

To: All Student /Athletes and Parent/Guardians of Elizabeth City State University

From: Roland T. Lovelace, MSed ATC (Head Athletic Trainer)

**Please read the following information carefully and answer all questions completely and honestly.**

1. All student athletes must present proof of primary insurance. Once the primary insurance had paid the maximum benefit then the secondary university insurance will pay any other outstanding bills. The following must also be completed

- a. Current physical form completed by a physician
- b. Assumption of risk form
- c. Insurance information if applicable
- d. Current health questionnaire

All of this information must be completed or the student athlete will not be allowed to participate in intercollegiate athletics.

2. ECSU holds an insurance policy for all students. This insurance policy can NOT be waived by student-athletes. There is a secondary policy to assist with any excess costs. This policy requires that primary insurance be filed first. This policy covers an excess of 65,000 max and **ANYTHING BEYOND 75,000 THE STUDENT MAY BE RESPONSIBLE FOR.**

3. All completed forms can be mailed to

Roland T. Lovelace (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 252-335-3389 or [RLovelace@mail.ecsu.edu](mailto:RLovelace@mail.ecsu.edu)

Name \_\_\_\_\_ Sport \_\_\_\_\_ SSN \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

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 co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Phone# \_\_\_\_\_ HMO or PPO(Circle one)

Mother \_\_\_\_\_  
Home address \_\_\_\_\_  
Phone(H) \_\_\_\_\_ Phone(W) \_\_\_\_\_  
Insuranceco. \_\_\_\_\_ 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 disabled 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 athletic injury.

Print \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL EXAMINATION (PLEASE TYPE OR PRINT IN BLACK INK)**  
 A physical examination is required at the beginning of each new school term for all intercollegiate athletes

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI \_\_\_\_\_

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_ School Yr. Entering: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Sch. # \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Pulse. \_\_\_\_\_ B/P. \_\_\_\_\_

Vision: Corrected: Right 20/ _____ Left 20/ _____	Urinalysis: Sugar: _____ Albumin: _____
Uncorrected: Right 20/ _____ Left 20/ _____	Micro: _____
Hearing: (gross) Right _____ Left _____	Hob or HCT (If Indicated) _____
	Date: _____ Results: _____
	Recommendations: _____

Are the abnormalities? If so describe fully	Yes	No	Examiners Initials	Description (attach additional sheets if necessary)
1. Eyes				
2. Head, Ears, Nose, Throat				
3. Respiratory				
4. Cardiovascular				
5. Gastrointestinal				
6. Hernia				
7. Genitourinary				
8. Musculoskeletal				
9. Metabolic/ Endocrine				
10. Neurological				
11. Skin				

A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_ No \_\_\_  
 Explain: \_\_\_\_\_

B. Is student under treatment for any medical or emotional condition? Yes \_\_\_ No \_\_\_  
 Explain: \_\_\_\_\_

C. Recommendation for physical activity: Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
 Explain: \_\_\_\_\_

D. Is student physically and emotionally healthy? Yes \_\_\_ No \_\_\_  
 Explain: \_\_\_\_\_

Signature of Physician/ Physician Assistant/ Nurse practitioner: / Print Name of Signature of Physician/ Physician Assistant/ Nurse practitioner: \_\_\_\_\_

Physicians Recommendations and or follow up information:  
 \_\_\_\_\_  
 \_\_\_\_\_

Print or Stamp Office Address and Phone Number: \_\_\_\_\_

MEDICAL HISTORY FORM

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

Has anyone in your close family ever had if so who???			Have you had or do you now have:		
Marfan's Syndrome	YES	NO	Back injury or frequent backaches	YES	NO
Hypertrophic Cardiomyopathy	YES	NO			
Clinically important Arrhythmias	YES	NO			
Diabetes (high blood sugar)	YES	NO	Knee injury (s) any type if yes name: When:	YES	NO
Allergies (hay fever/ asthma)	YES	NO	Ankle injury (s) if yes name: When:	YES	NO
Migraine Headaches	YES	NO	Other joint trouble	YES	NO
Hearing Trouble	YES	NO	Bone infections	YES	NO
High Blood Pressure	YES	NO	Have you ever had surgery:	YES	NO
Has anyone in our family under the age of 50 suddenly died	YES	NO	Have you had or do you now have:		
Have you had or do you now have:			Bone fracture	YES	NO
Brain Concussion (head injury)	YES	NO	Joint dislocation	YES	NO
Tendency to lose consciousness	YES	NO	Foot problems	YES	NO
Skull fracture	YES	NO	Shoulder injury	YES	NO
Convulsions or epilepsy	YES	NO	Osgood schlatler's (jumpers knee)	YES	NO
Neck injury	YES	NO	Shin splints	YES	NO
Burners, stingers, numbness of the neck or shoulder or hand	YES	NO	Have you had or do you now have:		
Have you ever been found to have only one of two functioning organs (kidney, eye, testicle or ovary)	YES	NO	Diabetes	YES	NO
Have you had or do you now have:			Tendency to bleed or bruise easy	YES	NO
Hernia	YES	NO	Anemia	YES	NO
Kidney problems	YES	NO	Weight problems (under/ over weight)	YES	NO
Blood in the urine	YES	NO	Hepatitis	YES	NO
(M) Loss of function or absence or testicles	YES	NO	Have you had or do you now have:		
(F) Menstrual problems	YES	NO	Hearing loss	YES	NO
Have you had or do you now have:			Perforated ear drum	YES	NO
Heart trouble or murmur	YES	NO	Discharge from the ear (recurrent infections)	YES	NO
High blood pressure	YES	NO	Sinus infections (chronic)	YES	NO
Persistent cough	YES	NO	Broken nose	YES	NO
Chest pain with exercise	YES	NO	Dental plate or dentures	YES	NO
Dizziness or fainting with exercise	YES	NO	Orthodontia (teeth straightened)	YES	NO
Weakness or illness in high temperatures	YES	NO	Pneumonia	YES	NO
Migraine headaches	YES	NO	Rheumatic fever	YES	NO
Frequent headaches	YES	NO	Mononucleosis	YES	NO
Have you had or do you now have:			Infectious disease	YES	NO
Asthma	YES	NO	Have you had or do you now have:		
Hay fever	YES	NO	Recurrent skin rashes	YES	NO
Hives or rashes	YES	NO	Fungal infections	YES	NO
Bee sting reactions (allergic)	YES	NO	Athletes foot	YES	NO
Reactions to medicine (allergy)	YES	NO	Recurrent boils	YES	NO
Food allergies	YES	NO			
Do You:					
Smoke	YES	NO	Do you experience frequent anxiety	YES	NO
Take medications regularly if yes name.	YES	NO	Do you experience frequent depression	YES	NO
_____					
Take medications for emergency use. If yes name:	YES	NO			
_____					

Additional comments or information: \_\_\_\_\_