EMBRY-RIDDLE UNIVERSITY
RE-EXAMINATION HEALTH HISTORY / PHYSICAL

Date:_____

Name _____ Sport _____
Last First Middle

Social Security Number _____ DOB _____ Age _____

Parent's Name _____
(or Guardian) Father's Last Father's First DOB

_____
Mother's Last Mother's First DOB

Father's Address _____
Street City State Zip
Father's Home Phone (_____) _____ Office Phone (_____) _____

Mother's Address _____
Street City State Zip
Mother's Home Phone (_____) _____ Office Phone (_____) _____

* Has your insurance changed since last year? YES / NO

Form Check List For Sports Medicine Staff Only			
_____	HISTORY RE-CHECK	_____	BLOOD P / PULSE
_____	HT / WEIGHT	_____	ORTHO / MEDICAL EXAM
_____	EYE CHART	_____	MEDICAL CLEARANCE (IF NEEDED)

Comments _____

_____

_____

EMBRY-RIDDLE UNIVERSITY
RE-EXAMINATION HISTORY

Please complete the following form in regard to your physical health since your last medical evaluation for the Embry-Riddle University Intercollegiate Athletics Program.

NOTE: SINCE YOUR LAST PHYSICAL EXAMINATION:

		YES	*NO*
1)	Have you had any illness? If yes please list them: _____		
2)	Have you been taking any medications? If yes please list them _____		
3)	Have you been hospitalized since your last physical examination?		
4)	Have you been unconscious for any reason?		
5)	Have you had any dental work done?		
6)	Are you now taking any supplements? If yes, please list: _____		

7) Have you had an injury to any of the following areas:

	YES	*NO*
Head		
Shoulder		
Arm / Hand		
Neck		
Ribs		
Back		

	YES	*NO*
Hip		
Thigh		
Knee		
Leg		
Ankle		
Foot		

If you checked yes to any of the orthopedic questions please explain the injury and action taken:

_____

_____

_____

8) Have you had any physical problems since your last physical examination which have not been Mentioned? If yes, please list and explain them: _____

_____

_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE STATEMENTS ARE TRUE.

_____ _____

Athlete's signature Date

PARENT'S INSURANCE FORM

E/05

Athlete's Name _____ SS# _____

Sport _____ School _____

Dear Parent:

Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports is "EXCESS" or "SECONDARY" to any other collectible group insurance benefits.
This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, **DO NOT** HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE:

1. Most employer's group insurance allows dependent coverage to be continued to age 25 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED; please circle the individual listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one)

Name _____ DOB _____ Social Security # _____

Home Address _____
(Street) (City, State & Zip Code)

Employer's Name _____

Employer's Address _____
(Street) (City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of Group
Insurance Company _____ Group # _____ Policy # _____

Mailing Address for Claims _____ Telephone # _____
(Street) (City, State & Zip Code)

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 insurance an HMO? YES _____ NO _____

Pre-authorization for services? YES _____ NO _____ Is your primary insurance a PPO? YES _____ NO _____

Mother/Guardian/Spouse/Self (circle one)

Name _____ DOB _____ Social Security # _____

Home Address _____
(Street) (City, State & Zip Code)

Employer's Name _____

Employer's Address _____
(Street) (City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of Group
Insurance Company _____ Group # _____ Policy # _____

Mailing Address for Claims _____ Telephone # _____
(Street) (City, State & Zip Code)

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 insurance an HMO? YES _____ NO _____

Pre-authorization for services? YES _____ NO _____ Is your primary insurance a PPO? YES _____ NO _____

_____ 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 _____.

_____ My son/daughter is NOT covered under my group insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.
A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____