

**UNIVERSITY OF NEVADA, LAS VEGAS
ANNUAL HEALTH INFORMATION AND RE-EVALUATION**

Last name of student-athlete _____

First name of student-athlete _____

Sport _____

Local Address (Las Vegas) _____

City / State / Zip Code _____

Local Phone # _____

Cell Phone # _____

Social Security # _____

Year of athletic eligibility: Please circle: Freshman / Sophomore / Junior / Senior

Mother / Guardian Name _____

Mother / Guardian Home Phone # _____

Mother / Guardian Work Phone # _____

Mother / Guardian Address _____

Mother / Guardian City / State / Zip Code _____

Father / Guardian Name _____

Father / Guardian Home Phone # _____

Father / Guardian Work Phone # _____

Father / Guardian Address _____

Father / Guardian City / State / Zip Code _____

Emergency Contact / Name _____

Emergency Contact / Work Phone # _____

Emergency Contact / Home Phone # _____

Has your personal medical insurance changed from last year? Yes / No

**UNIVERSITY OF NEVADA, LAS VEGAS
RETURNING STUDENT-ATHLETE HEALTH QUESTIONNAIRE**

Name: (Please Print) _____ **Sport:** _____

This annual form must be completed and returned before the student-athlete will be permitted to practice or play. The National Collegiate athletic Association's policies recommend that all student-athletes have a qualifying medical evaluation upon initial entrance into an institution's intercollegiate athletic program, and an annual "health status" review. The University of Nevada, Las Vegas supports this NCAA policy. Further medical evaluations may be required for specific matters.

The following information is vital to adequately screen and medically clear athletes for continued participation in their sport. The purpose of this form is to update each student-athletes chart with significant information regarding injuries, medical conditions, symptoms of concern, and use of medication since the student-athlete's entrance physical exam.

IN THE PAST YEAR, have any of the following happened to you? (Answer all questions)

	Yes/No	If yes, explain.		Still a problem? Yes/No
1. Hospitalized for any reason?	___	_____		___
2. Surgery of any kind?	___	_____		___
3. Significant injury (fracture, dislocation, etc)?	___	_____		___
4. Other injury (sprain, strain, etc)?	___	_____		___
5. Recurrent back pain?	___	_____		___
6. Are you currently undergoing physical therapy or rehabilitation for an injury?	___	_____		___
7. Do you currently have any incompletely healed injuries?	___	_____		___
8. Use of medications for more than 10 days?	___	_____		___
9. Are you currently taking any prescription or over the counter medications or pills or using an inhaler?	___	_____		___
10. Allergic reaction to food, medication, or stinging insects?	___	_____		___
11. Been diagnosed with diabetes?	___	_____		___
12. Been diagnosed with epilepsy?	___	_____		___
13. Passed out during or after exercise?	___	_____		___
14. Chest pain or dizziness during or after exercise?	___	_____		___
15. High blood pressure and/or high cholesterol?	___	_____		___
16. Irregular heartbeats?	___	_____		___
17. Significant head injury / Concussion?	___	_____		___
18. Knocked unconscious?	___	_____		___
19. Seizures?	___	_____		___
20. Any shortness of breath with exercise? Wheezing	___	_____		___

	Yes/No	If yes, explain.	Still a problem? Yes/No
21. Chronic or recurrent cough with exercises?	_____	_____	_____
22. Loss or decreased function of any organ?	_____	_____	_____
23. Have you had any illness lasting a week or more such as mono or a chronic or recurring illness or infection?	_____	_____	_____
24. Have you had any blood disorder, including sickle cell trait, anemia (low blood), unusual bleeding, etc.?	_____	_____	_____
25. Asthma / seasonal allergies that require medical treatment?	_____	_____	_____
26. Menstrual problems / irregularities?	_____	_____	_____
27. Recurrent heat exhaustion?	_____	_____	_____
28. New onset or unusual headaches?	_____	_____	_____
29. Have you been treated or evaluated for an eating disorder?	_____	_____	_____
30. Have you been treated, or encouraged to seek treatment for an alcohol or substance / drug abuse problem?	_____	_____	_____
31. Would you like information or to speak with someone confidentially concerning these issues?	_____	_____	_____
32. Any other significant illness or problem?	_____	_____	_____
33. Do you know of, or do you believe there is any health reason why you should not participate in intercollegiate athletics at UNLV?	_____	_____	_____

The undersigned, herewith:

A. Understands that he or she must refrain from practice while ill or injured, whether or not receiving medical treatment until he or she is discharged from treatment or is given permission by the clinical practitioner to restart participation despite continuing treatment.

B. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

C. Acknowledge, affirm and represent that the answers to the above questions are correct and true.

Student-Athlete Signature: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT & DISCLOSURES

CONSENT FOR MEDICAL TREATMENT AND USES AND DISCLOSURES OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO) AT THE UNIVERSITY OF NEVADA, LAS VEGAS

I give my permission to the University of Nevada, Las Vegas to educate, interview, examine, perform laboratory procedures and to treat my condition, as they deem necessary. I understand that in case of a life-threatening emergency, this consent may be implied for the time of the emergency.

I understand that the University of Nevada, Las Vegas is a teaching institution, therefore athletic training students, medical residents, medical students, dental students, nurse practitioner students and nursing students may participate in my care under the supervision of a certified athletic trainer, physician/dentist or nurse practitioner. I understand that other outside medical professionals may also be consulted as deemed necessary for my care.

For coordination of my care and services, I understand that I may be provided with referrals to off campus specialists and the University of Nevada, Las Vegas may assist other treating physicians/dentists in provision of my care.

- **Informed Consent:** If my condition requires an outpatient surgical procedure, the practitioner responsible for my care will explain to me the procedure to be performed, the general nature and extent of risks involved in such procedure and the alternative methods, if any.
- **Consent for Minor Students:** If you are a minor, we must have the signature of the parent or legal guardian (appointed by a court of law) on this form before any general treatment may begin, and such consent must be effective until you reach legal age in the State of Nevada (18 years old). Your parent or legal guardian must sign this consent form and receive a Notice of Privacy.
 - ◆ **Exemptions to this consent are** a life-threatening emergency, treatment for emancipated minors with court supporting documents and per **NRS 442.255** and **NRS 129.060** for family planning and contraceptive methods, screening for sexually transmitted infections, counseling and treatment of alcohol and substance abuse.
- **Additional Uses and Disclosures of Health Information:** I understand and agree that the University of Nevada, Las Vegas may use or disclose protected health information for treatment, payment and operations in accordance with the Notice of Privacy Practices that I have received, and any posted amendments to that Notice. I understand that the University of Nevada, Las Vegas will not use or disclose protected health information for any purpose other than treatment, payment and healthcare operations, unless such person or entity is authorized to receive such information under law or I have provided a written authorization. (*See full explanation of disclosures and rights in the Notice of Privacy Practices*) If I am being treated while I am a student, I consent and agree that my health information may be used and disclosed in accordance with the Notice of Privacy (and any posted revision of that Notice) and the federal Health Insurance Portability and Accountability Act.

In the process of receiving health care at the University of Nevada, Las Vegas, a provider may initiate a follow up call and a letter may be sent to continue care. Also, patients may receive a phone calls to remind them of a scheduled appointment.

I understand that if I agree to participate in a research study, I will be provided with a specific authorization to participate. (*See Notice of Privacy Practices*). I have the option to choose not to participate or to withdraw from the study at any time.

I understand that I have the right to revoke in writing any such authorization, unless the University of Nevada, Las Vegas has already used or disclosed my information in reliance on the authorization.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information to carry out treatment, payment, or healthcare operations and that the University of Nevada, Las Vegas is not required to agree to the restrictions requested.

Please note: I understand that if I request a restriction that may impede the ability of the University of Nevada, Las Vegas to provide proper care, or which restricts the release of information required by law to be released, that the University of Nevada, Las Vegas is unlikely to agree to the restriction and may cancel further services. Further, I understand that if I request a restriction that does not allow the University of Nevada, Las Vegas to release necessary information to insurance providers; it may affect my ability to obtain reimbursement for medical expenses.

I acknowledge receipt of a copy of the Notice of Privacy Practices, which contains a more complete description of uses and disclosure of patient health information.

I understand that the University of Nevada, Las Vegas reserves the right to change the Notice of Privacy Practices and a revised copy will be posted and available when requested.

Student-Athlete Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

If student-athlete is a minor:
Student-Athlete Representative Signature: _____ **Date:** _____

Description of Legal Guardianship: _____

NOTICE OF PRIVACY PRACTICES (effective August 1, 2003)

This notice describes how your health information may be used and disclosed by the University of Nevada, Las Vegas Athletic Training Department and your rights pertaining to that information. Please review it carefully.

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI)

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing your protected health information, it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464, even if this is not required in order to treat students. The law allows us to use and disclose your health information without your specific authorization for treatment, payment and operations and other specific purposes explained on the next page. This includes the sharing of information, when necessary and appropriate, with other health care components of the University, such as the athletic department, student health center or the counseling center, as necessary for your continued care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS You have a right to:

- Request a restriction on the uses and disclosures of your protected health information as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the designated Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- If you received the Notice of Privacy Practices electronically, you may request a paper copy of the Notice.
- Upon written request, you may inspect and obtain a copy of your health record for a fee of \$.60 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Send and receive confidential communications of protected health information by alternative means or at alternative location, other than our usual methods. You should address the request in writing to the designated Privacy Officer.
- Revoke an authorization to use or disclose health information at any time except where action has already been taken.

RESPONSIBILITIES OF THE UNLV ATHLETIC TRAINING DEPARTMENT We are required by law to:

- Maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and apply the change to all of your protected health information, including information obtained prior to the change.
- If we change our notice of privacy practices, we will post the new changes in the lobby and a copy will be available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.
- In some circumstance, state or federal law may prohibit or further restrict the disclosure of your health information. If that is the case, we are required to follow the more stringent law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, the Director of Athletic Training at (702) 895-3380. If you feel your rights have been violated, you may file a complaint in writing with the designated Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

We will use your health information for treatment: e.g. we will use information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist him/her in your treatment. We will disclose personal health information to coaches pertaining to your current medical condition and any conditions that may restrict your ability to compete.

We will use your health information for payment: e.g. we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used as necessary to obtain payment.

We will use your health information for regular health operations: e.g. members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal operations may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- Business Associates: There are some services provided in our organization through contracts with business associates, such as laboratory services and radiology services. We may disclose your health information to our business associate so that they can perform these services. To protect your health information, we require the business associate to appropriately safeguard your information.
- Notification: We may disclose your health information to a friend or family member involved in your care or assisting you in payment. We may also notify a family member, friend, or other person responsible for your care, about your location and general condition.
- Disclosures required by law or for threats to safety: We may disclose your health information as required by law, or if necessary to avert a serious threat to health or safety, although disclosures are limited if information is obtained through counseling or therapy.
- Public Health: As allowed by law, we may disclose your health information to public health or legal authorities to 1) prevent or control disease, injury or disability, 2) to report child abuse or domestic abuse, in which case you may be notified of the disclosure, 3) for purposes related to quality, safety, or effectiveness of FDA-regulated products or activity, 4) to identify exposure to, and prevent the spread of, communicable disease, including notification of individuals that may have been exposed to communicable disease, 5) to an employer to conduct medical surveillance of the workplace or to evaluate whether an employee has a work related illness or injury, 6) to health oversight agencies as provided by law and 7) to report births and deaths.
- Law Enforcement and Court Proceedings: We may disclose health information to law enforcement in the following circumstances 1) information required by law, 2) limited information for identification and location purposes, 3) information regarding suspected victims of crime, although we will usually attempt to first obtain your agreement to release the information, 4) information about a deceased individual if we have a suspicion that the death resulted from criminal conduct, 5) information that we believe in good faith establishes that a crime has been committed on our premises during our providing of emergency health care. We may also disclose health information to others as required by court or administrative order, or in response to a valid summons or subpoena, for civil subpoenas, we will seek assurances from the requesting party that reasonable efforts have been made to inform you of the subpoena.

- Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may disclose health information to where you have authorized such disclosure. We may also disclose health information where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or the disclosure is approved by an institutional review board (IRB) or properly constituted Privacy Board if the Board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information.
- Military, National Security and Correctional Department Disclosures: We may disclose health information in connection with the responsibilities of the armed services if you are a member, national security and intelligence, protective services for certain government officials, and to correctional officials for health and safety purposes if you are an inmate.
- Marketing and Appointment Reminders: We may contact you to provide appointment reminders or information about treatment alternative or other health related benefits and services that may be of interest to you.
- Fund raising: We may contact you as part of a fund raising effort.

Disclosures requiring authorization: All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of _____

Student-Athlete Signature: _____

Date: _____

If student-athlete is a minor:

Student-Athlete Representative Signature: _____

Date: _____

Description of Legal Guardianship: _____

TO BE COMPLETED BY THE UNLV MEDICAL STAFF

Name of Student-Athlete _____

Height _____ Weight _____ Blood Pressure _____

Vision / Right Eye _____ Left Eye _____

Upon completion of this health questionnaire, it will be reviewed and signed by a Staff Athletic Trainer.

Student-athlete needs to be referred for the following condition(s): _____

Signature: _____ ATC

Date: _____

EXAMINATION TO BE COMPLETED BY A PHYSICIAN IF NEEDED.

Cleared to participate. _____

Prior to participating, the student-athlete requires: _____

Deferred. Not cleared to participate. _____

Physician's Signature _____

Date _____