

CALIFORNIA LUTHERAN UNIVERSITY  
Health Services and Athletic Training  
60 West Olsen Road, Thousand Oaks, CA 91360

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

YEAR: \_\_\_\_\_ - \_\_\_\_\_

ATHLETE INFORMATION FORM  
(All information contained within is confidential)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Campus Address: \_\_\_\_\_ Phone/Ext.: \_\_\_\_\_

Class: \_\_\_\_\_ Participated in sport at C.L.U. last year: (Circle) Yes / No

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Known allergies: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Physician Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

In case of emergency contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

I, \_\_\_\_\_, do certify that all information contained on this form is accurate to the best of my knowledge and agree to update information, as needed based on current circumstances.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature

DO NOT FILL IN. FOR HEALTH SERVICES AND TRAINERS ONLY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Body fat: Bi \_\_\_ Tri \_\_\_ SC \_\_\_ IC \_\_\_ Snellen: R 20/ \_\_\_\_\_

Corrective lenses: (Circle) Contacts (Soft/Hard) Glasses None L 20/ \_\_\_\_\_

Blood Pressure (Left arm, sitting): \_\_\_\_\_ / \_\_\_\_\_ Repeat B/P result: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

Hemoglobin (women): \_\_\_\_\_ Pre-admission physical on file: \_\_\_\_\_

Medical Exam: ( Heart, Lungs, Abdomen, Hernia): \_\_\_\_\_ Cleared

Not Cleared

M.D./N.P./PA. Signature \_\_\_\_\_ Date: \_\_\_\_\_

Orthopedic Exam: \_\_\_\_\_

Practice Status: Red  Yellow  Green  Play Status: Red  Yellow  Green

Orthopedist/Team Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICAL HISTORY

1. Have you ever had any type of seizure, or been informed by an M.D. that you have epilepsy? Yes  No   
If yes, give dates and medication taken: \_\_\_\_\_
2. Have you been diagnosed with hepatitis within the last three (3) years? Yes  No  If yes, give dates and details: \_\_\_\_\_
3. Have you been treated for any infectious virus within the last year? Yes  No  If yes, give dates and details: \_\_\_\_\_
4. Have you ever been diagnosed or treated for diabetes? Yes  No  If yes, give dates and details: \_\_\_\_\_
5. Have you been diagnosed with a heart murmur or other associated problem? Yes  No  If yes, give dates and details: \_\_\_\_\_
6. Have you had an illness or injury within the past year that required overnight hospitalization? Yes  No   
If yes, give dates and details: \_\_\_\_\_
7. Have you had an illness or injury that required surgery? Yes  No  If yes, give dates and details: \_\_\_\_\_
8. Have you ever been diagnosed with asthma or any other bronchial or respiratory ailment? Yes  No  If yes, please specify: \_\_\_\_\_
9. Have you ever been diagnosed as anemic or as having an iron deficiency? Yes  No  If yes, please specify: \_\_\_\_\_
10. Are you currently on any medications (including Birth Control)? Yes  No  If yes, please specify: \_\_\_\_\_
11. Have you any type of head trauma within the last year? Yes  No  If yes, please explain: \_\_\_\_\_

ORTHOPEDIC HISTORY

Please place a check (✓) next to body parts with prior injuries, specify right or left, and if necessary, explain below:

- |                    |                |             |                         |
|--------------------|----------------|-------------|-------------------------|
| _____ Back / Spine | _____ Shoulder | _____ Elbow | _____ Wrist             |
| _____ Hand         | _____ Fingers  | _____ Neck  | _____ Head / Concussion |
| _____ Hip          | _____ Thigh    | _____ Knee  | _____ Lower Leg         |
| _____ Ankle        | _____ Foot     | _____ Toes  | _____ Other             |

Comments:

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**INSURANCE INFORMATION**

Father/Guardian Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Father's Employer: \_\_\_\_\_ Work phone: (    ) \_\_\_\_\_  
Health Insurance Company: \_\_\_\_\_ Covers student? Yes/No (circle)  
Policy #: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Mother's Employer: \_\_\_\_\_ Work phone: (    ) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Covers student? Yes/No (circle)  
Policy #: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: (    ) \_\_\_\_\_

Is your insurance an HMO or PPO? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, whom have you designated as your primary care provider in the Thousand Oaks area?  
Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Student Has Own Health Insurance:  
Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

**STATEMENT OF INSURANCE COVERAGE**

Sports activities have varying degrees of risk of injury which participants should recognize by the nature of the activity. Students who participate in the intercollegiate sports program must show proof of personal health insurance that covers intercollegiate athletic injuries. All full time and/or undergraduates are enrolled in an illness and injury plan which will fulfill this requirement. If a student has a plan in their name or a plan through a parent's insurance, this will act as their primary insurance. C.L.U. has an insurance policy for all intercollegiate participants that covers expenses incurred in excess of the student's primary and secondary insurance. This policy covers only injuries that occur during official practice or games of the sport in which the athlete is participating and may exclude pre-existing conditions. Should an injury occur, you must report this to a certified athletic trainer. You must have an injury report on file and a claim form completed by a certified athletic trainer. Health Services will discuss your options for medical care on an individual basis and will assist students in accessing appropriate medical care. If there is a remaining balance due after your insurance has paid for your treatment, Health Services will guide students through submitting claims to the student and athletic insurance carriers. No bills are "paid automatically." It is the student's responsibility to ensure that bills are paid in a timely manner.

Authorization: I have read and understand the information above. I hereby authorize any hospital, physician or other person who had attended or examined or has in his possession records pertaining to my care, to furnish C.L.U.'s current student or athletic insurance company or its representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records and all other information requested. A photocopy of this authorization shall be considered as effective and valid as the original.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Signature of claimant)

If claim for minor, parent signature required. Otherwise, Insured must sign above.

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip code)

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ACCEPTANCE OF RISK

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I fully understand that while playing or practicing to play/participate in intercollegiate athletics for C.L.U., serious injuries can occur, such as head, neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the dangers and risks of playing and practicing to play/participate in intercollegiate athletics may not only result in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social, and recreational activities, and generally to enjoy life. As a participant, I knowingly accept this risk.

Because of the dangers of participating in intercollegiate athletics, I recognize the importance to follow the coaches' and trainers' instructions regarding playing techniques, training and other team/game rules, and agree to abide by such instructions.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

FOOTBALL ONLY: I also understand that while participating in intercollegiate football it is a violation of the NCAA football rules to use the helmet, which I am wearing, to butt, ram, or spear an opposing player, teammate or object, and such use can result in severe head or neck injury, paralysis or death to me as well as possible injury to an opponent or teammate. Also, I understand that no helmet can prevent all head and neck injuries that I might receive while participating in intercollegiate football.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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EMERGENCY MEDICAL CONSENT

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I give C.L.U. athletic coaches and Sports Medicine Staff (i.e., Certified Athletic Trainers, team physician, paramedics, or emergency room physicians) as our agent(s), permission to consent to an administer emergency medical treatment in the event of a serious or life-threatening injury. This consent includes any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is rendered under the general or special supervision of any physician and surgeon licensed hospital, whether such examination, diagnosis, treatment, or hospital care being required and gives our agent(s) the authority and power to give specific consent to any and all such examinations, diagnosis, treatment, or hospital care which the physician in his/her best judgment may deem advisable.

This authorization is given pursuant to Section 25.8 of the Civil Code of California.

Information collected on this form is used for the purpose of determining medical status. Information on this form, as well as medical information collected throughout the school year pertaining to the practice and play of intercollegiate athletics, will be reviewed by Health Services staff as well as the Athletic Trainers and Team Orthopedist.

I authorize CLU Athletic training, the Team Orthopedist, and Health Services to review and discuss medical information as necessary to establish medical clearance to participate in Intercollegiate Athletics. Medical information not directly related to my medical clearance will not be discussed unless specifically authorized by me. I understand that information will not be shared with individuals not listed above, without my consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature:  
(if minor) \_\_\_\_\_ Date: \_\_\_\_\_