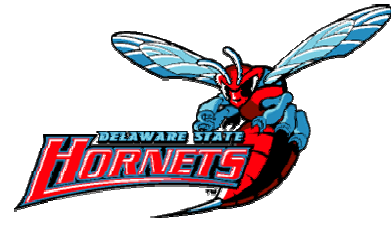


New Athlete Medical Team Information

Sports Medicine Department
Delaware State University
1200 N. Dupont Highway
Dover, DE 19901
Phone: (302)857-7554
Fax:(302)857-7553



Name_____

SSN#_____

Address_____

HS/Jr College_____

Address_____

Athletic Trainer_____ Phone_____

Primary Care Physician_____ Phone_____

Address_____

Specialist/Orthopedic Physician _____ Phone_____

Address_____

Other doctors (eye doctor, cardiologist)_____

Phone_____ Address_____

Physical Therapy Clinic Attended_____

Phone_____ Address_____

Do you have a Medical Insurance plan? Yes___ No___

This Information will be requested by the Delaware State University Sports Medicine Staff only after intent of participation has been determined by the signed NCAA document. Once permission is granted by the athlete and documents are received they are property of Delaware State University Sports Medicine. I understand that my information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 and may not be disclosed without my authorization.

Signature_____

Date_____

Parent/Guardian_____

Date_____

(If Athlete is under 18)