

BSU MEDICAL HISTORY FORM

Name _____

Have you experienced any of the following conditions? (If yes, please explain)

Heat Illness (cramps; exhaustion; stroke): _____

Allergies : _____

DISEASE or ILLNESS

	Yes	No		Yes	No
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections/Stones	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Skin Infections	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Mono	<input type="checkbox"/>	<input type="checkbox"/>

PREVIOUS INJURIES

(please put year and explain on back)

Head

- _____ Concussion
- _____ Unconsciousness
- _____ Nose
- _____ Other

Neck

- _____ Fracture
- _____ Pinched Nerve
- _____ Strain
- _____ Other

Back

- _____ Fracture
- _____ Sprain
- _____ Strain
- _____ Disc
- _____ Other

PREVIOUS INJURIES

Shoulder

- _____ Dislocation
- _____ Fracture
- _____ Sprain
- _____ Strain
- _____ Tendinitis
- _____ Other

Elbow

- _____ Dislocation
- _____ Fracture
- _____ Sprain
- _____ Strain
- _____ Tendinitis
- _____ Other

Hand/Wrist

- _____ Dislocation
- _____ Fracture
- _____ Sprain
- _____ Strain
- _____ Tendinitis
- _____ Other

Continued...

BSU Medical History Form (Page 2)

Trunk

- _____ Abdominal Injury
- _____ Contusions
- _____ Other

Knee

- _____ Sprain
- _____ Strain
- _____ Patellar Pain
- _____ ACL
- _____ Meniscus
- _____ Bursitis
- _____ Other

Thigh

- _____ Fracture
- _____ Strain
- _____ Strains
- _____ Contusions
- _____ Other

Lower Leg

- _____ Fracture
- _____ Stress Fractures
- _____ Shin Splints
- _____ Tendinitis
- _____ Strains
- _____ Other

Ankle/Foot

- _____ Fracture
- _____ Dislocation
- _____ Sprain
- _____ Flat Feet
- _____ Tendinitis
- _____ Other

PLEASE EXPLAIN ANY OF THE ABOVE

List any medications you currently are taking: _____

Do you need surgery now or in the future? Yes _____ No _____

Do you have any dental problems? Yes _____ No _____

BEMIDJI STATE UNIVERSITY ATHLETIC PHYSICAL EXAM

Name _____ Sport _____
Last Frist M.I.

SS# _____ Age _____ Sex _____ BP _____ Ht. _____ Wt. _____

HISTORY:

Allergies: _____ Medications: _____

Hospitalizations / Surgeries: _____

Serious Accident or Illness: _____ Seizures: _____

Recreational Drug Use: _____

Contact Lens/Glasses: _____

Orthopedic Conditions: _____

CHRONIC ILLNESS: (Self/family--positives circled with explanation)

DM Ca Heart Prob. Hypertension Asthma Arthritis

IMMUNIZATION STATUS: Last DT _____

PHYSICAL: (Check if normal; describe abnormal findings)

Skin: _____

Extremities / MS: _____

HEENT: _____

Peripheral Pulses: _____

Neck / Thyroid: _____

Neuro: _____

Cardiovascular: _____

Hernia: _____

Abdomen: _____

Genitalia: _____

LAB: Urinalysis: _____ Hgb: _____

COMMENTS:

I have examined the above client and find him/her able to participate in intercollegiate athletics.

Date

Signature

BEMIDJI STATE UNIVERSITY SECONDARY INSURANCE FORM
PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University Bemidji State University

This form is to be completed by the
Parents, Guardians or Student.

Address PE Complex #29: 1500 Birchmont Dr NE
City Bemidji State MN Zip 56601

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____
Social Security No. or Passport No. _____ Date of Birth _____
College Address _____ College Phone () _____
Home Address _____ Home Phone () _____
City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name _____
Social Security No. _____
Address _____
Employer _____
Address _____
Telephone () _____
Medical Insurance
Company or Plan _____
Address _____
Policy Number _____
Telephone () _____

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

MOTHER/GUARDIAN INFORMATION

Mother's Name _____
Social Security No. _____
Address _____
Employer _____
Address _____
Telephone () _____
Medical Insurance
Company or Plan _____
Address _____
Policy Number _____
Telephone () _____

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

PLEASE COMPLETE AUTHORIZATION ON SECOND PAGE OF THIS FORM



First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)
(please print)

Name of Authorized Representative, or Next of Kin

Signature of Claimant (if claimant is 18 or older) Date
Kin Date

Signature of Authorized Representative or Next of Kin

Relationship of Authorized Representative or Next of Kin to Claimant



Authorization to Permit Disclosure of Personal Health and Insurance Information

I hereby authorize all athletic trainers and medical personnel on the Bemidji State University staff, including full-time, part-time, and consultants, to provide information concerning my health status, nature of injuries/illnesses, treatment given, and rehabilitation received to the following entities:

- My parents or guardians,
- My coaches,
- University personnel,
- Medical personnel,
- The media,
- Professional scouts.

This information is to be used for the sole purpose of advising persons of my health or injury status.

I authorize the release of medical information and records from all of my past or present health care/medical treatment providers to the Bemidji State University Athletic Training staff.

I hereby authorize Bemidji State University to disclose my insurance or medical information to medical providers or insurance companies for the purpose of obtaining forms or communications necessary to submit athletic insurance claims to Bemidji State University's insurance company.

I understand that this authorization is valid for the duration of my participation as a student-athlete for Bemidji State University intercollegiate athletics. I also understand that I may revoke this authorization at any time by notifying BSU athletics **in writing**. I further understand that any action taken on this authorization prior to receipt of revocation is legal and binding.

I understand that my information may or may not be protected from re-disclosure by the recipient of the information. If the recipient is not covered by privacy laws, the recipient could re-disclose the information. I agree to release BSU from any liability resulting from this re-disclosure.

I understand that I may request a copy of this signed authorization. I also understand that a copy of this release is valid to the same extent as an original.

Signature of Student-Athlete

Date

(PLEASE PRINT) Name of Student-Athlete

(If under 18) Parent/Guardian Signature

Student-Athlete's Date of Birth

**BEMIDJI STATE UNIVERSITY EMERGENCY CONTACT & INSURANCE
INFORMATION**

Completion of information on this form is required prior to participation in athletics at BSU

Name: Last _____ First _____ MI _____

SS# _____ Date of Birth: _____ Sport(s) _____

Permanent (Home) Address

Address _____

City _____ State _____ ZIP _____

Phone _____ Cell or 2nd Number _____

Local (On/Off-Campus) Address

Address _____

City _____ State _____ ZIP _____

Phone _____ Cell or 2nd Number _____

Emergency Contact Information:

Primary (Parent/Guardian)

Secondary (optional)

Name(s) _____

Name(s) _____

Address _____

Address _____

Home Phone # _____

Home Phone # _____

Work Phone # _____

Work Phone # _____

Relationship _____

Relationship _____

Medical Information

Alerts (allergies, diabetes, asthma, heart condition, etc.):

Primary Care Physician or Provider:

_____ Phone # _____

Insurance Information: A photocopy of the front and back of your insurance enrollment card is **required** prior to participation in athletics at BSU.

Insurance Company _____

Policy Number _____ Group Number _____

ID Number _____

ASSUMPTION OF RISK AND CONSENT FOR TREATMENT

I understand that while I am participating in intercollegiate athletics, there is an inherent risk of injury. I understand that the dangers and risks include, but are not limited to, death, serious head, neck, and spinal injuries, paralysis, injuries or impairment to the musculoskeletal system, general health, and well being.

Do to the possibilities of any injury and illness while participating in an official, organized intercollegiate athletic activity, I recognize and take responsibility for reporting all such injuries and illnesses, including signs and symptoms of concussions to the athletic training staff.

I hereby grant permission to the Bemidji State University Athletic Trainers and Team Physician's to render to myself (son/daughter) any preventative measures for injuries, first aid, treatment, rehabilitation, or emergency treatment that they deem reasonable and necessary to the health and well being of the student-athlete.

Date _____

Printed or typed name

Signature student-athlete

Parent/Guardian Signature (if student-athlete is under the age of 18)