



SPORTS MEDICINE

Concordia University New Student Athlete Health Information Booklet 2011-2012

NAME: _____ SPORT: _____ Circle one:
FRESHMAN or TRANSFER

The following packet is for student athletes who are participating in the 2011-2012 athletic season.

- This packet must be completed and returned to Athletic Department **BY AUGUST 1st.**
- Please fill out in **black ink only**
- Physicals must be dated **AFTER June 1st, 2011**
- Please keep a copy of this booklet for your records
- High School physical forms will not be accepted
- Faxed or copied booklets will not be accepted
- Please make sure to include copies of insurance card(s), front and back
- Please make sure to include copy of immunization records
- Failure to return all pages (11) this packet, **properly completed**, will result in **INABILITY TO PARTICIPATE IN TEAM ACTIVITIES INCLUDING CONDITIONING AND WEIGHT LIFTING.**

Please direct any questions to the CUAA Athletic Department at 734.995.7342

Attn: Athletic Department
Concordia University
4090 Geddes Road
Ann Arbor, MI 48105-2797

Athletic Trainer use only:

- 1.) Athlete/Emergency Contact/Insurance Information Form
- 2.) Assumption of Risk
- 3.) Permission to Treat/Release of Information Authorization
- 4.) Insurance Policies and Procedures/Secondary Insurance
- 5.) 1st Agency Authorization
- 6.) 1st Agency Parent/Student Information Form
- 7.) CUAA Medical History Questionnaire
- 8.) CUAA Annual Physical Clearance Form
- 9.) Copies of all current insurance cards
- 10.) Copy of Immunization Record



Assumption of Risk

Participation in sport carries with it a risk of injury. I, _____, understand that voluntarily participating in intercollegiate athletics at Concordia University Ann Arbor may result in injury/illness, permanent physical and/or mental impairment or even death. I also understand that although all reasonable precautions may be carried out to prevent a catastrophic injury, the risk cannot be totally eliminated. Concordia University Ann Arbor and its staff cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or my own failure to follow the safety procedures or techniques made known to me by coaching staff, athletic training staff, or by strength/conditioning personnel. I understand and agree to the following:

Please initial in each box to acknowledge that you have read and agree with the corresponding statement

I accept that Concordia University and its personnel are not to be held responsible for any pre-existing medical conditions(s) that I may have or any medical conditions that I fail to disclose in my health history. I understand that having passed the physical examination by my physician does not necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at Concordia University, but only that the evaluator did not find a medical reason to disqualify me at the time of the physical examination. I also understand that hiding any previous medical condition that may alter my ability to play may result in my immediate dismissal from the athletic program.

I understand and agree that if I experience an injury/illness, it is my responsibility to inform the coaching staff and athletic training staff of this condition and adhere to the established injury management protocol. Following an injury/illness requires restrictions per my physician; I must follow up with that physician for clearance to return to my sport. I know that I also must provide proper written documentation of said clearance to the athletic training staff before returning to activity.

I agree to wear the proper equipment as dictated by the rules of my sport. I may also have to wear padding or braces as indicated by the Athletic Trainer or tending physician. Failure to do so may put me at risk for further injury; however I understand that my safety cannot be entirely dependent upon a rulebook, equipment standards, or officiating.

I have read and understand the following (football players only):

Do not use helmet to butt, ram, or spear an opposing player. This is a violation of the football rules and can result in severe head, brain or neck injury, paralysis, or death to you and/or your opponent. There is a risk that injuries may occur as a result of accidental contact and no helmet can prevent all injuries. I can take action to reduce my risk of injury by making sure my helmet fits according to regulation with straps fastened properly, and by reporting to coaching staff when maintenance is necessary.

Furthermore, I understand and agree that participation in intercollegiate athletics includes an inherent risk of injury; I waive Concordia University Ann Arbor and its staff from any and all responsibility for any injury, illness or impairments suffered by myself due to my participation.

Student-Athlete Signature: _____

Date: _____

Student-Athlete Name printed: _____

If athlete under 18 years of age:

I, as the parent/legal guardian of the above named minor, have read the Assumption of Risk, fully understand it, and hereby voluntarily agree on behalf of myself as well as the minor I am responsible for. I agree to hold Concordia University Ann Arbor harmless for any claim or injury arising from the student-athlete’s participation in athletics.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name printed: _____

Permission to Treat/Release of Medical Information:

I, the undersigned, hereby affirm and acknowledge the following provisions:

A.) Permission to Treat:

I hereby grant the athletic training staff at Concordia University Ann Arbor, who is under the direction and guidance of the University of Michigan Health System – MedSport Sports Medicine Physician(s) to render any medical treatment they deem reasonably necessary for my health and well-being, including but not limited to preventative first aid, rehabilitation, emergency treatment, and referrals to outside medical professionals. I also hereby authorize the Concordia University staff, including coaches and administrators, to provide any emergency and/or other care deemed necessary to maintain my health and well-being, within their respective scope of practice or training. In the event that emergency care is required, I grant permission for my transportation to and hospitalization at an accredited medical facility.

B.) Release of Medical Information:

While enrolled at Concordia University Ann Arbor, I authorize the CUAA Athletic Training Staff to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purposes of health care treatment, payment for said treatment, or any other purpose which is permitted or required by law.

Personal Health Information includes but is not limited to: information regarding the nature and treatment of an injury/illness, medical history, insurance coverage and copies of medical and hospital records. This information will be released ONLY for the purposes of additional treatment (referrals to specialists and other health care providers), admission of participation status to your team’s coaching staff for your own health and safety, or to obtain payment for bills incurred in treating an athletic injury covered by CUAA’s secondary athletic insurance.

I agree to the release of general information to appropriate CUAA coaching and administrative staff concerning my medical status and condition, previous and current injuries, prognosis, treatment and other pertinent information related that will directly affect my participation. I further grant Concordia University Ann Arbor athletic training staff to release my medical records to my parent(s)/guardian(s)/spouse, and to other health care providers for the purpose of providing medical treatment. This authorization is valid for one year from the date of my signature below unless revoked as set forth in the following section.

C.) Revocation of Authorization:

I understand and hold the right to revoke this authorization, in writing, at any time by delivering this written notification to the athletic director at Concordia University Ann Arbor. I understand and agree that such a revocation is not effective until the athletic director acknowledges receipt of my notification via a written response and that such a revocation is not effective to the extent that anyone, including Concordia University Ann Arbor, has acted in accordance of this authorization to disclose medical information prior to the effective revocation of this statement.

I have read and understand the provisions listed above in their entirety.

Student-Athlete Signature: _____

Date: _____

Student-Athlete Name printed: _____

If athlete under 18 years of age:

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name printed: _____

Student-Athlete Insurance Policies and Procedures

To CUAA Student-Athlete/Primary Insurance Policy Holder:

All Concordia University student-athletes **must** be covered by primary individual health insurance before participating in any athletic activity including but not limited to competition, practices, conditioning, weight lifting or any other form of team activity. All student-athletes must provide proof of primary insurance by including a copy (front and back) of their insurance card(s) for medical, dental and/or vision coverage. It is the responsibility of the student-athlete to notify the athletic department if a cancellation or change in coverage of individual health insurance occurs. Failure to do so will render said student-athlete ineligible for participation in any and all forms of team activity; also, any medical bills incurred during this time will become the student-athlete's responsibility.

Concordia University-Ann Arbor has a student health insurance plan available for its students to purchase through UnitedHealthcare StudentResources. This plan gives students an option to purchase a health insurance plan if they currently do not have coverage; it provides comprehensive benefits along with specific coverage for intercollegiate athletic injuries. For more information about this plan, its benefits and the application process for coverage, please visit <http://www.uhcsr.com>, click on "Find My School's Plan" and search for "Concordia – Ann Arbor." You may also call Customer Service at 1-800-767-0700.

Any additional questions can be forwarded to Eric Chambers, the Executive Director of Student Services; he can be reached by phone at 734-995-7419 or via email at chambee@cuaa.edu.

Secondary Insurance Information

Concordia University Ann Arbor provides a secondary accident insurance plan for its student athletes through 1st Agency, Inc. **THIS POLICY IS SECONDARY TO, OR IN EXCESS PRIMARY MEDICAL INSURANCE COVERAGE. The availability of secondary insurance DOES NOT mean that Concordia University Ann Arbor accepts responsibility for student-athlete medical expenses of any kind.**

The secondary insurance covers **only** injuries/illness/accidents resulting from the direct participation in the intercollegiate athletic program during the dates of the primary competitive season and designated off-season programs as approved by the Athletic Department according to NAIA guidelines; this does not include overuse or chronic injuries. Concordia University's provides secondary dental insurance that covers **only** the cost to repair damage to natural teeth that resulted from participation in the sanctioned activities of their sport as defined by NAIA guidelines.

For the secondary coverage to be accessed the student/athlete must have stayed within the guidelines of their primary carrier. If your primary insurance plan is an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization), you must follow proper procedures required by your plan in order for CUAA's secondary insurance company to complete its portion of the claim. This is especially important if your plan requires pre-authorization to be treated if out of your plan's service area.

PLEASE NOTE: Student-athletes must notify the athletic training staff if receiving treatment or examination outside of staff referrals for injuries occurring during NAIA sanctioned activities if they anticipate receiving secondary insurance benefits. The CUAA Athletic Training Staff will provide the student-athlete with further instructions in regards to secondary insurance coverage. Failure to do so may result in the forfeit of said benefits and any balances that are not covered through primary insurance will become the athlete's responsibility.

I have fully read and understand the information provided above and should I have any questions or concerns, I will contact the Concordia University Ann Arbor Athletic Training Staff during regular hours of operation.

Student-Athlete Signature: _____

Date: _____

Policy Holder's Signature: _____
(Required)

Date: _____



First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501
269-381-6630

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative of Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant



PARENT/GUARDIAN/STUDENT INFORMATION FORM

First Agency, Inc.

5071 West H Avenue
Kalamazoo, MI 49009-8501

RETURN FORM WHEN COMPLETE TO

Name of College/University Concordia University Ann Arbor

Attention Athletic Department

Address 4090 Geddes Rd

City Ann Arbor State MI Zip 48105-2797

This form is to be completed by the
Parents, Guardians or Student

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete Sport
Social Security No or Passport No Date of Birth
College Address College Phone ()
Home Address Home Phone ()
City State Zip

FATHER/GUARDIAN INFORMATION

MOTHER/GUARDIAN INFORMATION

Father's Name
Social Security No.
Date of Birth
Address
Employer
Address
Telephone ()
Medical Insurance
Company or Plan
Address
Policy Number
Telephone ()

Mother's Name
Social Security No.
Date of Birth
Address
Employer
Address
Telephone ()
Medical Insurance
Company or Plan
Address
Policy Number
Telephone ()

Is this plan an HMO or PPO? [] Yes [] No
Is pre-authorization required to obtain treatment? [] Yes [] No
Is a second opinion required before surgery? [] Yes [] No

Is this plan an HMO or PPO? [] Yes [] No
Is pre-authorization required to obtain treatment? [] Yes [] No
Is a second opinion required before surgery? [] Yes [] No

Concordia University Medical History Questionnaire

Name _____ Date _____ Sport: _____

DOB ____/____/____ Height: _____ Weight: _____ Blood Pressure: _____

Please answer the following questions accurately. Please explain in space provided if answered "YES"

FAMILY MEDICAL HISTORY: *Have any blood relatives had?*

	NO	YES	WHO:		NO	YES	WHO:
Cancer				Stroke			
Diabetes				Epilepsy / Seizures			
High Blood Pressure				Mental Illness			
Depression				Sickle Cell Trait			
Die suddenly before age 50				Blood Disorder			
Heart Disease							
Other:							

HAVE YOU EVER EXPERIENCED OR BEEN DIAGNOSED BY A PHYSICIAN FOR ANY OF THE FOLLOWING CONDITIONS?

(Continues on next page) *If you are currently in the care of a specialty physician for anything listed below, you may need clearance for athletic participation from that physician... please see athletic trainers*

	NO	YES	DATE	EXPLAIN (tests, results, surgeries, physicians, etc)
CARDIOPULMONARY:				
Marfan Syndrome				
Hypertropic Cardiomyopathy				
Heart Murmur				
Heart Disease				
Mitral Valve Prolapse (MVP)				
Supraventricular Tachycardia (SVT)				
High Blood Pressure				
Bradycardia (slowed heart beat)				
Tachycardia (rapid heartbeat)				
Arrhythmia				
Syncope				
Hyperventilation				
Difficulty Breathing				
Frequent Chest Pain				
Enlarged heart				
Asthma				
	NO	YES	DATE	
NEUROLOGIC:				
Numbness / Tingling				
Loss of sensation				
Frequent Headaches				
Migraines				
Seizures or Epilepsy				
Concussion:				
	NO	YES	DATE	
PSYCHOLOGICAL:				
Mood Disorders				
Depression				
Anxiety				
Eating Disorder				

Concordia University Medical History Questionnaire – CONTINUED

GENERAL MEDICAL:

	NO	YES	DATE	EXPLAIN
Diabetes				
Cancer				
Sickle Cell Trait				
Anemia				
Blood Disorder				
Lyme Disease				
Cyst				
Tumor / Growth				
Kidney Trouble				
Kidney Stones				
G.I. Disorder				
Liver Trouble				
Gall Bladder				
Appendicitis				
Intestinal Trouble				
Hernia				
Cellulitis				
Staph Infection				
MRSA				
FEMALES:				
Irregular Menses				
Absence of Menses				
Ovarian Cyst				
Pap smear within 1year?				

DO YOU CURRENTLY WEAR OR HAVE:

	NO	YES	EXPLAIN
Dental gear or appliances			
Contacts			
Glasses			
Protective eye wear			
External devices (<i>insulin pump, heart monitor, etc</i>)			
Internal Implants			
Pacemaker			

ILLNESS HISTORY: Have you ever had?

	NO	YES	DATE or AGE:		NO	YES	DATE or AGE:
Sinus infection				Measles			
Ear infection				Mumps			
Throat infection				Tuberculosis			
Chicken Pox				Meningitis			
H1N1				Mononucleosis			

ALLERGIES:

	NO	YES	REACTION:		NO	YES	REACTION:		NO	YES	REACTION:
Aspirin				Penicillin				Bee Stings			
Ibuprofen				Erythromycin				Hay Fever			
Acetaminophen				Ibuprofen				Tetanus			
Iodine				Vicodin				Sulfa Drugs			
Betadine				Novocain				Codeine			
Bacitracin				Tylenol III				Demerol			
Hydrogen Peroxide				Tylenol				FOOD ALLERGIES:			
Tuff Skin/Adhesives				Latex							

Concordia University Medical History Questionnaire – CONTINUED

HAVE YOU EVER HAD ANY INJURIES TO THE FOLLOWING? *Please indicate type of injury (sprain, strain, fracture, dislocation, etc) and the treatment for the injury (surgery, rehab, etc)*

	NO	YES	DATE	EXPLAIN		NO	YES	DATE	EXPLAIN
Foot/ Ankle					Chest				
Lower Leg					Shoulder				
Knee					Arm				
Thigh / Hip					Elbow				
Abdomen					Wrist / Hand				
Low Back					Face				
Upper Back					Head				
Spine					Neck				

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING WITH EXERCISE?

	NO	YES	EXPLAIN		NO	YES	EXPLAIN
Dizzy				Chest Pain			
Lightheaded				Nausea			
Fainting				Vomiting			
Difficulty Breathing				Fatigue			
Abnormal heart beat				Dehydration			
Intolerant to exercise				Heat-Related illness			

Please indicate and explain any other medical conditions, injuries, or illnesses not previously mentioned:

Do you have an epi-pen, rescue inhaler, or other emergency medication / treatment? YES NO

**If so, please provide extra treatment for athletic trainer to have in the event of an emergency*

Please list any medications you are currently taking (including Birth Control):

Please list any supplements you are currently taking (vitamins, creatine, N.O., etc.):

I have completely and accurately filled out the Medical History Questionnaire. I understand I may need to follow up with the Athletic Training Staff as necessary regarding my medical history. I understand it is my responsibility to inform the Athletic Training Staff of any changes in my health.

Student-Athlete Signature: _____

Date: _____

Parent Signature: _____

Date: _____

(If athlete under 18 years old)



SPORTS MEDICINE

Concordia University Annual Physical Clearance Form 2011-2012

Name _____ Date _____

DOB ____/____/____ Sport: _____ Year: Fresh Soph Jr Sr

Blood Pressure _____ Pulse _____ Height _____ Weight _____

	NORMAL	ABNORMAL	COMMENTS
Cardiac			
Lungs			
Spine			
Skin			
Abdominal			
Genitourinary			
Gastrointestinal			
Head / Neurologic			
Eyes/Ears/Nose/Throat			
Shoulder			
Elbows			
Wrists			
Hands			
Fingers			
Hips			
Knees			
Ankles			
Feet			

Other Medical Findings: _____

I certify that I have reviewed the medical history of this athlete and recommend:

- ____ Clearance for intercollegiate athletic participation with no limitations
- ____ Clearance pending further evaluation or testing -- Please Explain: _____
- ____ Disqualified from participating in intercollegiate athletics -- Please Explain: _____

Signature of examining Physician _____ Date _____

Name of examining Physician _____ Phone # _____ Fax # _____

Please attach Business Card or VOID Prescription note of examining Physician for further contact regarding this physical exam. Thank You.

