INSURANCE INFORMATION FORM

Athlete's Name:_____ School: Chowan University SSN#:_____

Sport: _____ Sex:_____ Date of Birth:_____ Age:___

School Address (Mail Box #):_____ Home Address:_____

_____

The School's athletic insurance policy provides coverage for injuries occurring during the play or practice of intercollegiate sports. It is an EXCESS or SECONDARY policy. This simply means that any claim must first be filed with any other valid and collectible group insurance policy under which the athlete is covered. After the PRIMARY carrier has all available benefits, the School's policy will consider remaining amounts based on USUAL and CUSTOMARY charges. THE SCHOOL DOES NOT HAVE THE OPTION OF WAIVING THE REQUIRED TO FILE WITH THE PRIMARY CARRIER. The school's athletic policy covers athletic injuries only and is not a substitute for comprehensive medical coverage, so please do not cancel coverage presently in force.

Father/Spouse Information (please answer all questions)

Father/Spouse Name: _____ SSN#: _____

Home Address:_____ Date of Birth:_____

Employer's Name:_____ Employer's Address:_____

Home Telephone:_____ Work Telephone:_____

Group Insurance Company:_____ Group Policy Number:_____

Claims Telephone # (Check ID Card):_____ Claims Mailing Address:_____

_____

Is Athlete covered under the above policy:_____ Is Pre-Certification Required:_____
Is above policy an HMO?_____ Is above policy a PPO?_____

Mother/Spouse Information (Please answer all questions)

Mother/Spouse Name: _____ SSN#: _____

Home Address:_____ Date of Birth:_____

Employer's Name:_____ Employer's Address:_____

Home Telephone:_____ Work Telephone:_____

Group Insurance Company:_____ Group Policy Number:_____

Claims Telephone # (Check ID Card):_____ Claims Mailing Address:_____

_____

Is Athlete covered under the above policy:_____ Is Pre-Certification Required:_____
Is above policy an HMO?_____ Is above policy a PPO?_____

Authorization to File Under Primary Policy (please circle one)

_____ I hereby authorize a claim to be filed on my behalf under the_____
(Name of Insurance Company)

group medical policy in the event of an athletic injury is sustained by my son/daughter/spouse named above

_____
(Signature of Parent/Guardian who is policy holder)

_____My son/daughter/spouse is NOT covered under my group insurance plan.

Authorization to Obtain Information (Please sign and date)

To all physicians; medical professionals; hospitals; clinics; other health care providers; insurers; employers; group policyholders; insurance support organizations; and other persons who have information about the patient. I permit the release of medical information about me to ABCO 100 (School's Athletic Insurance). This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The company will use this information to find out if my claim is eligible. A copy of this authorization will be valid as this one. I certify that the above information given by me is true and correct to the best of my knowledge.

Signature of Athlete: _____Date:_____

Signature of Parent/Guardian: _____Date:_____

CHOWAN UNIVERSITY ACCEPTANCE OF RISK

I,_____, am aware of and accept the risk of serious injury that may render me disabled or paralyzed as a result of intercollegiate athletics in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible condition and will follow the advice of the team physician(s), treatment, rehabilitation, and maintenance of athletic injury.

_____
Signature

ACKNOWLEDGEMENT STATEMENT

Insurance policy number_____, I acknowledge receiving the "Athletic Injury Insurance Letter". I understand the extent of the University's responsibility to an athlete who becomes injured as a result of participation in the intercollegiate athletic program at Chowan University. I also understand that there is assumed risk involved in intercollegiate athletics. I hereby authorize the Chowan University Department of Athletics and/or its medical vendors to make direct claim for bills incurred to the above named student-athlete.

_____ _____
Date Signature of Parent/Guardian

INFORMED CONSENT

Athlete's Name:_____ Date:_____

CHOWAN UNIVERSITY employs a Nationally Certified Athletic Trainer who is qualified to assess, treat, and rehabilitate most injuries you may incur while participating in our intercollegiate athletic programs. The Certified Athletic Trainers qualifications include:

1. Certification by National Athletic Trainer's Association Board of Certification
2. Licensed by the State of North Carolina Board of Athletic Trainer Examiners
3. Certified in CPR and First Aid

(Please circle appropriate response)

I DO - I DO NOT give my permission for the Athletic Training Staff to assess, treat, rehabilitate, and refer me as appropriate during the upcoming year.

_____

Signature

** Failure to give permission will result in the athlete being responsible for any and all injuries that may occur during the sports season. This results in the denial of first aid treatment, taping and wrapping, rehabilitation, and consultation. The athlete will be responsible for finding an outside source for all medical coverage.

CHOWAN UNIVERSITY ATHLETIC TRAINING RETURNING ATHLETE QUESTIONNAIRE

Name:_____Sport:_____Date:_____

Any problems you have had should be addressed and formal treatment identified. This annual form must be completed each season of sport participation. Any findings will be referred to the Team Physician or consulting physicians for review and additional treatment as indicated. This examination will be a comprehensive examination for those completing eligibility. Further medical evaluations may be required for specific matters.

1. Were you sent to the hospital for any illness/injury since the last sports season YES or NO

If yes, explain:

_____

2. Are you currently ill in any way? YES or NO

If yes, explain:

_____

3. Did you have a major injury (including cerebral concussion) since the last sports season?

YES or NO

If yes, explain:

_____

4. Do you have any incompletely healed injury/condition? YES or NO

If yes, explain:

_____

5. Are you currently taking any medications and/or supplements? YES or NO

If yes, explain:

_____

6. Have you seen a physician for any reason since the last sports season?

YES or NO

If yes, explain:

_____

Did you experience any of the following problems since the last sports season?

	Yes	No		Yes	No
High Blood Pressure			Dizziness		
Pain in chest			Heat problems		
Shortness of Breath			Concussion		
Fractures (explain below)			Other Illness(explain below)		

Signature Date

The undersigned herewith:
a. Understands that he or she must refrain from activity while ill or injured—whether or not medical treatment is being received—until cleared to do so by the Team Physician or a member of the Athletic Training staff under the direction of the Team Physician.
b. Clarifies that the answers to the above are true.

Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

I, _____ hereby authorize _____Chowan University_____
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my protected health information will be used only by the NCAA's Injury Surveillance System (ISS) for the purpose of conducting research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA, NCAA sports rules committees, athletic conferences, researchers and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injury/illness 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 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

_____
Signature Date

_____
Printed Name of Student-Athlete

Chowan University Athletic Department

Student Athlete Nutritional Supplement Disclosure and Review Form

I, _____ am taking or intend to take the following
(print name)
nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products do not contain substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NCAA endorses a product or approves its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's Head Athletic Trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's Head Athletic Trainer.

Brand Name	**Listed Ingredients**

_____ _____

Student Athlete Date Athletic Trainer Date

*** Please use the back of this sheet to list any additional supplements you are taking. Supplements include pills, powders, vitamins, energy products, protein and supplemental drinks.**

STUDENT-ATHLETE AUTHORIZATION FOR RELEASE OF INFORMATION TO MEDIA

I, _____, HEREBY AUTHORIZE AND REQUEST the
Student- Athlete Print Name

Chowan University Board of Trustees, the Chowan University Athletics and Sports Medicine Departments, and their duly authorized officers, employees and agents (including coaches, athletic trainers, physicians, and physical therapists) to furnish TO SPORTS INFORMATION AND/OR JOURNALISTS AND/OR OTHER MEDIA OUTLETS any and all information concerning or having a bearing on my participation in athletics at Chowan University. This authorization shall include, but is not limited to, any and all information within their knowledge, or contained in any records under their supervision or control concerning my physical condition, illnesses, injuries, and any treatment, hospitalization, surgery, examinations, diagnostic testing, and otherwise, and to make such reports concerning myself to such persons or organizations as they may request.

This authorization DOES NOT apply to the release of any records pertaining to psychiatric, psychological or psychotherapeutic services.

I understand that a record will be kept of all individuals requesting information under this Authorization and the date of the request. This information is normally confidential and except as provided in this Authorization will not be otherwise released by the parties in charge of the information.

This Authorization remains valid for *[check one]:*

- ☐ one (1) year following the date I sign below; or
- ☐ to this date _____.

I understand that I may revoke this authorization by providing a written revocation of authorization to the Athletic Director that specifically mentions release of information to MEDIA, including journalists, reporters, sports information, or any other media outlet representatives. I understand that a revocation is not effective to the extent that Chowan University has relied on this authorization to use or disclose any information about me.

I hereby fully release and discharge the Chowan University Board of Trustees and all its successors, assigns, trustees, officers, agents, and employees from any and all claims, demands, and causes of action whatsoever in connection with or in any way related to or arising out of the disclosure of information under the terms of this Authorization.

_____ _____
Student-Athlete Signature Date

_____ _____
Witness Signature Witness Print Name

HELMET WARNING STATEMENT

(Football Only)

Below is a reprint of the ***Warning Statement*** which is attached to all football helmets. Please read the statement carefully, then sign where indicated to signify that you have read the statement and understand what it implies. If you do not understand the statement, contact the athletic trainer and he/she will provide further explanation.

Do not strike an opponent with any part of this helmet or facemask. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death.

Severe brain or neck injury may also occur accidentally while playing football.

NO HELMET CAN PREVENT SUCH INJURIES
YOU USE THIS HELMET AT YOUR OWN RISK

Players Name (Print) _____

Players Signature _____

Date _____

Parent, spouse, or legal guardian signature,
if under the age of 18 _____

To: Chowan Student-Athletes and their Parents/Guardians
From: Chowan University Sports Medicine Department
RE: Insurance Coverage

Each student athlete is required to have a physical examination prior to any participation in any intercollegiate sport. The final decision on physical qualifications or reason for rejection is the responsibility of the team physician or athletic director. The team physician or athletic director also makes the decision on when an athlete may return to competition after a previous injury.

INJURIES----MEDICAL BILLS----INSURANCE COVERAGE----CLAIM PROCEDURE

Accidents do occur and we attempt to provide our athletes with the very best possible care. Medical bills may be incurred when the athlete is treated for bodily injury due to an accident, whether it be locally, during a road trip, or by a medical vendor in his/her own home area.

ONE FIRM STATEMENT: The NCAA discourages any college or university from providing coverage or paying the bills incurred for expenses related to illnesses or conditions which are not sustained as the direct result of an accident in our intercollegiate sports program. (This includes pre-existing conditions and non-athletic injuries.)

INSURANCE COVERAGE: The athletic accident insurance at *Chowan University* provides coverage for your son/daughter for accidents while participating in the play or official team practice of intercollegiate sports, including sponsored and authorized team travel.

CLAIM PROCEDURE: All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the college or university has instructed the medical vendors otherwise. In some cases the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the bill incurred to be sent.

A. Submit the bills incurred to your family, employer group coverage or plan first. They will do one of two things:
   1. Honor the claim and pay all or a portion of the bills incurred.
   2. Not honor the claim and send you a letter of denial. An example might be that your son/daughter is no longer part of your group policy after attaining the age of twenty-three.

B. If there remains a balance after your family, employer group insurance or plan has contributed towards the claim, send the claim sheet from the insurance company and a copy of the itemized bills incurred to the college or university's athletic department.
   If you receive a letter of denial from your family, employer group insurance or plan administrator, then send the letter of denial and a copy of the bills incurred to the college or university's athletic department. If no coverage is available, a letter from your employer with verification will be necessary.

C. If the bills incurred and not paid by the family, employer group insurance or plan is large enough, the claim will be sent from the athletic department to our insurance carrier office, which is in Kalamazoo, Michigan for processing. If they need any additional information, please cooperate with them and they will process the claim in the least possible amount of time. It is in your best interest to have the claim settled promptly since all the bills incurred are in your name.

PLEASE NOTE: If the primary family coverage is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) you must follow the proper procedures required by your plan in order for the college's insurance to satisfactorily complete its portion of the claim. This is especially important if your plan requires pre authorization to have your son/daughter treated if out of your plan's service area.

In order to provide the best medical treatment for the student-athletes here at Chowan University, here are some possible ways to ensure that your insurance will cover any doctor visits that may occur.

1) If your insurance policy is a HMO or PPO plan see if you can switch primary care providers (PCP) to a local physician. The general family practioner who sees most of the student-athletes is Dr. Frank Taylor in Conway, NC. If you can switch the PCP to a local physician then if you need to visit you will more than likely only have to pay the co-pay (the amount that you would normally pay to see a physician).
2) If you can not or do not want to switch your PCP please call the insurance company before the season begins to find out what the pre-authorization/referral procedures are for the insurance company. Ask the insurance company if it is possible to provide a contact number that we (the Athletic Trainers) could use to obtain the pre-authorization/referral or if the insurance can pre-approve any physician in this area.
3) Please call the insurance company and ask for a list of approved providers in this area. The Athletic Trainers can use this list in the case of the student-athlete has to see a physician.

Be sure to tell the Athletic Trainers if your PCP has been switched to a local physician. Also provide a written/typed form with any pre-authorization/referral information and the list of approved providers so it can be filed in the student-athletes medical file. Hopefully the student-athlete will not have to see a physician for an athletic related injury but it is better to be prepared for such a case. By providing this information it will also help to reduce the chance of having to pay an out-of-network fee or having to pay the full cost of the treatment. Please remember that the student athlete must have a primary insurance policy in order to participate. Chowan University Athletics carries a **SECONDARY** policy on all athletes. The student athlete is responsible for the $500 deductible in case of injury.

Parents should retain this letter for future references. Your cooperation in this important area will help make this program successful in minimizing delays and accomplishing the purpose for which it is intended.