



*[for 1<sup>st</sup> year participants in MIT varsity athletics]*

## Student-Athlete Demographics/Emergency Contact Information

### Personal Information:

Last Name:	First Name:	Email Address:	Year of Graduation:
MIT ID#:	Birth Date:	Campus Phone:	Cell Phone:

### Sport/Team Information:

under the appropriate season, list the team(s) that you wish to join

Fall Sport:	Winter Sport:	Spring Sport:
Other Sport(s) Club or Intramural: (list)		

### Emergency Contact Information:

Emergency Contact Name:	Relationship:	
Home Phone:	Work Phone:	Cell Phone:

### Father's Information:

### Mother's Information:

Name:			Name:		
Address:			Address:		
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:

### Insurance Information:

Do you have the MIT Student Extended Insurance Plan (MIT SEIP)?				<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have existing group medical coverage other than MIT SEIP? If yes, please include details below				<input type="checkbox"/> No <input type="checkbox"/> Yes	
Policy Holder Name: (parent/self)	Policy Holder DOB?	Policy Holder SS#:	Policy Holder Employer Name:		
Insurance Company Name:	Insurance Policy #:	Group #:	Insurance Company Phone #:		
Insurance Company Address:					



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### Mother's Information:

Name:			Name:		
Address:			Address:		
Home Phone:	Work Phone:	Cell Phone:	Home Phone:	Work Phone:	Cell Phone:

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Do you have the MIT Student Extended Insurance Plan (MIT SEIP)?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you have existing group medical coverage other than MIT SEIP? If yes, please include details below	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Policy Holder Name: (parent/self)	Policy Holder DOB?	Policy Holder SS#:	Policy Holder Employer Name:
Insurance Company Name:	Insurance Policy #:	Group #:	Insurance Company Phone #:
Insurance Company Address:			



<b>OFFICE USE ONLY:</b>	
MR on file..... <input type="checkbox"/>	Notes: _____
<b>MEDICAL CLEARANCE STATUS:</b>	
Pending..... <input type="checkbox"/>	
Cleared..... <input type="checkbox"/>	
ATC : _____	
Date: _____	

## Varsity Athletics Pre-Participation Medical Screening Form 2008-2009

### **Instructions for completion:**

- Student-Athletes that fail to complete the Pre-Participation Medical Screening Form completely or accurately will not be allowed to begin practicing with their team.
- Mark "yes" or "no" next to each item that corresponds to a medical or health issue on the following pages.
  - After marking "yes", DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED.
  - Include any ongoing medical care that you are receiving. Note if you currently have any restrictions or limitations due to the particular condition.
- Do **not** leave any item unanswered.
- In the *Acknowledgement and Authorization* section, you are required to check "YES" and initial each item to acknowledge that you have read and understand each statement. If you find that you cannot agree to each item, you will not be allowed to participate in the varsity sports program.
- **NOTE: If you are not yet 18 years old, you must have your parents read and sign where indicated.**
- Please utilize the table below to assure that you completed all necessary components of this form.

**Again, Student-Athletes that fail to complete the Pre-Participation Medical Screening Form completely or accurately will not be allowed to begin practicing with their team.	Check when complete
<b>1. Demographics/Emergency contact form complete</b>	
<b>2. Personal and Family Medical History sections (pg 3-6) complete with details for "Yes"</b>	
<b>3. Initials in all three areas of Acknowledgement and Authorization section (pg 7-8)</b>	
<b>4. Student signature and date, or student/parent/guardian signature if under 18 (pg 9)</b>	

Return forms via mail to: **Athletic Eligibility**  
**120 Vassar Street, Bldg. W35-297**  
**Cambridge, MA 02139**

**Personal Health History:** Indicate answer by marking "yes" or "no" concerning the following conditions:

**If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED**

Condition:	MUST MARK
1. Illness requiring medical attention in the past year?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Are you under observation by a physician for a problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. EKG's in the past/ history of abnormal EKG?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Heart Murmur?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Irregular or extra heart beats?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you ever had chest pain, dizziness, shortness of breath, excessive fatigue during exercise?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. Have you ever fainted or lost consciousness during exercise?	<input type="checkbox"/> No <input type="checkbox"/> Yes
8. Diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes
9. Bleeding Disorders?	<input type="checkbox"/> No <input type="checkbox"/> Yes
10. High Blood Pressure?	<input type="checkbox"/> No <input type="checkbox"/> Yes
11. Asthma/ exercise induced asthma?	<input type="checkbox"/> No <input type="checkbox"/> Yes
12. Heat related illness, especially loss of consciousness in the heat?	<input type="checkbox"/> No <input type="checkbox"/> Yes
13. Mental Health Disorder (anxiety, depression, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes
14. Seizures?	<input type="checkbox"/> No <input type="checkbox"/> Yes
15. Loss or problem with any paired organs (e.g. eyes, testicles, ovaries, kidneys, breasts)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
16. Do you have any incompletely healed or non-rehabilitated injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
17. Other (specify):	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.** If you have any current restrictions or limitations, please provide details.

e.g. #8 – diagnosed at age 10; managed via diet and insulin pump. OK with exercise  
 e.g. #11 – diagnosed age 12, take Flovent and Albuterol daily

<b>WOMEN ONLY:</b>	MUST MARK
1. Do you have a history of irregular menstrual periods?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. How many menstrual periods have you had in the past twelve months?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Have you ever missed your period for 3 consecutive months or more?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you had a pelvic exam by an OB/GYN?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Have you had an abnormal PAP smear?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.**

e.g. #1 – seen by family doctor & OB/Gyn about this. I am taking BC and blood tests are normal.

**Family History:** Indicate your answer by marking "yes" or "no" concerning the following conditions as they relate to your immediate family.

**If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED**

Condition:	MUST MARK	List Relation(s): (e.g. mother, father, sister, brother)
1. High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2. Sudden Death	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4. Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	
5. High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	
6. Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
7. Marfan's Syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes	
8. Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Hereditary Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Mental Health Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Other: (describe below)	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.**

e.g. #1 & #5 – my mother manages her blood pressure and cholesterol with diet, exercise, and medication; my blood pressure is normal

### Diet/Nutrition and Eating Habits:

**If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED**

	MUST MARK
1. Are you currently following a weight loss/ diet program or regimen?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Would you consider yourself to have disordered eating?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Have you ever been diagnosed with or treated for an eating disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you consulted a Nutritionist?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.**

e.g. #1 – I am trying to lose weight to be faster in my sport. I don't eat carbs

### Body Composition:

**If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED**

1. What is your current height?	in.
2. What is your current weight?	lbs.
3. Has your weight fluctuated more than 15lbs in the past year?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.**

e.g. #3 – I had mono in January and lost 15 lbs.

## Head Injury:

If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED

		MUST MARK
1.	Have you ever had a concussion? (i.e. "bell rung", "brain injury", "head injury")	<input type="checkbox"/> No <input type="checkbox"/> Yes
1a.	If you have had a concussion, how many?	_____
1b.	When was your most recent concussion?	_____
2.	Did you lose consciousness as the result of your concussion(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2a.	If you did lose consciousness, for how long?	_____ minutes
3.	Have you had any long-term problems after a concussion (symptoms lasting more than 1 week)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4.	Have you ever been kept out of sports after a concussion?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATES AND OUTCOME OF ALL EPISODES OF CONCUSSION.**  
Note if you have any current limitations or restrictions of activity due to your history of concussion.

e.g. #3 – I had a headache and difficulty concentrating for 2 weeks  
e.g. #4 – I was held out of soccer for the rest of the season.

**Orthopedic/ Sports Injuries:** Indicate answer by marking "yes" or "no" concerning the following conditions:

If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED

	Body Region:	MUST MARK
1.	Neck	<input type="checkbox"/> No <input type="checkbox"/> Yes
2.	Upper Back	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.	Lower Back	<input type="checkbox"/> No <input type="checkbox"/> Yes
4.	Shoulder	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.	Arm	<input type="checkbox"/> No <input type="checkbox"/> Yes
6.	Elbow	<input type="checkbox"/> No <input type="checkbox"/> Yes
7.	Hand/ Wrist/ Finger	<input type="checkbox"/> No <input type="checkbox"/> Yes
8.	Hip/ Pelvis	<input type="checkbox"/> No <input type="checkbox"/> Yes
9.	Thigh	<input type="checkbox"/> No <input type="checkbox"/> Yes
10.	Knee	<input type="checkbox"/> No <input type="checkbox"/> Yes
11.	Lower Leg	<input type="checkbox"/> No <input type="checkbox"/> Yes
12.	Ankle	<input type="checkbox"/> No <input type="checkbox"/> Yes
13.	Foot/ Toe	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND TYPE OF INJURY/CONDITION AND DETAILS CONCERNING ABOVE CONDITIONS.** If you have any current restrictions or limitations, please provide details.

e.g. #10 – I tore my ACL in March 2005. I had surgery in April 2005. Work with Physical Therapist all summer. I have included documentation for your review.  
e.g. #12 – I sprained my right ankle in February and May of 2003. I did rehabilitation. I get my ankle taped to play.

## Allergies/ Medications:

If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED

	Conditions	MUST MARK
1.	Do you have allergies to any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2.	Do you have any food, insect, or environmental allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3.	Have you ever been told you should carry an Epi-Pen Auto-injector for your allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4.	Have you ever had an unexplained allergic reaction?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5.	* Are you currently taking any medications (over-the-counter or prescription)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.**

e.g. #1 – I'm allergic to pollen and dust. I use Claritin/Alavert/Zyrtec daily. I am allergic to bee stings.  
e.g. #2 – I carry an epi-pen with me when I am outdoors

*\* New NCAA requirements may apply to you and the medication you are being prescribed.*

## Other Conditions:

If you marked "yes" for any condition; DESCRIBE THE CONDITION OR CONCERN IN THE SPACE PROVIDED

1.	Other bone, joint, or muscle problems not discussed above?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2.	Have you ever been treated for a serious injury not mentioned above?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Explain by item number in this space. **PROVIDE THE DATE AND OUTCOME OF ALL CONDITIONS LISTED ABOVE IN THIS SPACE.** If you have any current restrictions or limitations, please provide details

## Acknowledgement and Authorization section

### Description of Condition(s)/Health Status:

As part of the process of enrolling at MIT, I completed a "Medical Report" form, which included being examined by a physician, and/or his/her designee, and submitted these forms to MIT Medical as instructed. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing my prior medical history (including immunizations); that my "Medical Report" was fully and accurately completed; that all of my present symptoms, complaints, ailments, disabilities, and/or prior injuries have been disclosed in writing to, and discussed with, a physician and/or his/her designee; and that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or problems not so disclosed and discussed. At the time of my examination, my physician, and/or his/her designee, found no contraindications for participation in collision, contact, or non-contact sports. Furthermore, I consent to laboratory analysis, urine screen, blood chemistry, orthopedic, internal, and any other examination deemed necessary to determine my physical/mental condition as related to my health and safety while participating in the varsity sports program.

I understand that the process of receiving medical clearance may require the collection of, and analysis of, additional documentation from my health care provider(s) regarding prior or existing medical conditions and that I may be required to obtain and submit copies of this medical documentation as needed. This includes, but is not limited to, physician's dictations and records, X-rays and related reports, Magnetic Resonance Images and related reports, emergency department, surgical or operative and follow-up care notes, related rehabilitative physical therapy or occupational therapy notes.

No  Yes initial \_\_\_\_\_

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### MIT Health Insurance Coverage Requirements:

I understand that all MIT students must have insurance coverage before commencing and while participating in any strength & conditioning session, practice, game, competition, and/or team travel that is supervised by approved MIT coaching staff and approved by the Director of Athletics, according to NCAA regulations. My coverage must meet the requirements of the Massachusetts Qualified Student Health Insurance Plan (QSHIP) and United States Information Agency regulation (International students only). For more information, the guidelines can be accessed via a link found at: <http://web.mit.edu/medical/p-student.html>

I understand that regular, registered MIT students, and special students taking more than 27 units, are automatically enrolled in the MIT Student Extended Insurance Plan and billed for the cost. For more information, review the plan at: <http://web.mit.edu/medical/p-student.html>. I understand that if I have comparable insurance, I can ask to waive mandatory enrollment in the MIT Student Extended Insurance Plan. To do so, please follow the instructions for the MIT online waiver process. This link can also be found at: <http://web.mit.edu/medical/p-waiver.html> I also understand that my medical/health insurance coverage shall include *a provision for sports injury/illness related medical care with a limit of at least \$75,000.* (MIT Student Extended Insurance Plan meets these criteria)

I understand that if my medical/health insurance coverage lapses, *or* if there is a material change in my existing coverage, I shall notify the MIT Health Plan Office, I shall notify DAPER's Head Athletic Trainer, and *I shall discontinue participation* in the varsity sports program until I procure an acceptable level of coverage (see above).

I understand that since participation in the varsity sports program is *voluntary*, MIT shall not be responsible for medical and/or dental bills, including deductibles, not covered by my medical/health insurance policy. I understand that coverage or reimbursement for costs associated with hospital emergency room visits, off-campus office visits, off-campus hospitalization, and other health care (e.g. lab tests, imaging, orthotics, physical therapy), even when referred by the Sports Health Care Team\*, MIT Medical Providers, or others (e.g. coach and non-MIT health care providers), shall be determined solely by my medical/health insurance policy.

No  Yes initial \_\_\_\_\_

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\* The Sports Health Care Team includes health care providers from MIT Medical as well as the staff of Certified Athletic Trainers from the Department of Athletics, Physical Education, and Recreation.

**Informed Risk:** *If I am under the age of 18, the undersigned parent/guardian grants such permission*

I understand that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of playing, practicing, or training in any athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the neuro-musculo-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I also understand that there are risks involved with traveling in connection with the varsity sports program.

I understand that receiving medical clearance does not reduce the risk of injury(s) that may occur while participating in the varsity sports program, including re-injury or aggravation of a pre-existing injury, illness, or condition.

In order to minimize the risk of injury/illness, I shall be aware of and abide by applicable policies, procedures, techniques, safety rules, and guidelines. I shall also engage in sound conditioning and training programs designed to help in the prevention of injury/illness. I shall follow the advice of the Sports Health Care Team\*, strength and conditioning staff, and/or coaching staff concerning the prevention, treatment, and rehabilitation of athletic injuries. Furthermore, I understand that the possibility of injury/illness, including catastrophic injury/illness, does exist even though proper rules and techniques are followed to the fullest.

I understand that any improper use or abuse of equipment could result in serious injury to me, my teammates, and/or my opponents. I understand that equipment (e.g. football, hockey, and lacrosse helmets, sticks, and crosses) may not be used to butt, ram, or spear an opposing player and that not only is such use in violation of sport rules, but serious head or neck injuries, paralysis, and even death can result from equipment misuse.

I understand that proper use of equipment helps only to minimize the risk of injury and no equipment can prevent all injuries, which I might receive while participating in the varsity sports program. I understand that any adjustments in my equipment shall be reviewed with the Sports Health Care Team\* and equipment personnel.

**Authorization for Treatment:** *If I am under the age of 18, the undersigned parent/guardian grants such permission*

I hereby authorize the Sports Health Care Team\* (or designee at off-campus contests), my coaches, and/or student first-responders to provide emergency first aid and/or to arrange for transport, and/or to secure medical treatment, including hospitalization, for myself for injuries that might arise as a result of my participation. Additionally, I hereby authorize the Sports Health Care Team\* to examine and treat injuries that might arise as a result of my participation.

**Exchange of Health Information:** *If I am under the age of 18, the undersigned parent/guardian grants permission*

I give the Sports Health Care Team\*, and all consulting health care providers, my permission to obtain and release to one another, written and/or orally, information concerning injuries and illnesses that may impact my health and safety while participating in the varsity sports program. This includes, but is not limited to, medical information contained in MIT's "Medical Report" as well as this "Varsity Athletics Pre-Participation Medical Screening Form" and physician's dictations and records, X-rays and related reports, Magnetic Resonance Images and related reports, emergency department, surgical or operative and follow-up care notes, related rehabilitative physical therapy or occupational therapy notes, and needed information to process insurance claims associated with injuries, conditions, and illnesses that occur as a result of my participation. This permission extends throughout the time in which I am enrolled at MIT.

Furthermore, I consent and authorize the Sports Health Care Team\* to communicate with athletic department officials and coaching staff regarding their findings and recommendations as related to my health and safety while participating in the varsity sports program.

I understand that, in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information shall be not be released to any other party without my written consent.

**Change in Health Status:**

I acknowledge that I have a duty to provide the Sports Health Care Team\* with timely notice of any subsequent injuries or illnesses which might impair my ability to participate in the varsity sports program, or be detrimental to my health and safety, or that of fellow participants.

No  Yes **initial** \_\_\_\_\_

\* The Sports Health Care Team includes health care providers from MIT Medical as well as the staff of Certified Athletic Trainers from the Department of Athletics, Physical Education, and Recreation.

**Acknowledgement:**

In consideration of the opportunity to participate in the varsity sports program at the Massachusetts Institute of Technology during my entire period of eligibility, I hereby acknowledge, with this signature, that I have read and understand the above statements, that I have had an opportunity to ask for explanations or clarifications of any portion, and that I agree to observe these and other related rules and practices which may be employed to minimize my risk of serious injury/illness and facilitate my health care delivery while pursuing the benefits of the varsity sports program.

I understand that this completed form is needed in addition to the pre-entrance physical exam (i.e. “**Medical Report**”) sent to MIT Medical by my physician and/or his/her designee.

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Student Signature

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Date Signed

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Student Name

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Date of Birth                      Age

---

Parent/Guardian Signature (if under 18)

---

Date Signed

Questions or comments related to this form? Contact the Kasser Sports Medicine Staff, by phone at 617-253-4908 or via email at: [athletic-trainers@mit.edu](mailto:athletic-trainers@mit.edu)

\* The Sports Health Care Team includes health care providers from MIT Medical as well as the staff of Certified Athletic Trainers from the Department of Athletics, Physical Education, and Recreation.

# Drug and Alcohol Use Survey 2008-2009

OFFICE USE ONLY:

ATC : \_\_\_\_\_

Date: \_\_\_\_\_

**Personal Information:**

Last Name:	First Name:	MIT ID#:
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Consistent with our emphasis to guard the health and safety of our participants; and in an effort to enhance the availability and ease of access of services, questions associated with alcohol or other drug use are included as a component of the pre-participation clearance process.

Your voluntary responses are not anonymous, but will be kept confidential. Your responses will NOT be disclosed outside the Sports Health Care Team\*, nor become part of your academic or judicial record. Your individual responses will not be shared with others including coaches, administrators, or the media.

Evaluation results of this program will only be reported in group-form, without reference to any identifying information of the individual participants. The confidential responses provided shall be used to determine subsequent voluntary participation in an interview with a MIT Medical staff member, for which you will be paid. Individual identifiers will be removed from this data immediately after it is reviewed and an invitation (if indicated) is sent out.

After the interview with a MIT Medical staff member, you will also be asked to consent to allow MIT Medical to mail a follow-up survey to solicit your feedback. Completion of this follow-up survey will also be voluntary and confidential.

1. Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Do you ever use alcohol or drugs while you are by yourself, alone?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Do you ever forget things you did while using alcohol or drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you ever gotten into trouble while you were using alcohol or drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7. If you choose to drink alcohol, how many drinks on average do you consume per occasion? (insert “0” if you don’t consume alcohol)	_____

The following are brief questions regarding medication use. Again, your answers are confidential. Thank you for your honest responses. Please circle the response that best fits.

In the past 12 months, how many times have you used the following medications *with a doctor’s prescription*:

- A. taken Adderall (with a doctor’s prescription):  
0 times   1-2 times   3-5 times   6-9 times   10-19 times   20-39 times   40+ times
- B. taken Ritalin (with a doctor’s prescription):  
0 times   1-2 times   3-5 times   6-9 times   10-19 times   20-39 times   40+ times
- C. taken Oxycontin (with a doctor’s prescription):  
0 times   1-2 times   3-5 times   6-9 times   10-19 times   20-39 times   40+ times
- D. taken Vicodin (with a doctor’s prescription):  
0 times   1-2 times   3-5 times   6-9 times   10-19 times   20-39 times   40+ times

\* The Sports Health Care Team includes health care providers from MIT Medical as well as the staff of Certified Athletic Trainers from the Department of Athletics, Physical Education, and Recreation.

2. In the past 12 months, how many times have you used the following medications *without a doctor's prescription*:
- A. taken Adderall (without a doctor's prescription):  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
- B. taken Ritalin (without a doctor's prescription):  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
- C. taken Oxycontin (without a doctor's prescription):  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
- D. taken Vicodin (without a doctor's prescription):  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
3. In the past 12 months, how many times have you used the following medications *with a doctor's prescription* and *as a study aid*:
- A. Adderall:  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
- B. Ritalin:  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times
- C. Other \_\_\_\_\_ (write in medication):  
 0 times    1-2 times    3-5 times    6-9 times    10-19 times    20-39 times    40+ times

Questions about this survey, its content, or procedures can be directed to the Athletic Training Staff at 617-253-4908 or via email at: [athletic-trainers@mit.edu](mailto:athletic-trainers@mit.edu)

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