

TO: PARENTS OF ST. ANDREWS INTERCOLLEGIATE ATHLETES

We are extremely pleased to have your son/daughter as a student athlete at St. Andrews and hope that he/she will achieve academic, social, and athletic success.

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 St. Andrews 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.

Parents should retain this letter for future references. In addition, we ask that you complete the attached form IN DETAIL and return to us prior to any athletic participation. Your cooperation in this important area will help make this program successful in minimizing delays and accomplishing the purpose for which it is intended.



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

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University St Andrew's Presbyterian College
 Attention Athletic Training Department
This form is to be completed by the Address 1700 Dogwood Mile
Parents, Guardians or Student City Laurinburg State NC Zip 28352

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 _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
Employer _____	Employer _____
Address _____	Address _____
Telephone (____) _____	Telephone (____) _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____	Address _____
Policy Number _____	Policy Number _____
Telephone (____) _____	Telephone (____) _____
Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No



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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

Medical History

Please answer each of the following questions by circling **YES** or **NO**. Fill additional information as needed. The information provided is strictly confidential and used for health care purposes only.

Family History:

Has any parent, grandparent, or sibling had:

Cancer	YES	NO
Leukemia	YES	NO
Tuberculosis	YES	NO
Diabetes	YES	NO
Heart disease	YES	NO
High blood pressure	YES	NO
Asthma	YES	NO
Liver disease	YES	NO
Migraine headaches	YES	NO
Emphysema	YES	NO
Stroke	YES	NO
Epilepsy/Seizures	YES	NO
Bleeding disorder	YES	NO
Kidney disease	YES	NO
Glaucoma	YES	NO
Sickle cell anemia	YES	NO
Arthritis	YES	NO
Alcohol or drug abuse	YES	NO
Nervous or mental disease	YES	NO
Other serious disease	YES	NO
Sudden death before age 50	YES	NO

Medications:

Are you currently taking any drugs, medicines, birth control pills, or vitamins (prescription and non-prescription)? YES NO
 What? _____

Allergies:

Latex	YES	NO
Penicillin	YES	NO
Sulfa drugs	YES	NO
Other antibiotics	YES	NO
What? _____		
Aspirin	YES	NO
Other drug/medicine	YES	NO
What? _____		
Any food item	YES	NO
What? _____		
Bee stings/Insect bites	YES	NO
Other allergy	YES	NO
What? _____		

Personal History:

Do you smoke?	YES	NO
Do you use any other forms of tobacco?	YES	NO
If yes, what? _____		
How much? _____		
Do you drink:		
Beer?	YES	NO
Wine?	YES	NO
How much? _____		
Do you use drugs?	YES	NO
Are you on a special diet?	YES	NO
Have you lost weight in the past year?	YES	NO

Are you satisfied with your weight?	YES	NO
Do you think you have an eating disorder?	YES	NO

Health History:

Do you now, or have you in the past had any of the following:

Concussion	YES	NO
Loss of consciousness	YES	NO
Memory loss	YES	NO
Numbness/weakness in arm or leg	YES	NO
Migraine headaches	YES	NO
Mouth/tooth/tongue problem	YES	NO
Recurrent nosebleeds	YES	NO
Epilepsy/Seizures	YES	NO
Heat related illness	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Blindness (either eye)	YES	NO
Blurred vision (not corrected by glasses)	YES	NO
Ear infections	YES	NO
Deafness/Hearing Deficiency	YES	NO
Difficulty sleeping	YES	NO
Asthma	YES	NO
Shortness of breath/wheezing	YES	NO
Coughing up blood	YES	NO
Hay fever	YES	NO
Chronic Bronchitis	YES	NO
Tuberculosis	YES	NO
Heart murmur	YES	NO
Pain/pressure in chest	YES	NO
Rheumatic fever	YES	NO
High blood pressure	YES	NO
Mononeucleosis	YES	NO
Hepatitis	YES	NO
Acid Reflux disease	YES	NO
Stomach or Duodenal Cancer	YES	NO
Colon trouble	YES	NO
Rectal trouble	YES	NO
Bladder/Urinary tract infection	YES	NO
Kidney infection	YES	NO
Kidney stones	YES	NO
Loss of kidney	YES	NO
Other kidney disease _____		
Anemia	YES	NO
Poor blood clotting	YES	NO
Diabetes	YES	NO
Taking insulin?	YES	NO
Overactive thyroid	YES	NO
Underactive thyroid	YES	NO
Arthritis	YES	NO
Phlebitis	YES	NO
Recurrent boils	YES	NO
Changing mole	YES	NO
Other skin disease	YES	NO
What? _____		
Depression/Anxiety	YES	NO
Serious emotional illness	YES	NO

Health History (continued):

Neck injury	YES	NO
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Shoulder injury	YES	NO
What?		

What? _____		
Wrist/hand injury	YES	NO
What? _____		
Back injury	YES	NO
What? _____		
Hip/thigh/groin injury	YES	NO
What? _____		
Knee injury	YES	NO
What? _____		
Ankle/foot/lower leg injury	YES	NO
What? _____		
Broken bone	YES	NO
What? _____		
Stress fracture	YES	NO
What? _____		
Facial injury	YES	NO
What? _____		
Surgery	YES	NO
Please explain. _____		

<i>Women</i>		
Menstrual difficulty	YES	NO
Ovarian cyst	YES	NO
Regular periods	YES	NO
Breast lump	YES	NO
Other GYN problems _____		
<i>Men</i>		
Loss of testicle	YES	NO
Other _____		

Please provide further information if needed for any of the previous questions. _____

Do you have any condition or disease not listed on this form?	YES	NO
Please explain: _____		

- A. I have personally reviewed the information provided in this Sports Health Information Summary and attest that it is true and complete to the best of my knowledge.
- B. I understand that participation in sports requires an acceptance of risk for injury.
- C. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the athletic training staff, including physician referral. I understand that I am responsible for all medical costs incurred when physician referral is necessary.
- D. I understand that I (my son/daughter) must refrain from practice or play while ill or injured until I (he/she) am/is discharged from treatment or given permission by the athletic training staff to restart participation despite continuing medical treatment.
- E. I understand that having passed the sports physical examination does not necessarily mean that I (my son/daughter) am/is physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
- F. I hereby give my permission to the athletic training staff to disclose my (my son's/daughters) personal health information when it pertains to my (his/her) athletic injury/illness, treatment, and/or ability to participate in collegiate athletics to my (his/her) coaches, parents/guardian, and/or other health care providers involved in my (his/her) medical care (ie. SAPC Health and Wellness, referring physicians, etc...).
- G. I understand that if I feel that my privacy has been violated without my consent, I may file a complaint to the U.S. Health and Human Resources Department.

Student-Athlete Name (print) _____

Signature of Student-Athlete _____

Date _____

Signature of Parent/Guardian (if student is under age 18) _____

Date _____

Authorization and Consent

Statement by Student-Athlete or Parent/Guardian, if Student-Athlete is Under Age 18

This authorization allows our licensed athletic training staff to treat you, refer you to a physician for treatment, or obtain emergency treatment for you, while you are a student-athlete at St. Andrews. If you are over age 18, we will proceed without notifying parents prior to treatment. If you are under 18, your parent or legal guardian must also sign this authorization. This authorization is also required to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA was created to protect the privacy of personal health information (PHI). HIPAA regulations prohibit the disclosure of PHI unless written authorization is given. Therefore, in order to communicate with your coaches, parents/guardian, or other health care providers about your injury and/or condition, the athletic training staff must obtain your permission.

Athletic Physical Exam
(To be completed by a physician)

Student-Athlete's Full Name: _____ Date: _____

Sport(s): _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: *Uncorrected:* Right 20/____ Left 20/____ *Corrected:* Right 20/____ Left 20/____
Both: 20/____ Glasses/Contacts _____

Heart: Heart Inspection _____ Palpation _____
 Rhythm _____ Sounds & Murmurs _____

Genitalia: _____ Not Examined _____

	Satisfactory		Physician's Comments	Follow-up	
	Y	N		Y	N
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thorax and Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal:

General Posture/ Deformities/ Scars: _____

Neck/ Cervical-Spine/ Back: _____

Lower Extremities:

Hip	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Shin	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Calf	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Toes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Upper Extremities:

Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Wrist, Hand, Fingers	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Athletic Participation Approved: Yes _____ No _____

Additional Comments/ Limitations: _____

Physician's Signature: _____ Date: _____

Physician's Office Phone Number: _____