

Summer 2009

Dear Parents and Student-Athletes:

Welcome to the Louisburg College Athletic Program. We hope your summer break is going well. The Louisburg College Athletic Training Staff is here to assist you in any way we can while you are a student-athlete at Louisburg College.

Enclosed you will find some important forms that must be read and **completed before you will be allowed to participate in any Louisburg College athletic activity** (games/practices). Please take time to complete these forms and return them to the Athletic Training Staff at the address below. These forms must be received no later than August 1, 2009. **IF THESE FORMS ARE NOT COMPLETED AND RETURNED IN TIME, YOU WILL NOT BE ALLOWED TO PARTICPATE IN ANY ATHLETIC ACTIVITY UNTIL ALL FORMS ARE SIGNED AND COMPLETED IN THEIR ENTIRETY.** ***Please note you will receive health forms from student-life, returning those forms to student-life **will not be sufficient** for clearance for athletic participation. It is your responsibility to submit a **separate** copy of your physical directly to the athletic trainer. Please indicate on the forms which sport you are here to play.

THE FORMS THAT MUST BE COMPLETED, SIGNED & RETURNED ARE:

1. **Athletic Medical History**
2. **Parent/Student Insurance Information (Including a copy of insurance cards. If no insurance clearly state NONE on the insurance form)**
3. **Physical Form (Either a copy of the student life form or the enclosed form)**
4. **The information letter signed**

The physical must be dated on or after June 2008 to ensure its validity throughout the 2009-2010 academic year. **Previous high school physicals and doctor's notes on a prescription pad WILL NOT BE ACCEPTED AS VALID PHYSICALS.**

All Louisburg College student-athletes are covered under a school accidental insurance policy. This policy is a **SECONDARY** policy. **The school athletic policy will only cover injuries incurred during an organized practice or competition while representing Louisburg College.** This policy does not cover pre-existing conditions or illnesses. If a student-athlete does sustain an injury or illness, it is their sole responsibility to report it to the Athletic Training Staff within one week to ensure the proper paperwork can be filed. Louisburg College Sports Medicine team is comprised of two Certified Athletic Trainers, an orthopedic surgeon and a general practitioner. If you need medical assistance first seek the evaluation of the staff Athletic Trainers who will help to make appointments with the appropriate medical professionals. If you sustain an injury and receive medical bills it is imperative the Athletic Trainers receive copies of all bills to help insure timely and appropriate payment. The Athletic Trainers can also assist in filling out and filing the paperwork to the secondary insurance policy.

The processing of Athletic Related Injury Claims is as follows:

1. The claim is processed through the student-athlete's primary insurance. This means if the athlete has an HMO or PPO, everything will be attempted to get the proper referrals. This should ensure proper payment by the primary insurance company first. If the student-athlete does not have primary insurance, assistance can be obtained in extenuating circumstances.
2. Parents or student-athletes will begin receiving bills and Explanation of Benefits (EOB) regarding partial payment, full payment, or deductibles from the provider and the insurance company. It is the student-athletes or parents responsibility to contact the Athletic Trainers so that these bills/statements may be appropriately processes and forwarded on to the secondary insurance company. Please send copies of all bills and EOB's to the athletic trainer's upon receipt.
3. It is likely that parents and student-athletes will continue to receive bills and EOB's for months after the date of service. This is due to the lengthy process of insurance companies. Parents and student-athletes should continue to forward this information to the Athletic Training Staff.

It is also the responsibility of the parents or student-athletes to notify the Louisburg College Athletic Training Staff of any changes in medical insurance coverage during the school year. If there is a lack of notification, payment responsibility may fall solely on the primary insured.

Please complete all forms legibly. All signatures are required and all questions must be answered to the best of your knowledge. These forms are due no later then August 1, 2009. Should you have any questions please do not hesitate to call Amanda Ryan at (919) 497-3435. It is strongly recommended that you make copies of all forms being turned in. Please send all forms and any correspondence to:

**Athletic Training Staff • 501 N. Main St. • Louisburg, NC 27549
(919) 497-3435 (office) (919) 496-7330(fax)**

Respectfully,

Amanda L. Ryan, MS, ATC, LAT
Head Athletic Trainer

I have read this packet in its entirety and fully understand the information mentioned in the letter above. I understand that I am responsible for all forms being returned to the Louisburg College Athletic Training Staff, and I am aware of the basic process of the athletic injury insurance policy.

Parent Signature

Date

Student-athlete Signature

Date

**PLEASE READ THE FOLLOWING CONSENT FROMS CAREFULLY:
(If you are under 18 years of age, your parents must also sign)**

Medical Consent:

I, _____, hereby grant permission to the Louisburg College team physicians and/or their consulting physicians to render to myself any treatment, medical or surgical care that they deem reasonably necessary to my health or well-being. In the event that hospitalization is required, I give my permission for hospitalization at an accredited hospital.

I also herby authorize the athletic training staff at Louisburg College who are under the direct supervision of the team physicians, to render any preventative treatment, first aid, rehabilitation or emergency treatment that they deem reasonably necessary to my health and well-being.

• _____
Athlete's Signature

Date

• _____
Parent/Guardian Signature

Date

Assumption of Risk:

I, _____, verify that I have been informed that I may be injured while participating in intercollegiate athletic practice or competition. I understand that it is possible that I may sustain an injury, which may result in permanent disability, paralysis or possibly death. I understand that paralysis may include loss of movement, feeling and use of my arms, legs and trunk. I further understand that paralysis may involve complete loss of sexual function and/or bowel and bladder control which would require the use of external aids, attached or inserted into my body for the collection and removal of body wastes.

I understand that paralysis and its effects could last my entire lifetime.

In addition, I understand that an injury to any of my body joints (i.e. ankle, knee, hip, spine, shoulder) may result in disfigurement, loss of movement, strength or feeling which may last my entire lifetime.

I understand that it is my responsibility to adhere to all rules and regulations of my chosen sport. I understand that infraction of the rules may result in injury to myself or my opponent. I also understand that no modification of protective equipment or uniform should be made.

I understand that all injuries are to be reported to the athletic trainer assigned to my sports team and that I am responsible for the follow-up care and treatment of my injuries under the supervision of the athletic trainer assigned to my sport.

I accept these risks of participation in _____ during the duration of my attendance at Louisburg College. (sport)

• _____ (Athlete's Signature) _____ (Date)

• _____ (Parent's Signature) _____ (Date)

**Louisburg College
Athlete Authorization/Consent
for Disclosure of Protected Health Information**

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Louisburg College to receive and release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in Louisburg College athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be obtained from or given to other health care providers, parents/guardians, hospitals and/or medical clinics and laboratories, athletic coaches, strength and conditioning coaches, medical insurance coordinators, insurance carriers, medical supply vendors and/or service companies, academic counselors, and athletic and/or Louisburg College administrators.

I understand that my authorization/consent for the disclosure of my protected health information is a condition for participation as an athlete for Louisburg College. I understand that my protected health 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 (Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Director of Sports Medicine, but if I do, it will not have any effect on the actions Louisburg College in reliance on this authorization/consent prior to receiving the revocation. I also understand that revocation of this authorization/consent may affect my athletic eligibility.

Name of Student-Athlete

Signature of Student-Athlete

Date

Social Security Number

Date of Birth

Louisburg College
Pre-participation Physical Examination

PLEASE TYPE OR PRINT IN INK

Name _____ SS# _____

Sport _____ Age _____ Date of Birth _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Visual Acuity (corrected) (uncorrected) _____

General Medical Examination

Please check and describe every abnormality in detail below:

1. HE _____ 6. ABD _____

2. ENT _____ 7. GU _____

3. NECK _____ 8. HERNIA _____

4. CHEST _____ 9. NEURO _____

5. CV _____ 10. SKIN _____

Remarks:

General Orthopedic Examination

Cervical Spine

Flexion _____ yes or no Normal thoracic curve _____ yes or no
Extension _____ yes or no Normal lordotic curve _____ yes or no

Lateral Flexion R _____ L _____ Range of Motion _____

Rotatoin R _____ L _____ Hip

Compression/distraction _____ Flexion R _____ L _____

Shoulder Extension R _____ L _____

Flexion R _____ L _____ Abduction R _____ L _____

Extension R _____ L _____ In/Ex Rotation R _____ L _____

Abduction R _____ L _____ Knee

Ex Rotation R _____ L _____ Flexion R _____ L _____

In Rotation R _____ L _____ Extension R _____ L _____

Scap. Winging R _____ L _____ General Knee Stability R _____ L _____

Ant/Post Glide R _____ L _____ Ankle

Elbow Inversion R _____ L _____

Flexion R _____ L _____ Eversion R _____ L _____

Extension R _____ L _____ Anterior Drawer R _____ L _____

Comments: (please note any pre-existing conditions)

The athlete (may) (may not) participate in Louisburg College Athletics

Physician's Signature

Date

Print Physicians Name, Address, Phone Number

Please Return to: Athletic Trainng, Louisburg College, 501 N. Main St, Louisburg, NC 27549

Louisburg College
Medical Insurance Information

Athlete's Name _____ SS# _____ DOB _____
Sex _____ Sport _____ Home Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____

Primary Insurance

Parent/Guardian _____ SS# _____
Home Address _____
State _____ Zip _____ Home Phone Number _____
Employer _____ Phone # _____
Employer Address _____
Insurance Co. _____ Phone # _____
Claims Address _____
Policy Number _____ Group Number _____

Is your son/daughter covered under the above policy? Yes No
Type of Coverage: (circle one) Does your insurance require?
Health Maintenance Organization(HMO) Second Opinion for surgery Yes No
Preferred Provider (PPO) Pre authorization Yes No
Comprehensive Plan
Other(please list): _____

Primary Care Physician and Phone # _____

Secondary Insurance

Parent/Guardian _____ SS# _____
Home address _____
Home phone number _____
Employer _____ Phone # _____
Employer address _____
Insurance Co _____ Phone # _____
Claims Address _____
Policy Number _____ Group Number _____

Is your son/daughter covered under the above policy? Yes No
Type of Coverage: (circle one) Does your insurance require?
Health Maintenance Organization(HMO) _____ Second Opinion for surgery Yes No
Preferred Provider (PPO) _____ Pre authorization Yes No
Comprehensive Plan _____
Other(please list): _____

Dental-Eye or Other Insurance Coverage

Parent/Guardian _____ SS# _____
Insurance Co _____ Phone # _____
Claims Address _____
Policy Number _____ Group Number _____

Is your son/daughter covered under the above policy? Yes No
I hereby authorize the physician(s) rendering service to submit a claim to my Health Insurance Company for all covered services rendered by the physician(s) and direct the Health Insurance Company to issue payment check(s) directly to the physician signing this report to furnish complete information of my Health Insurance Company regarding service rendered, and I hereby claim the amount of indemnity specified with my Health Insurance Company.

• _____
Signature of Policyholder(s) _____ Date _____

Please include a photocopy of front and back of insurance cards