

Southern Oregon University INSURANCE QUESTIONNAIRE INTERCOLLEGIATE ATHLETICS

****ATHLETES MUST HAVE PRIMARY HEALTH INSURANCE**** They must be covered by their parents, spouse or have their own primary health insurance. The athlete's own group insurance or that of the parents/spouse must be billed first. Intercollegiate insurance will only pay when the athlete's coverage is exhausted or does not apply. The following information is essential to assure that expenses are adequately and completely covered by the proper insurance. Inadequate or incomplete answers will delay payment of medical bills and may jeopardize the athlete's credit rating. No medical expenses will be met out of institutional funds without a signed, accurate questionnaire on file.

It's the athlete's sole responsibility to keep the information contained in this document current.

Instructions: Do not leave any blank lines, if not applicable write N/A. Use ink and print.

Section 1-Athlete Information

Name _____		Single ___ Married ___	
Last	First	MI	
Local Address _____			
Street	City	State	Zip
Cell # _____			
Date of Birth _____		Social Security # _____	

Section 2-Emergency Contact

Primary Emergency Contact (circle)

Father Mother Grandparent Spouse Friend

Secondary Emergency Contact (circle)

Father Mother Grandparent Spouse Friend

Name _____	Name _____
Address _____	Address _____
Street	Street
City State Zip	City State Zip
Home Phone # _____	Home Phone # _____
Employer _____	Employer _____
Work Phone # _____	Work Phone # _____

Section 3-Medical Insurance

Primary Medical Insurance Carrier (circle) Father Mother Spouse Own

Insurance Co. _____			
Address _____			
Street	City	State	Zip
Phone # _____	Policy/ID/Group Number _____		

I hereby certify that the foregoing answers are true, complete, and correct to the best of my knowledge. I hereby authorize any insurance company, organization employer, hospital, physician, surgeon, or pharmacy to release any information with respect to injury, treatment, or insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Athlete Signature _____ Date _____ Sport _____

*****Must Attach Copy of Primary Health Insurance Card*****

Athletic Insurance and Medical Agreement

I, _____, attest that I have insurance coverage under a current insurance policy for injuries that occur during my participation in intercollegiate athletics.

If there is a material change in coverage or expiration of coverage, I agree to notify Southern Oregon University Sports Medicine Staff of this development and update the insurance information I have on file with SOU Sports Medicine Staff.

Insurance Procedure:

- All injuries and any loss must be reported to the supervising athletic trainer on duty or the head coach during the contest/practice, or immediately thereafter. Otherwise, expenses incurred will be the student-athlete's responsibility.
- Student-athletes should not go to the student health center for injury care without seeing the athletic trainers first, except in cases of emergency, illness occurring during the night or when the training room is closed. In such cases, the student athlete will report the incident to the athletic training staff as soon as possible.
- Appointments with consulting physicians, specialists or dentists are made through the Sports Medicine Staff. Except for emergency cases. A student-athlete is at liberty to depart from this policy and seek unauthorized outside consultation, but in doing he/she assumes all incident risks and the expense of the medical service.
- The first medical expense must be incurred within **90 days** of the date of the accident and only expenses incurred within **1 year** from the date of the accident will be reimbursed.
- Medical bills must be given to the Southern Oregon University Sports Medicine Staff to submit to the secondary insurance within **1 month** of the bills date, if presented after 1 month, those costs incurred will be the athlete's responsibility.
- Medical Services covered would include those of licensed physicians and surgeons, nurses, clinicians and other licensed professionals rendering curative, therapeutic or diagnostic services, hospitalization and transportation when required. Chiropractic and Physical Therapy care is excluded, unless otherwise noted.
- Southern Oregon University Athletic Department is not responsible for any pre-existing injury or operation not covered by Southern Oregon University insurance.
- Southern Oregon University Athletic Department is not responsible for medical services or fees during the time a student athlete is out of his/her official sport season.

I understand that Southern Oregon University will assume no responsibility whatsoever for the payment of, or authorization to pay medical expenses resulting from not following the proper procedure, as stated above.

Athlete's Signature

Today's Date

Acceptance of Risk/Liability Waiver

The undersigned hereby:

1. Understands that Southern Oregon University's Sports Medicine Staff may review this questionnaire and insurance information and, if necessary, require additional questioning or information before clearing the athlete to participate.
2. Understands and accepts the risks of injury, permanent disability, and/or death inherent to their sport. By signing below he/she pledges to do their best to reduce risks by using proper techniques in practice and play, keeping in the best possible condition, and following the advice of the Sports Medicine Staff and Coaches concerning the prevention, treatment, and rehabilitation of athletic injuries.
3. Will promptly notify the Coach and /or Sports Medicine Staff of any changes in his/her health status, including injuries or illnesses.
4. I understand it is my responsibility to communicate with the coaching staff and Sports Medicine Staff when I have an injury which may limit my ability to function in practice or competition. It is also my role as a collegiate student-athlete to follow injury prevention and rehabilitation programs developed for me. I realize it is important to communicate daily with the athletic training staff and coach regarding my progress or complications which occur during a rehabilitation program.
5. If seen by a physician return to participation is determined by a physician clearance to participate in practices and games, along with clearance by the Southern Oregon University Sports Medicine Staff
6. I grant permission to the Sports Medicine Staff to hospitalize and secure treatment for myself for any athletic injuries or serious medical conditions.
7. I grant permission for the Coaching Staff and the Sports Medicine Staff at Southern Oregon University to communicate to one another, written and/or orally any athletic related information concerning injuries and illnesses that affect their athletic involvement.
8. I understand that I must have proof of athletic injury/accident insurance that is in effect during all practices, tryouts, competition or special exhibition events in order for me to participate during in-season.
9. My participation in athletics is purely voluntary; no one is forcing me to participate and I elect to participate in spite of the risks, stated within this document.

I, the undersigned, have read and understand the preceding Acceptance of Risk/Liability Waiver and agree to follow its procedures. I also hereby release Southern Oregon University, the Sports Medicine Staff, coaches and its agents and employees from any liability caused by or arising out of my participation in this college athletic program/event.

My signature acknowledges that I have read this document and have fully informed myself of its contents. I sign it voluntarily, knowing that in doing so I am limited my legal rights to which I might otherwise be entitled.

Name (printed) _____ SSN _____
Signature _____ Date _____

Authorization Form
For Uses and Disclosures of Patient Protected Health Information

I, _____ (print name) hereby authorize Southern Oregon University Department of Athletics to release my protected health information. I understand that this authorization will only be used on a need-to-know-basis to insure quality treatment/care.

I. Protected health information may include:

1. Injury or illness relevant to past, present, or future participation in intercollegiate athletics at Southern Oregon University.
2. Information contained in my personal medical record unrelated to my participation in intercollegiate athletics at Southern Oregon University.
3. Information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and other related personally identifiable health information, including injury reports, test results, x-rays, progress reports, and any other documentation regarding my health status.

II. Authorization is granted for release of my protected health information to:

1. Health care providers (including but not limited to athletic trainers, physicians, nurses, physician assistants, or physical therapist) allowing for open communication channels to ensure my safety and proper treatment while participating in my intercollegiate sport(s).
2. My parents/guardian and/or spouse for the purpose of assisting me in making healthcare decisions while I am a student-athlete.
3. The coaches, assistant coaches, and other athletic staff so that they may make decisions regarding my athletic ability and suitability to compete while I am a student-athlete.
4. The Cascade Conference and the National Association of Intercollegiate Athletes (NAIA) for the purpose of making determination regarding my eligibility status while I am a student-athlete.
5. Applicable insurance providers for the purpose of processing insurance claim while I am a student-athlete.

III. I understand my rights, as described herein:

1. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
2. I may revoke this authorization at any time by delivering a signed and dated letter to the Head Athletic Trainer (Kelly Mason ATC).
3. If I revoke this authorization it does not affect any uses or disclosures made before my revoke was received.
4. If the persons or entities that authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
5. The information authorized for release may include records, which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, HIV, AIDS and/or mental health information.

Name (printed)_____ SSN_____

Signature _____ Date_____ Sport_____

This authorization will automatically expire 18 months from the date it is signed.

Southern Oregon University Athletics

Health History Re-Examination

Name _____ Sex _____ Age _____ Date _____

Sport(s) _____ Position(s) _____ Eligibility year RFR FR SO JR SR

Current Medications _____

Allergies _____

Please complete the following form in regard to you physical health since your last physical examination for the Southern Oregon Intercollegiate Athletic Program.

Note: Since your Last Physical Exam:

1. Have you had any illness that lasted more then one week? YES NO
Please Describe _____
2. Have you been hospitalized? YES NO
Please Describe _____
3. Have been unconscious for any reason? YES NO
Please Describe _____
4. Have you had a concussion, been knocked out, "had your bell rung", had a seizure, or convulsions YES NO
Please Describe _____
5. Have you had a heat related illness? YES NO
Please Describe _____
6. Have you any laxatives, food restriction, vomiting or dehydration to control you body weight? YES NO
Please Describe _____
7. Have you had an injury to any of the following areas:

	YES	NO	EXPLAIN
Neck/Head			
Back			
Ribs			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip			
Thigh			
Knee			
Leg/Ankle			
Foot			

8. Do feel that you need to see the Team Orthopedic for any reason? YES NO
Please Describe _____

9. Any other medical changes in the past year? YES NO
Please Describe _____

I hereby state that I have fully and completely disclosed and described every part of my medical history of which I have knowledge. Further, I have fully and completely disclosed any and all past and preexisting injuries, congenital defects, and any and all ailments that would potentially cause me to be unable to perform as a player. As to all of the above which I have not made full and complete disclosure, I hereby waive my rights to any and all claims against Southern Oregon University, the Athletic Department and their employees, and the Team Physicians for medical expenses and any or all other claims.

Athlete's Signature _____ Date _____