



SPORTS MEDICINE

Hamilton

SPORTS MEDICINE  
Yearly Student-Athlete Information

Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Graduation Year \_\_\_\_\_

First Name \_\_\_\_\_ SS# \_\_\_\_\_

Campus Phone and/or Cell Phone Number \_\_\_\_\_

Sport(s) To Be Played \_\_\_\_\_

**YEARLY UPDATE** – *Please indicate if you have had ANY injuries during the past year:*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Knocked out or Concussion | <input type="checkbox"/> Kidney Injury/Blood in Urine | <input type="checkbox"/> Started taking Medicine          |
| <input type="checkbox"/> Fainted during Exercise   | <input type="checkbox"/> Hip Injury                   | <input type="checkbox"/> Dizzy during/after Exercise      |
| <input type="checkbox"/> Other Injury/Illness      | <input type="checkbox"/> Knee Injury                  | <input type="checkbox"/> Chest Pain during/after Exercise |
| <input type="checkbox"/> Neck Injury               | <input type="checkbox"/> Ankle Injury                 | <input type="checkbox"/> Racing of your Heart             |
| <input type="checkbox"/> Back or Spinal Injury     | <input type="checkbox"/> Broken Bones                 | <input type="checkbox"/> Skipped Heartbeats/ Murmur       |
| <input type="checkbox"/> Shoulder Injury           | <input type="checkbox"/> Gotten Dental Appliances     | <input type="checkbox"/> High Blood Pressure              |
| <input type="checkbox"/> Elbow Injury              | <input type="checkbox"/> Surgery                      | <input type="checkbox"/> High Cholesterol                 |

**FOR ALL CHECKED ANSWERS ABOVE, PLEASE GIVE DETAILS, INCLUDING DATES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

- Asthma
- Exercise Induced Asthma
- Mold, Pollen, Dust
- Penicillin
- Sulfa
- Bee Stings
- Other

Person to Notify in an Emergency \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Current Medications \_\_\_\_\_

**Insurance Information MUST be Completed**

Insurance Co \_\_\_\_\_ Identification Number \_\_\_\_\_

Phone Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is a referral for a specialist required?  Yes  No PCP Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

**I hereby certify that the answers to the above questions are true and correct and I authorize the release of the above information to Hamilton College Athletic Training Services.**

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