

UNIVERSITY OF CENTRAL ARKANSAS  
Medical History Form

Sport: \_\_\_\_\_

INSTRUCTIONS: Please respond to each question. This form is required to be completed and returned BEFORE pre-season practice begins.

Name \_\_\_\_\_ Sex  M  F Birthdate \_\_\_\_\_ SSN \_\_\_\_\_  
Last First MI

Home Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_ Class:  Fr  Soph  Jr  Sr

Parent/Guardian's Name \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
(Other than parents)

Do you now or have you ever had any of the following conditions? (Place a check to the left of each item that applies to you.)

Has your physical activity been restricted during the past five years?  Yes  No

**Explain all that apply in explanation section below**

<input type="checkbox"/>	Albumin in Urine	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Headaches, Frequent	<input type="checkbox"/>	Multiple Concussions
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Neck Injury
<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Pleurisy (pleura inflammation)
<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	Heat Related Injury/Illness	<input type="checkbox"/>	Rectal Trouble
<input type="checkbox"/>	Bloody Urine	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Bone/Muscle/Joint Injury	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Infectious Mononucleosis	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Skin Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	Testicle absence or Undescended
<input type="checkbox"/>	Duodenal Ulcer	<input type="checkbox"/>	Liver/Gallbladder Disease	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Enlarged Spleen	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Menstrual Disorders	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Mental Illness (list)	<input type="checkbox"/>	Other Disorders (list)

EXPLANATIONS FOR ABOVE:(give month and year) \_\_\_\_\_

Allergy to drugs, foods, plant, others: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Immunization Dates: (most recent): Diphtheria \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Polio \_\_\_\_\_ Rubella \_\_\_\_\_ Tetanus \_\_\_\_\_

**PERMISSION TO PROVIDE MEDICAL TREATMENT AGREEMENT**

All physical activity has risks that may range from a fall, to muscle and ligament damage, to circulatory or heart disorders. I am duly aware of the risks and hazards that may arise through participation in said activity and that participation in said activity may result in loss of life, limb, property, or all. My decision to participate in the University of Central Arkansas intercollegiate athletic program is made voluntarily and willingly, with full knowledge of the attendant risks.

I HEREBY give my permission to undergo appropriate medical treatment for any injury or illness sustained or acquired while engaging in intercollegiate athletics at the University of Central Arkansas.

\_\_\_\_\_  
Student Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

# STUDENT-ATHLETE INSURANCE INFORMATION FORM

(Please Print Neatly all information in ink)

1. THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE COMPLETED, SIGNED AND RETURNED BEFORE THE STUDENT-ATHLETE MAY PARTAKE IN ANY INTERCOLLEGIATE ACTIVITY AT UCA.
2. A FRONT AND BACK ZEROX COPY OF YOUR INSURANCE CARD MUST BE RETURNED WITH THIS FORM, IF THE STUDENT-ATHLETE HAS COVERAGE.
3. ANY CHANGE IN INSURANCE STATUS MUST BE BROUGHT TO THE ATHLETIC TRAINING STAFF'S ATTENTION AS SOON AS POSSIBLE.

## NO INSURANCE COVERAGE

(Skip to section II if you have insurance coverage)

- SECTION I.** - By my signature I attest that I have **NO insurance coverage**, either through, Self, Employer, Spouse, Father, Mother, or Guardian.  
- I understand that if I gain coverage while participating in intercollegiate sports at UCA I will notify the Athletic Training Staff of my change in Coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## INSURANCE COVERAGE

(Section II does not need to be filled out if you do not have insurance coverage)

- SECTION II.** The student-athlete has coverage under: (circle one)- Self, Father, Mother, Guardian, Spouse.

### A. Personal Information of policy holder:

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Last First MI

Home phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Employers Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

### B. Insurance Information:

Name of Insurance Company \_\_\_\_\_

Group# \_\_\_\_\_ Policy # \_\_\_\_\_ Member # \_\_\_\_\_

Insurance Mailing Address (claims) \_\_\_\_\_  
Street City State Zip

Insurance Claims Services Phone # (\_\_\_\_) \_\_\_\_\_ or (\_\_\_\_) \_\_\_\_\_

IS YOUR DEPENDENT, SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your insurance require: A second opinion for surgery? Yes \_\_\_ No \_\_\_ : Is your primary a PPO? Yes \_\_\_ No \_\_\_  
Pre-Authorization for services? Yes \_\_\_ No \_\_\_ : Is your primary an HMO? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
(Initial) I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by: \_\_\_\_\_  
(Print Name)

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, including but not limited to copies of medical records, concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original.

\_\_\_\_\_  
(Student-Athletes Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent's/ Guardian's Signature)