Voorhees University

Health Services
PO Box 678
Denmark, SC 29042

Phone: (803) 780-1077
Fax: (803)-780-4644
swilliams@voorhees.edu

Voorhees University
Student/Athlete
Parent Information

Failure to complete all blanks will result in claims processing delays:
NOTE: Complete all blanks. If information is not available, indicate the reason (e.g. deceased, unknown)

1. Name of Athlete: ______________________________ Sport: ________________________
   Social Security #: ______________________________ Date of Birth: ___________________
   College Address: ____ Phone: _______________________
   Home Address: ____ Phone: _______________________
   City: ______________________ State: ___________________ Zip Code: _____________________

2. Father/Guardian: ___________________________ Mother/Guardian: ________________________________
   Social Security: ____________________________ Social Security:__________________________________
   Address: __________________________________ Address:____
   ____ ____

3. Employer: _____________________________________ Employer____
   Address: _____________________________________ Address____
   _____________________________________ _______________________________________
   Phone: ____ Phone:____

4.
5. Medical Insurance Company or Plan: Medical Insurance Company or Plan:
   ____________________________________ ____
   Address: _____________________________________ Address_______________________________________
   ______________________________________ ____
   Policy#: __________________________________ Policy#:____
   Group#: __________________________________ Group#:____

Is the company or plan listed above considered a Health Maintenance Organization (HMO), or a Preferred Provider Organization (PPO)?
Yes________ No________

Does your insurance company or plan require a second opinion before surgery? Yes_________ No_________

I hereby authorize Voorhees University to secure copies of case history records, laboratory reports, diagnosis, x-rays, and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize the college or its insurance agent to pay the medical vendors direct for any bills incurred from accidents that are covers by the college.

Parent's Signature: ____

Student Athlete's Signature: ____

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Medical History

Name:
____Date:_________________________________
Last   First   Middle
Sport: ______________________________ SS#: _________________ Age: ___________ Birthdate:_____________

Home Address: ____ Phone:_________________

School Address: ____ Phone:_________________

In Case of Injury Notify: ____ Phone: _________________

Family Doctor: ____ Phone: _______________

Past History (answer yes or no; DO NOT leave anything blank-if it does not apply put NA)

Diseases:
Rheumatic Fever______ Scarlet Fever________
Tuberculosis_________ Measles ____________
Mumps_____________ Hepatitis Epilepsy or
Mononucleosis_______ Convulsions__________

Surgery (list all operations and dates)
1. ___________________________________
2. ___________________________________
3. ___________________________________

Injures: (list type and date; athlete or otherwise)
1.____
2.____

Allergies:
Penicillin__________ Hay fever________
Sulfa Drugs________ Asthma_________
Novocain__________ Other___________

Present Medications (list any medications presently being taken)
1.____
______

2.____
______

Family History:
Father (age)______ Brothers (number and ages) _________
Mother (age)_____ Sisters (number and ages) ___________

Check following diseases if present in any family member
Diabetes ______ Heart trouble __________
Cancer ________ Blood diseases _________

Head:
Frequent Headaches_____ Frequent dizziness _____
Injures________________ Frequent fainting spells_____
Difficulty in heat________ # of times unconscious_____

Skin:
Excessive sweating_____ Discoloration___________
Rashes ______________ Temperature Changes____

Ears:
Hearing loss___________ Ringing_________________
Drainage______________ Tenderness______________

Eyes:
Wear glasses_________ Blurred vision________
Wear contacts________ Itching______________
Frequent infection_____ Contacts filled by______
Full address________________________________

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Mouth and Throat:
Dentist last seen (date)_____ Sore Throat_______
Abnormal bleeding_________ Tonsillitis__________
Frequent Infection__________
Wear mouthguard in HS________________________
Do you wear artificial teeth____________________
Frequent sore throats or colds__________________
Trouble swallowing___________________________
Wisdom Teeth-In_________ Out________ Hurt________

Cardiorespiratory:
Shortness of Breath______ Heart Murmur__________
Frequent cough_________ Ever cough up blood _____
Chest pain______________ Wheeze ______________

Neck:
Pain__________ Stiffness___________
Swelling_______ Limitation of motion_____

Gastrointestinal:
Frequent nausea_____ Frequent diarrhea_______
Frequent vomiting____ Frequent constipation____
Food allergies________ Abdominal pain_________
Indigestion__________ Hemorrhoids____________
Ever vomit blood_____

Genitourinary:
Painful urination______ Bloody urine_____
Frequent urination____ Hesitancy________
Urgency_____________ Venereal disease___

Nervous System:
Excessive nervousness_____ Paralysis_______
Impaired sensation________ Tremor________

Marital History:
Married_________ Single___________ Children____

To the best of my knowledge, the above statements are true.

Print name_____________________________________

Signature______________________________________

Date____

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Please Answer Each Question With a Yes or No

Have you ever had	Yes	No	If yes, give date and explain circumstances
Buriers or stingers			
Once			
Occasionally			
Frequently			
Shoulder sprain			
Shoulder separation			
Shoulder dislocation			
Shoulder operation			
Broken arm			
Elbow injury			
Broken wrist			
Jammed finger which is still swollen/painful			
Back injury			
Back pain when sitting			
Back pain when standing			
Back pain when bending forward			
Back pain when bending backward			
Hip pointer			
Hip problem			
Pulled muscle			
Broken leg			
Knee sprain			
Knee pain or swelling			
Knee locking or catching			
Knee giving away			
Ankle sprain			
Once			
Occasional			
Frequent			
Heel cord or Achilles tendon injury			
Foot problem			

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Flat feet			
High arches			
Heel pain			
Corn, Calluses			
Bunions			
Injured toes			

Voorhees University
Department of Athletics

Athletic Participation Examination

Name____ Sport_____________________________

SEX M / F Age__________________________
Class______________________________

General Information:

Ht.__________ Wt.__________ B/P__________ Pulse_________ Urinalysis__________

Physical Examination:

Examination	Normal	Abnormal
Ears		
Eyes		
Nose		
Throat		
Lungs		
Heart		
Abdomen		
Hernia		
Skin		
Head		
Neck		

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Shoulders		
Knees		
Spine		
Hips		
Elbows		
Hands		
Feet		
Ankles		

Physician's Statement

1. Approved for sports Yes_________ No__________
2. Approved pending further study.
Explain:____
____
3. Approved with limitations. Explain:
____
____
4. Disapproved comments:
____
____

Date____________________________

Signature________________________

Responsibility Waiver and Assumption of Risk of Liability

As an athlete, student, or staff member at Voorhees University, I agree that Voorhees University and/or the athletic department and their staff, coaches, trainers, or employees will not be held responsible or liable for any non-athletic accidents, injures, or loss of personal property, however caused, and agree to release the university from all claims or damage which may arise as a result of such non-athletic accidents or loss, or noncompliance when an individual does not follow the required treatment plan of the school or doctor to include all follow up visits and appointments.

It is further agreed that all risks attendant to watching and /or participating in any athletics at Voorhees University are assumed by the student athlete and his/her parents or guardian and that this assumption is acknowledged, approved by their signature below.

Date____

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Print name____

Signature____
If under the age of 18, parent or guardian's signature