ School email: ______________

Athlete's Local Phone: ______________________ Athlete's Cell Phone: ______________________

Athlete's Address: ____________________________________________

City ______________________ State ______________ Zip ______________

Date of Birth: ______________ Soc. Sec. No. ____________ Student ID: ______________

| **Everyone must complete this Emergency Notification section** | | |
|---|---|---|
| Parent/Guardian or Spouse Name | | |
| Address | | |
| Phone Numbers (Work) | (Cell) | (Home) |

***In an emergency if parents/spouse cannot be reached, contact to following:***

Name ______________________ Relationship ______________ Phone Number ____________

***Medical Information***

Contact Lenses? ( Y or N ) Dental Appliances? ( Y or N ) Physical Impairments? ( Y or N )

Known Allergies ____________________________________________

Chronic Disabilities ____________________________________________

| **Are you covered by your parent's insurance (as a dependent)? If so, complete this section** | | | |
|---|---|---|---|
| Name of Parent/Guardian Health Insurance Company | | | |
| Address of Health Insurance Company | | | |
| Policy Number | Check One: | ☐ HMO | ☐ PPO |
| Name and Address of Employer | | | |

| **Are you self-insured? If so, complete this section** | | | |
|---|---|---|---|
| Name of Health Insurance Company | | | |
| Address of Health Insurance Company | | | |
| Policy Number | Check One: | ☐ HMO | ☐ PPO |

**I release from liability and waive my right to sue the Department of Athletics, the Athletic Medicine Team, State of California, the Trustees of The California State University, California State University San Marcos and their employees, officers, volunteers and agents (collectively "University") from any and all claims, including the Athletic Medicine Team and University's negligence, resulting in any physical injury, illness (including death) or economic loss I may suffer because of my participation in this try-out.**

I hereby certify by my signature that the above information is true, accurate and complete to the best of my knowledge.

______________________________________________

(Signature of Student)—Try-Out (Date)

California State University
SAN MARCOS

*Office of Athletics*

**Medical History Questionnaire for New Student-Athletes**

Name:_______________________________________Age:______________________Year:_____________________

Address:_________________________________________________________ Sport:_____________________

Phone:__________________________________________________________ Date: _____________________

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Are you currently under a doctor's care for any reason? | | | 17. Have you had any problems with eyes or vision? | | |
| 2. Have you ever been hospitalized? | | | 18. Do you wear glasses or contacts or protective eyewear? | | |
| 3. Have you ever had surgery? | | | 19. Do you use any special equipment? (splints, neck rolls, mouth guards, etc.) | | |
| 4. Are you currently taking any prescription medications and/or supplements? | | | 20. Has anyone in your family died of a heart problem or sudden death before the age of 50? | | |
| 5. Do you have any allergies? (Medications, bee stings, etc.) | | | 21. Do you have only one working organ of usually paired organs? (only one eye, kidney, etc.) | | |
| 6. Have you ever been dizzy or fainted during or after exercise? | | | 22. Have you ever sprained, broken , dislocated, or had repeated swelling or pain of any bones or joints? | | |
| 7. Have you ever had chest pain during or after exercise? | | | 23. Have you had any medical problems or injuries? (asthma, mono, diabetes, etc.) | | |
| 8. Have you ever had high blood pressure? | | | 24. Have you ever used an inhaler or taken any asthma medications? | | |
| 9. Have you ever been told you have a heart murmur? | | | 25. Any special instructions or precautions? | | |
| 10. Have you ever had a racing heart or skipped heartbeats? | | | 26. When was your last tetanus shot? _______ | | |
| 11. Have you ever had a head injury? | | | 27. Do you feel your emotional responses to situations have ever interfered with your athletic or competitive performance? | | |
| 12. Have you ever been knocked out or unconscious? | | | 28. Have you ever had difficulty balancing the demands on your time? | | |
| 13. Have you ever had a seizure? | | | 29. Are you happy with your weight? | | |
| 14. Have you ever had a stinger, burner, or pinched nerve? | | | 29. Has anyone recommended to you that you change your weight or eating habits? | | |
| 15. Have you ever been dizzy or passed out due to the heat? | | | 30. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 16. Do you have trouble breathing during or after exercise? | | | | | |

31. Have you ever had a bone/joint injury that required X-ray ☐ MRI ☐ CT ☐ Surgery ☐ Injections ☐ Rehabilitation ☐ Physical Therapy ☐ Brace ☐ Cast ☐ Crutches ☐

32. Are any of these bothering you currently? Head ☐ Neck ☐ Chest ☐ Shoulder ☐ Back ☐ Hand ☐ Wrist ☐ Elbow ☐ Forearm ☐ Hip ☐ Thigh ☐ Knee ☐ Ankle ☐ Shin/Calf ☐ Foot ☐

33. (Women only) Date of first menstrual period? ____________________ When was your last menstrual period? ____________________
When was the longest period of time between your periods during last year? ______________________________________________

Explain all "YES" answers by question number and indicate dates for each item (include any special instructions): ________________

____________________________________________________________________________________________________

*I, ________________________________________, hereby certify that the answers to the above health questionnaire are true.*
*(print name)*

Signature_______________________________________ Parent/Guardian Signature (If under 18)______________________________

(Student Athlete)

California State University
SAN MARCOS

*Office of Athletics*

## Pre-Participatory Physical Screening

**Name:**___________________________ **Sport**: ______________________________ **Today's Date:** ___________

**Date of Birth:** ____________ **Campus ID:** ________________

| | Satisfactory | | | Comments |
|---|---|---|---|---|
| | YES | NO | NE | |
| Height | | | | |
| Weight | | | | |
| BP____/ | | | | |
| General | | | | |
| Head | | | | |
| Vision | | | | |
| ENT | | | | |
| Dental | | | | |
| Chest | | | | |
| Heart | | | | |
| Abdomen | | | | |
| Genitalia | | | | |
| Skin | | | | |
| Ortho | | | | |
| Flex/Strength | | | | |

**While this does not constitute a complete physical nor replace the need for a periodic health evaluation by a family physician, this individual appears to be physically capable of participation in intercollegiate sports as of this date, except as indicated below.**

☐ Cleared for sport without restrictions

☐ Cleared with the following restrictions: ____________________________________________________________

☐ Cleared after completing evaluation/rehabilitation for: ________________________________________________

☐ Not Cleared Reason: __________________________________________________________________

Comments/Recommendations: ______________________________________________________________

Physician's Name:_______________________________Physician's Signature:__________________________________

Physician's Stamp: