

**MARIETTA COLLEGE ATHLETIC DEPARTMENT  
INSURANCE FORM**

Name of Student \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Sport(s) in which I will be participating \_\_\_\_\_ DOB \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
MC Address \_\_\_\_\_

I **have** registered with the Marietta College Health and Accident Insurance program  
 I **have not** registered with the Marietta College Health and Accident Insurance program  
 I verify that I have checked with my health insurance company and my son/daughter is covered under my plan while attending Marietta College & network HMO or PPO doctors are available in the Marietta area. My child is currently insured under the following plan:

**This form must be on file at the College before you can participate in any sport(s). The following questions must be answered in detail. This information is necessary in order to process insurance claims.**

Father's Name \_\_\_\_\_ Soc. Sec# \_\_\_\_\_ DOB \_\_\_\_\_  
Employed? Y \_\_\_\_\_ N \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Do you have group medical insurance coverage through your employer? Y \_\_\_\_\_ N \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_ Policy # \_\_\_\_\_  
Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Soc. Sec# \_\_\_\_\_ DOB \_\_\_\_\_  
Employed? Y \_\_\_\_\_ N \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Do you have group medical insurance coverage through your employer? Y \_\_\_\_\_ N \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Address \_\_\_\_\_ Policy # \_\_\_\_\_  
Phone # \_\_\_\_\_

Type of Plan (*check coverage if you have HMO, PPO, or Participating Provider Group*):  
 Health Maintenance Organization (HMO)       Standard Medical & Hospitalization Coverage  
 Preferred Provider Organization (PPO)       other (describe) \_\_\_\_\_

If you have medical insurance coverage, and your son/daughter is not covered or is partially covered due to policy limitations, please explain: \_\_\_\_\_  
\_\_\_\_\_

If your son/daughter has medical insurance coverage as an eligible dependent from your previous marriage, as mandated in a divorce decree, please give details for filing a claim: \_\_\_\_\_  
\_\_\_\_\_

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE & COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

Father/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Mother/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please return **this form & copy of insurance card** to: Sam Crowther, Sports Medicine,  
Marietta College, Marietta, OH 45750

DATE: \_\_\_\_\_

SPORT: \_\_\_\_\_

**Marietta College Sports Medicine Athlete History Form**

NAME (printed) \_\_\_\_\_ CLASS STATUS---- FR SO JR SR

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_ SEX: M F

EMERGENCY CONTACT/PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

The National Collegiate Athletic Association’s policies recommend that all student athletes have qualifying medical evaluations upon their initial entrance to an institution’s intercollegiate athletic program. Marietta College supports and adheres to this NCAA policy. Further medical evaluations may be required in specific cases.

**Drugs (More than occasional use)**

Birth control pills	YES	NO
Alcohol use	YES	NO
Tobacco use	YES	NO
Sedatives	YES	NO
Appetite suppressants	YES	NO
Hormones	YES	NO
Street Drugs	YES	NO
Antidepressants	YES	NO
Analgesics (ibuprofen, tylenol)	YES	NO

**Medications**

Are you currently taking any physician prescribed medications? YES NO

If so, what medications? \_\_\_\_\_

\_\_\_\_\_

**Prior Immunizations**

Tetanus Date \_\_\_\_\_

Polio Date \_\_\_\_\_

Smallpox Date \_\_\_\_\_

MMR Date \_\_\_\_\_

Please provide dates of vaccines or attach copy of immunization record.

**Known Allergies**

Penicillin YES NO

Sulfa Drugs YES NO

Bees or Insects YES NO

Any known food allergy \_\_\_\_\_

Any other known allergies \_\_\_\_\_

What is the reaction to the identified allergens? \_\_\_\_\_

\_\_\_\_\_

Do you carry any anaphylactic medication?

**Have you ever...**

Been knocked out or unconscious YES NO

Had a concussion YES NO

If yes, how many \_\_\_\_\_

Had a seizure YES NO

Been dizzy or passed out YES NO

Had frequent headaches YES NO

Had migraine headaches YES NO

**Have you ever.....**

Had a neck injury YES NO

Had a burner or stinger YES NO

Had a spinal injury YES NO

Had chronic back pain YES NO

Had chest pain with exercise YES NO

Had heart palpitations (flutters) YES NO

Had difficulty breathing YES NO

Had mononucleosis YES NO

Had a stomach ulcer YES NO

Had other GI problems YES NO

Had a hernia YES NO

Had a kidney or bladder infection YES NO

Had pneumonia YES NO

Had heat cramps/heat exhaustion YES NO

Had a mental illness YES NO

Had psychological counseling YES NO

Been depressed YES NO

Had an eating disorder YES NO

Had an eye injury YES NO

Had a dental injury YES NO

Had any skin problems YES NO

(ie; rashes, itching, severe acne, eczema)

Been advised to have a surgery you did not have?

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Personal Medical History and Family History**

Have you or anyone in your immediate family had any of the following conditions? If yes, please explain on the lines provided.

	YOU	FAMILY
Cancer	YES NO	YES NO
Heart Disease	YES NO	YES NO
Heart Murmurs	YES NO	YES NO
Stroke	YES NO	YES NO
High Blood Pressure	YES NO	YES NO
Sickle Cell Disease	YES NO	YES NO
Diabetes	YES NO	YES NO
Epilepsy	YES NO	YES NO
Asthma	YES NO	YES NO

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

**Orthopedic and Injury History**

For any body area listed below, please describe any significant injury to the area (sprains, strains, fractures, dislocations, surgeries, etc.) Please make special note of any incompletely healed injury.

Body Area	Description of Injury	Year of Injury
Head and Neck	_____	_____
Spine (Back)	_____	_____
Shoulder	_____	_____
Chest/Abdomen	_____	_____
Elbow/Wrist/Hand	_____	_____
Hip and Pelvis	_____	_____
Knee	_____	_____
Ankle and Foot	_____	_____

**Females Only**

Have you ever had menstrual irregularities	YES	NO
Do you suffer from severe menstrual cramping	YES	NO
Have you ever lost your menstrual cycle	YES	NO
Are you pregnant	YES	NO

**Consent for Medical Treatment**

I do \_\_\_\_\_, do not \_\_\_\_\_ give Marietta College medical staff the right to obtain medical history, perform pre-participation physical exams, and treat any injuries I may obtain while participating in a college sport. I understand that the athletic training staff will perform only those procedures that are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. If further measures are needed they will refer me to the specialist that is appropriate.

**Authorization to Release Information**

I do \_\_\_\_\_, do not \_\_\_\_\_ give consent for the Marietta College medical staff to release information to the coaching staff, emergency personnel, and other medical professionals as appropriate for the purpose of communicating the nature and status of injury sustained and treatment. I understand that I will allow the medical staff to make the best decision regarding return to play. I understand the College will not release my record to third parties without my consent, unless such release is required or permitted under this agreement or applicable law. This release remains valid until revoked by me in writing.

_____ Signature of Athlete	_____ Date	_____ Signature of Witness	_____ Date
_____ Signature of Parent/Guardian (if minor)	_____ Date		