Athletic Insurance Information

Form 1

Athlete's Name_____ Date of Birth_____

Permanent Address_____City_____ State_____ Zip_____

ASU Address_____ CID _____

City _____ State _____ Zip _____

Email _____ASU Phone (Cell) _____

Social Security Number_____ Sport _____

Father'sName_____Home(Cell) Phone_____

Address_____City_____ State_____ Zip_____

Social Security Number_____Father's DOB _____

Name of Employer_____Employer's Phone_____

Employer's Address_____City_____ State_____Zip_____

Mother's Name_____Home(Cell)Phone_____

Address_____City_____ State_____ Zip_____

Social Security Number_____Mother's DOB:_____

Name of Employer_____Employer's Phone_____

Employer's Address_____City_____ State_____Zip_____

Name of Insurance Company_____Phone_____

Name of Policy Holder_____Policy Number_____

Deductible Amount_____Group Number_____

Claims Mailing Address_____

City_____State_____Zip_____

Is athlete married?	Yes	No
Is a second surgical opinion required?	Yes	No
Pre-Authorization for services required?	Yes	No
Is your Primary insurance an HMO/PPO?	Yes	No

Affidavit of Insurance

Form 2

This form must be completed, signed and returned to the athletic department before ANY student-athlete will be allowed to participate in any practice or activity at ASU. Please check the response appropriate for your son or daughter.

_____ I/We do hereby authorize the athletic department to utilize my/our insurance policy on Form 1 and assign the university or designated entity (physician, hospital, etc.) the payment of benefit under this plan.

_____ I or my/our son/daughter is NOT covered by my personal medical insurance. Please send me more information on the Student Health Insurance Policy.

_____ I or my/our son/daughter have no medical insurance or any type of accident and health plan under which my/our son or daughter is covered.

_____ _____

Date Signature of Student-Athlete or Parent/Guardian (if under 18)

***Do you have a policy to cover dental work for your son or daughter?**

Yes_____ No_____

If yes, please provide the policy number and company if different from your health insurance.

Name of Insurance Company_____

Policy Holder_____

Policy Number_____

Address_____

City/State/Zip_____

Phone_____

Deductible/Co-pay_____

***Do you have a policy to cover glasses or contact lenses for your son or daughter?**

Yes_____ No_____

If yes, please provide the policy number and company if different from your health insurance.

Name of Insurance Company_____

Policy Holder_____

Policy Number_____

Address_____

City/State/Zip_____

Phone_____

Deductible/Co-pay_____

Primary Care Physician/Optometrist Information

Form 3

Please complete the following if your health insurance company requires a referral from your primary care physician.

Name of Primary Care Physician_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Please complete the following as ASU requires a copy of the student-athlete's prescription to be on file to replace contact lenses of glasses that are lost or damaged during practice, scrimmages, or competition. If your optometrist will not provide you with a prescription, ASU will contact your physician to obtain a copy.

Name of Optometrist_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Assumption of Risk Statement

This is a warning to the student—athlete and parent/guardian of the risk your son/daughter takes while participating in athletics at ASU. By participating in any athletics at ASU a student-athlete can sustain any one of the following injuries. This forewarning and a nonexclusive list of injuries are given to make you aware of the inherent dangers and risks involved while participating in athletics.

1. Head injuries - can result in coma, brain damage, and/or death.
2. Spine injuries - can result in quadriplegia, paraplegia, and/or death.
3. Strains – completely torn, partially torn, and/or stretched muscles or tendons.
4. Sprains – completely torn, partially torn, and/or stretched ligaments.
5. Contusion.
6. Laceration, abrasion, and other flesh wounds which can result in infection.
7. Internal organ damage - such as a ruptured spleen or kidney, etc.
8. Loss of limb or vital organ of the body.
9. Cartilage damage in the joints of the body.

There are other injuries/illnesses that are not included in this list. The undersigned acknowledge this forewarning and its purpose of making the student-athlete and parent/guardian aware of the seriousness of possible injuries that occur to you the undersigned and son or daughter of the undersigned while participating in athletics at ASU.

_____ _____

Date Signature of Student-Athlete

_____ _____

Date Signature of Parent/Guardian

Permission for Treatment Consent

Form 4

I understand that a pre-season physical is given for no other purpose than to clear me for athletic participation at ASU. I understand it is not a physical for illnesses which may be developing or might develop in the future. I further agree that such illnesses will be taken to the student health service, personal physician, or athletic trainer for referral and care. I give authorization to the athletic trainer or team physician to evaluate and treat any injuries that occur during my athletic tenure at ASU. This includes immediate first aid and treatment, X-ray, orthopedic or physical exam, follow-up care, and rehabilitation. I understand the team physician has the authority to eliminate me from further participation because of any injury and/or an undue risk to other athletes and ASU.

_____ _____

Date Signature of Student-Athlete

Authorization to Release Medical Information

This form must be signed and returned to the athletic department before ANY student-athlete will be allowed to participate in any practice or activity at ASU.

1. We/I hereby authorize any insurance, hospital, physician, or other persons who have attended or examined the undersigned student-athlete to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescriptions, treatment and copies of all hospital and medical records.

2. We/I hereby authorize the ASU athletic training staff to release information concerning previous injuries and medical conditions to the news media representatives, professional scouts, and insurance company representatives for claim processing.

3. We/I hereby authorize the ASU athletic training staff, team physician, or designated physician to secure medical services that are in the best interest of our son or daughter.

By our/my signature, we/I agree with all statements outlined in the medical, dental, contact lens, second opinion policies, and payment of expenses and certify that all information is true and correct to the best of our/my knowledge. We/I do hereby affirm that we/I have received a copy of the ASU medical policies and procedures and acknowledge that we/I are/am familiar with them as set forth within. A photocopy of all documents in the policy will be considered as effective and valid as the original.

_____ _____

Date Signature of Student-Athlete

_____ _____

Date Signature of Parent/Guardian

Copy of Parent/Student Athletic Insurance Card

Form 5

Initial below if completed:

_____ Please include a CURRENT copy of your insurance card and prescription card for purposes of verification. The hospital now requires all individuals to show proof of insurance. All athletes who have a copy available to them at the time of injury would benefit by receiving services without a delay in treatment.

Please attach a legible copy of BOTH the FRONT and BACK of the insurance card and prescription card to the packet of insurance papers.

ADD/ADHD Documentation Required by the NCAA

Form 6

Must Circle One

Is your son/daughter currently being treated and taking medication for ADD/ADHD? **YES NO**

If you son or daughter has been diagnosed with ADD/ADHD and is currently taking medication, the NCAA is requiring certain documents to be kept on record in their confidential medical file. These documents must be included with the insurance packet when returned to ASU:

1. Record of student-athlete's evaluation by diagnosing physician.
2. Statement of the Diagnosis, including when it was confirmed.
3. Copy of most recent prescription (as documented by the prescribing physician).
4. History of ADD/ADHD treatment (previous/ongoing).

Division II Sickle Cell Testing Requirements

Form 7

Initial below if completed:

_____ Sickle Cell is not a disease. Sickle Cell Trait is an inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle Cell Trait will not turn into a disease. Beginning August 2012, Division II is requiring certain information be obtained from the student athlete prior to any practice sessions being performed. As an ASU student athlete, one of the following items must be provided to the ASU sports medicine staff prior to any practice and/or competition involvement.

1. Demonstrate proof of a prior sickle cell test.
2. Have a sickle cell test performed prior to the first practice.

Surgery Information

Form 8

Initial below:

_____ Any student-athlete that is required to have surgery for an injury sustained while participating in athletics at ASU will have the surgery performed in San Angelo with an ASU Team Physician unless the procedure cannot be performed by said Team Physician. If a student athlete chooses to have surgery performed by a physician of their choice, the cost incurred will be the responsibility of the student athlete.

Acknowledgement

I/We have read and understand the insurance procedures at Angelo State University listed within the preceding packet, including pre-season physical examination procedures, previous injury or illness procedures, dental policy, contact lens policy, second medical opinion policy, and payment of medical expenses. Also, I/We have completed all sections of the insurance packet, including FORMS 1-8. I/We understand that missing or incomplete information may cause a delay in treatment of me and/or our son/daughter. Non-compliance with the procedures listed within and set forth by the athletic training staff may cause me and/or parent/guardian to be responsible for the full financial amount of injury related expenses.

Name of Student Athlete (Printed) _____

Signature of Student Athlete_____

Name of Parent/Guardian (Printed) _____

Signature of Parent/Guardian_____

Date_____