

To: All Student-Athletes and Parent/Guardians of Elizabeth City State University
From: Shirley-Ann R. Lee, Med ATC/L (Head Athletic Trainer)
Re: Student-Athlete Insurance Claim Procedure
Date: April 26, 2011

All student-athletes have student and athletic related insurance. Pearce and Pearce is offered to all students attending Elizabeth City State University (ECSU). K&K Insurance covers all athletic injuries incurred by student-athletes while representing the university. Student athletes on scholarship do not have the option of waiving either of the required insurances while participating in intercollegiate athletics at ECSU.

In an effort to ensure that ECSU student-athletes have the best support when injuries occur, the following policies and procedures have been established.

Insurance Claim Filing Process

In order to adequately process claims and to ensure that the student-athletes do not incur a balance during athletic participation or at the end of their eligibility, the following guidelines must be adhered to:

1. **Primary Insurance:** Student-athletes must provide the athletic department with a copy of their private insurance, if available.
2. **Secondary Insurance:** After private insurance has been filed, a claim will be submitted to Pearce and Pearce – 3,000 maximum benefit.
3. **K&K Insurance:** If a balance still remains and Pearce and Pearce has reached its maximum benefit, a claim will be filed with K&K to pay the remaining balance. K&K Insurance covers an excess of 65,000 max and **ANYTHING BEYOND 75,000 THE STUDENT MAY BE RESPONSIBLE FOR.**

Special Note: All bills received by the student-athlete must immediately be sent to the athletic department for prompt processing. Send bills to the attention of:

Shirley-Ann R. Lee
Head Athletic Trainer
Elizabeth City State University
1704 Weeksville RD, Campus Box 900
Elizabeth City, NC 27909

If you have any questions, comments, or concerns feel free to contact me at 252-335-3389 or slee@mail.ecsu.edu

Elizabeth City State University
Department of Athletics
Requirements for Student-Athlete Participation

The following are required before student-athletes can participate in athletics at ECSU- **No Exceptions**.
Please ensure that you have the following required documents.

____ Current physical form completed and signed by a physician

____ Sickle Cell screening results

____ Current ECSU Health Questionnaire

All of the above mentioned documents must be submitted to the athletic trainer before any form of athletic activity takes place. By signing this document you are confirming that all required documents are being submitted.

Student Signature

Date

Name _____ Sport _____ SSN _____

Sex _____ Date of Birth _____ Phone _____

Permanent Address _____ City _____ State _____ Zip _____

ECSU athletic insurance policy provides coverage assistance for injuries that occur during the participation of practice or competition of intercollegiate sports. This policy is a secondary policy that indicates that any claim must first by law be filed with a primary insurance carrier. After the primary insurance has paid all benefits then the secondary policy will consider the remaining amounts based on usual and customary charges. ECSU's athletic insurance policy covers athletic injuries ONLY and is not a substitute for comprehensive coverage.

INSURANCE INFORMATION AND EMERGENCY CONTACTS

Father _____
Home address _____
Phone(H) _____ Phone(W) _____
Insurance company _____ Policy _____
Claims address _____
Phone _____ HMO or PPO(Circle One)

Mother _____
Home address _____
Phone(H) _____ Phone(W) _____
Insurance company _____ Policy _____
Claims address _____
Phone _____ HMO or PPO(Circle One)

I hereby authorize a claim to be filed on my behalf under the Group medical policy in the event that an intercollegiate athletic injury is sustained by my son/daughter while at ECSU.

Signature of Parent/Guardian _____ Date _____

ELIZABETH CITY STATE UNIVERSITY ACCEPTANCE OF RISK STATEMENT

I, _____ am aware of and accept the risk of serious injury that may render me disable or paralyzed as a result of intercollegiate athletics in which I will be participating. I will do my part to reduce the risk of injury by keeping myself in the best possible condition and will follow the advice of the team physician, athletic training staff, and the Health Center personnel concerning the prevention, treatment, rehabilitation, and management of an athletic injury.

Print _____

Signature _____ Date _____

Please answer each question as accurately as possible. If answering YES to any of these questions, please list the date and physician seen-if applicable

Has anyone in your family ever had?, if so who			Have you had or do you have now?		
Marfan's Syndrome	YES	NO	Back injury or frequent backaches	YES	NO
Hypertrophic Cardiomyopathy	YES	NO	Knee Injury(S) if yes name what type	YES	NO
Clinically Important Arrhythmias			Ankle Injury(S)if yes name what type	YES	NO
Diabetes(high blood sugar)			Other Joint Trouble	YES	NO
Allergies(hay fever/asthma)	YES	NO	Bone Infections	YES	NO
Migraine Headaches	YES	NO	Have you ever had surgery?	YES	NO
Hearing Trouble	YES	NO			
High Blood Pressure	YES	NO			
Has anyone in your family under the age of 50 died suddenly?	YES	NO			
Have you had or do you have now?			Have you had or do you have now?		
Brain Concussion(head injury)	YES	NO	Bone Fracture	YES	NO
Tendency to lose consciousness	YES	NO	Joint Dislocation	YES	NO
Skull Fracture	YES	NO	Foot Problems	YES	NO
Convulsions or epilepsy	YES	NO	Shoulder Injury	YES	NO
Neck Injury	YES	NO	Osgood Schlatter's(jumpers knee)	YES	NO
Burners, stingers, numbness of the neck, shoulder, or hand	YES	NO	Shin Splints	YES	NO
Have you ever been found to have only one of two functioning organs(kidney, eye, testicle, ovary)	YES	NO	Diabetes	YES	NO
Hernia	YES	NO	Tendency to bleed or bruise easy	YES	NO
Kidney Problems	YES	NO	Anemia	YES	NO
Blood in the urine	YES	NO	Weight Problems	YES	NO
(M)Loss of function or absence of testicles	YES	NO	Hepatitis	YES	NO
(F)Menstrual Problems	YES	NO	Hearing Loss	YES	NO
Heart Trouble or Murmur	YES	NO	Perforated Ear Drum	YES	NO
High Blood Pressure	YES	NO	Discharge from the ear(infections)	YES	NO
Persistent Cough	YES	NO	Sinus Infections(chronic)	YES	NO
Chest Pain with Exercise	YES	NO	Broken Nose	YES	NO
Dizziness or fainting with exercise	YES	NO	Dental Plate or Dentures	YES	NO
Weakness or illness in high temperatures	YES	NO	Orthodontia(teeth straightened)	YES	NO
Migraine Headaches	YES	NO	Pneumonia	YES	NO
Frequent Headaches	YES	NO	Rheumatic Fever	YES	NO
Asthma	YES	NO	Mononucleosis	YES	NO
Hay Fever	YES	NO	Infectious Disease	YES	NO
Hives or Rashes	YES	NO	Recurrent Skin Rashes	YES	NO
Bee Sting Reactions(Allergic)	YES	NO	Fungal Infections	YES	NO
Reactions to Medicine(allergy)	YES	NO	Athletes Foot	YES	NO
Food Allergies	YES	NO	Recurrent Boils	YES	NO
Do you smoke?	YES	NO	Do you experience frequent anxiety?	YES	NO
Do you take medications? If so Name _____	YES	NO	Do you experience frequent depression?	YES	NO
Take medications for emergency use?	YES	NO			

Have you ever been hospitalized overnight within the past four years? If so please explain:

Have you ever had any injury or illness requiring doctor care since your last physical? If so please explain:

Have you ever been advised by a medical doctor not to participate or to restrict activity within the past five years? If so please explain:

Have you had any problems or complications related to an injury in the past year? If so please explain:

Please list in detail any past injuries; List the body part, the injury, when it occurred, and if you saw anyone for it and what they said.

Any past injuries must present clearance from a qualified physician. Injuries that have occurred and have not been cleared or have been ignored by the athlete will be the sole responsibility of the individual to which they have occurred.

I acknowledge that past injuries are my responsibility. If I sustain a re-injury to a past or chronic problem that it is my responsibility and not that of ECSU.

Signature _____

Date _____

Physical Examination(Please type or print in blue or black ink)

Last Name _____ First Name _____ MI _____
 Date of Birth _____ SS# _____ School Yr Entering _____
 Permanent Address _____ Phone _____ School# _____
 Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision:

Corrected: Right 20/____ Left 20/____
 Uncorrected: Right 20/____ Left 20/____
 Hearing(gross) Right _____ Left _____

Urinalysis:

Sugar: _____ Albumin _____ Micro _____
 HOB or HCT(if indicated) _____
 Date: _____ Results _____
 Recommendations _____
 Sickle Cell Results _____

Are there abnormalities? If so describe fully	YES	NO	Exaimers Initials	Description(attach additional sheets if necessary)
Eyes				
Head, ears, nose, throat				
Respiratory				
Cardiovascular				
Gastrointestinal				
Hernia				
Genitourinary				
Musculoskeletal				
Metabolic/Endocrine				
Neurological				
Skin				

Is there any loss or seriously impaired function of any paired organs? YES _____ NO _____

Explain _____

Is the student under treatment for any medical condition or emotional condition? YES _____ NO _____

Explain _____

Recommendation for physical activity: Unlimited _____ Limited _____

Explain _____

Is the student physically and emotionally healthy? YES _____ NO _____

Explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner:/Print Name

Physicians Recommendations and or follow up information

Print or Stamp Office Address and Phone Number _____

Informed Consent

Athletes Name: _____ Date _____

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

1. Certification by the National Athletic Trainers Association board of certification
2. Licensure by the state of North Carolina Board of Athletic Trainer Examiners
3. Certified in CPR and First Aid
4. Masters Degree in related fields
5. Up to date continuing education hours. (Eighty are required every three years)

_____ I DO give permission for the Athletic Training staff to assess, treat, rehabilitate, and refer me as appropriate during the upcoming year. Signature _____

_____ I DO NOT give permission for the Athletic Training staff to assess, treat, rehabilitate, and refer me as appropriate during the upcoming year. Signature _____

Failure to do 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.

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, and 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 she or he 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 accidently 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 _____

