USD Sport Club New Athlete Registration Steps

All Sport Club members are required to complete and submit all required registration forms. Follow the steps below to ensure you are registered. You will not be released to participate until ALL documents are completed.

**STEP ONE - Prior To Tryout**

- Sign Tryout Release of Liability Form prior to trying out
- Read Sport Club Participant Guidelines

**STEP TWO - Once you decide to join a Sport Club; Register as a Sport Club participant at**
http://www.sandiego.edu/campusrecreation/registration/clubs.php

- Fill In Registration Form Online
- Pay Your Club Dues when registering

**STEP THREE - Print out and fill in all Medical Information and Driver Forms at**
http://www.sandiego.edu/campusrecreation/sports_clubs/forms.php

- Complete Pre-Participation Health History Form-Take this to your physical appointment.
- Complete Physical. Take the completed Health History Form and blank Physical Form to the appointment.
  - Bring both the Health History and the Physical form back to USD Sport Club office along with your provider's business card.
- Sign Medical Consent form (submit the last two pages only - keep the rest!)
- Fill in Health Insurance Form and copy front and back of insurance card onto one page.
- Fill in Driver Form
- Attach all required documents listed on forms

<table>
<thead>
<tr>
<th>Health History Form</th>
<th>Physical Form</th>
<th>Provider Business Card</th>
<th>Medical Consent Form</th>
<th>Health Insurance Form</th>
<th>Copy of Insurance Card</th>
<th>Driver Form</th>
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- Return all completed forms and required documents in one packet to the Sport Club office at the Sport Center

**DUE DATE:** Must be submitted and approved prior to participation and/or practice.

The USD Campus Recreation Director's office reserves the right to decline an athlete packet for any reason. Incomplete packets will not be accepted and individuals are to refrain from participation until all completed materials have been received.
UNIVERSITY OF SAN DIEGO SPORT CLUBS
MEDICAL INSURANCE VERIFICATION FORM

I, ____________________________, desiring to participate with the above named club, understand that I am required to have personal medical insurance.

No student is permitted to practice or participate in any club activity until this form is completed and on file with the Director of Campus Recreation/Athletic Trainer. The student's signature alone is adequate if the student is 18 years of age or older. If the student is under 18 years of age, this form must be co-signed by a parent or guardian.

A photocopy of the student's medical insurance card front and back must be attached to this form. Please copy both the front and back onto one page.

Medical Insurance Carrier

Effective dates

Policy Number

Primary Insured

By signing this form I verify that I have the insurance listed above and will keep said insurance in force while participating on a Sports Club. If at any time, my insurance changes, I will notify the athletic trainer by submitting photocopies of my new card.

Signature

Date

If under the age of 18 parent co signature required.

Parent co-signature

Date

AGAIN: A photocopy of the student's medical insurance card front and back must be attached to this form. Please copy both the front and back onto one page.
University of San Diego-Sports Clubs

PRE-PARTICIPATION PHYSICAL HEALTH HISTORY

Take this form to your physical appointment.

Athlete Name: ____________________________       Today’s Date: ____________________________

Date of Birth: ____________________________    Student ID Number: ____________________________

Sex: ____________________________    Cell Phone: ____________________________

Email: ____________________________

Physical Exam Date: ____________________________

Local Address: ____________________________

Athlete Name: ____________________________

Date of Birth: ____________________________    Age: ____________________________

Parent/Guardian Signature (if athlete under 18 yrs):

Signature of Athlete: ____________________________

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.

Mark an “X” in one of the boxes below. Explain “Yes” answers below.

Circle questions you don’t know the answer to.

1. Has a medical provider ever denied or restricted your participation in sports for any reason? Why? ____________________________________________________________________________________________

2. If under 18 years of age

   Parent/Guardian Signature: ________________________________________________________________________________

   Signature of Athlete: ____________________________________________________________________________________

3. Are you currently taking any prescription or nonprescription (over-the-counter) medication or supplements? What & how often? __________________________________________________________________________

4. Are you using alcohol, tobacco, marijuana or illegal substances? (Disclosure in this form is not required: Please discuss with your provider.)

5. Do you have allergies to medicines, pollens, foods, or stinging insects? If so, What? __________________________________________________________________________________

6. Do you require medication for anaphylaxis?

7. If so, are teammates/friends aware of what your allergy is, medication location and how to assist you? __________________________________________________________________________________

8. Have you ever passed out or nearly passed out DURING exercise? __________________________________________________________________________________

9. Have you ever passed out or nearly passed out AFTER exercise? __________________________________________________________________________________

10. Have you ever had discomfort, pain, or pressure in your chest during exercise? __________________________________________________________________________________

11. Does your heart race or skip beats during exercise? __________________________________________________________________________________

12. Has a medical provider ever told you that you have (check all that apply):

   □ High Blood Pressure  □ A Heart Murmur
   □ High Cholesterol  □ A Heart Infection

13. Has a medical provider ever ordered a test for your heart (for example, ECG, echocardiogram)?

14. Has anyone in your family died for no apparent reason? __________________________________________________________________________________

15. Does anyone in your family have a heart problem?

16. Has any family member or relative died of heart problems or of sudden death before age 50? __________________________________________________________________________________

17. Does anyone in your family have Marfan syndrome?

18. Have you ever spent the night in a hospital? __________________________________________________________________________________

19. Have you ever had surgery?

20. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:

21. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:

22. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:

23. Have you ever had a stress fracture?

24. Have you been told that you have or you have had an x-ray for atlantoaxial (neck) instability?

25. Do you regularly use a brace or an assistive device?

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?

27. Is there anyone in your family who has asthma?

28. Have you ever used an inhaler or taken asthma medicine?

29. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?

30. Have you had infectious mononucleosis (mono) within the last month?

31. Do you have an rashes, pressure sores or other skin problems?

32. Have you had a MRSA infection?

33. Have you had a herpes skin infection?

34. Have you had a concussion?

35. Have you ever been hit in the head and been confused or lost your memory?

36. Have you ever had a seizure?

37. Do you have headaches with exercise?

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?

39. Has a medical provider ever told you that you or someone in your family has sickle cell trait or sickle cell disease?

40. When exercising in the heat, do you have severe muscle cramps or become ill?

41. Has anyone in your family had a heart murmur?

42. Have you had any problems with your eyes or vision?

43. Do you wear glasses or contact lenses?

44. Do you wear protective eyewear, such as goggles or a face shield?

45. Are you satisfied with your weight?

46. Are you trying to gain or lose weight?

47. Has anyone recommend you change your weight or eating habits?

48. Do you limit or carefully control what you eat?

49. Do you have any concerns that you would like to discuss with a medical provider?

50. Have you had a menstrual period?

51. How old were you when you had your first menstrual period?

52. How many periods have you had in the last 12 months?

EXPLAIN “YES” ANSWERS HERE:

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.

Signature of Athlete: ____________________________

Parent/Guardian Signature (if athlete under 18 yrs):

(If under 18 years of age)
USD - Sports Clubs -MEDICAL CONSENT INFORMATION - Athletic Medicine Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your information is personal and private.
We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. A medical record documenting the care of your athletic related and non-athletic related injuries and illnesses will be kept in a secure confidential area in the athletic training room. This notice applies to all of the records kept on file in the athletic training room.

Athletic Medicine Staff refers to all persons working under the direction of the director and medical staff of USD Health Center and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, student athletic trainers, and designated observing students. In addition it includes USD Public Safety.

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

USD medical staff may use or share your information for reasons directly connected to your treatment, payment for that health treatment or health plan operations. The information we use and share includes, but is not limited to: your name, address, personal facts, medical care given to you, and your medical history. Some actions we may take while caring for you include: checking your insurance eligibility and enrollment; approving and paying for health care services; checking the quality of care that you receive; and coordinating the care you receive. Some examples include:

For treatment: You may need medical treatment that requires us to get approvals from a health plan for consultations with specialists or surgeons. We will share information with doctors, hospitals, insurance companies and others in order to get you the care you need.

For health care operations: We may use information in your health record to judge the quality of the health care you receive. We also may use this information in audits, planning, and general administration.

B. OTHER USES FOR YOUR HEALTH INFORMATION

i. Your medical information regarding injuries or illnesses associated with your participation in Sport Clubs at USD may be shared with coaches, campus recreation, USD administration, and others as stated in a separate release, Sport Club Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

ii. Sometimes a court will order us to release your health information. We also will give information to a court, investigator, or lawyer under certain circumstances. This may involve disclosure and discussion of your health information with the University Risk Manager or attorneys employed/retained to represent the University.

iii. You or your doctor, hospital, and other health care providers may appeal decisions made about claims for your health care. Your health information may be used to make these appeal decisions.

iv. We also may share your health information with agencies and organizations that check how our athletic training department is providing services.

v. We must share your health information with government agencies when they are checking on how we are meeting privacy rules.

vi. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.

vii. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.

C. WHEN WRITTEN PERMISSION IS NEEDED

If we want to use your information for any purpose not listed in this notice, we must get your written permission. If you give us your permission, you may cancel or revoke it in writing at any time.

D. WHAT ARE YOUR PRIVACY RIGHTS?

i. You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.

ii. You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

E. COMPLAINTS If you believe that we have not protected your privacy and you wish to complain, you may file a complaint (or grievance) by calling or writing the Director of Campus Recreation: Gary Becker. gbecker@sandiego.edu   (619) 260-4276
USD Sport Clubs - MEDICAL CONSENT AUTHORIZATION FORM

Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Background:
This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

1. As a club athlete you enter into an agreement with Campus Recreation & Sports Clubs with unique rights and responsibilities. Sharing medical information about your injuries or illnesses with coaches, USD Campus Recreation and USD Administrators is helpful (such as when a coach is planning a roster for an upcoming competition).

2. Often other athletes are within hearing distance while you are being evaluated or treated in the training room or on the field for your athletic injuries and illnesses. We may also ask a teammate, roommate or friend to help monitor you for signs/symptoms of a concussion.

3. Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:
Athletic injuries and illnesses: This may refer to any injury or illness that impacts your ability to play and/or perform for University of San Diego Sport Clubs. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities.

Athletic Medicine Staff refers to all persons working under the direction of the director and medical staff of USD Health Center and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, student athletic trainers, and designated observing students. In addition it includes USD Public Safety.

Consent:
I, _____________________________, acknowledge that I have read and understand the Background and Definitions above and I have been given a copy of, read and understand a separate document “USD Notice of Privacy Practices”

I, _____________________________, hereby authorize University of San Diego and its athletic medicine staff (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my athletic injuries and illnesses to the following groups/persons:

List A: Groups/Persons
1. Campus Recreation Director
2. USD Campus Recreation Department Administrators including but not limited to
3. Teammates, Roommates and other Sport Club athletes
4. Parents or guardians
   I understand that the information released may have different purposes and is dependant on to whom the information is released.

List B: Purposes
1. Campus Recreation Department operations
2. Explaining the typical course of an injury or illness to a coach or another athlete
3. Informing concerned parents or guardians

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in Sports Club teams.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to campus recreation. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Printed Name of Sports Club Athlete

Signature of Sports Club Athlete

Sports Club Team

Date
University of San Diego  
Athletic Medical Examination-Sport Clubs  

M.D.'s or D.O.'s are the ONLY physicians approved to perform USD physicals.

<table>
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<tr>
<th>Name:</th>
<th>USD ID#:</th>
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Sport:  
Eligibility: Fresh Soph Jr Sr 5th Year+

I. I have not had any illness or injury; or developed any new symptoms since I completed the Health History Form on: ____________________________

Athlete Signature: ____________________________

II. Health Hx Form Reviewed: MD/NP/PA Initials ________

EXAM: Height: ________ Weight: ________ (% ) Pulse: ________ BP: _____/_____

Vision: R____/____ L____/_____ Corrected: Y N Pupils: Equal Unequal

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Dr. Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
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<tr>
<td>Eye/Ears/Nose/Throat</td>
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<tr>
<td>Neuro</td>
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<tr>
<td>Heart</td>
<td></td>
<td>Exam performed supine, standing, and with valsalva</td>
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<tr>
<td>Pulses</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<tr>
<td>Genitalia (males only)</td>
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<td>Skin</td>
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<tr>
<td>Musculoskeletal</td>
<td>Medical exam performed by:</td>
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<td>Neck</td>
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<tr>
<td>Back</td>
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<tr>
<td>Shoulder/Arm</td>
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<tr>
<td>Elbow/forearm</td>
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<td>Wrist/hand</td>
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<tr>
<td>Hip/thigh</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Leg/Ankle</td>
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<tr>
<td>Foot</td>
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<tr>
<td>Other</td>
<td>Stigmata of Marfan's?</td>
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Orthopedic exam performed by:

CLEARANCE:  

- **Cleared** - Based on my examination of this patient, I determine he/she can fully participate in sports clubs at USD.
- **Cleared after completing rehabilitation for:** ____________________________
- **Not cleared for:** ____________________________
- **Reason:** ____________________________
- **Clearance decision deferred pending further work-up or obtaining records.**

COMMENTS and RECOMMENDATIONS: ____________________________

ATTACH PHYSICIAN'S BUSINESS CARD HERE  
(physical is invalid without business card)

MD/NP/PA Signature: ____________________________ Date: ____________________________