

OAKLAND UNIVERSITY INTERCOLLEGIATE ATHLETIC MEDICAL INSURANCE

We are extremely pleased to have your son/daughter as a student-athlete at Oakland University 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 trainer. The team physician and/or athletic trainers also make the decision on when a student- athlete may return to competition after a previous injury.

INJURIES-MEDICAL BILLS-INSURANCE COVERAGE-CLAIM PROCEDURE

Injuries do occur and we attempt to provide our student athletes with the very best possible care. Medical bills are incurred when the athlete is treated, whether it is locally, during a road trip, or by a medical vendor in his/her home area.

Report all injuries to the athletic trainer. A Certified Athletic Trainer will then refer you to the appropriate doctor if your case warrants further treatment or examination. **Please remember that the Athletic Department will not assume responsibility for fees you incur with outside physicians, dentists, or healthcare facilities/providers unless the sports medicine personnel have referred you to such services.**

ONE FIRM STATEMENT:

The NCAA does not permit us or any college or university to provide coverage or pay the bills incurred for expenses related to illnesses or conditions that are not sustained as a direct result of an accident in our intercollegiate sports program.

INSURANCE COVERAGE:

Oakland University provides a secondary athletic accident insurance for your son/daughter for accidents incurred while participating in the play or official practice of intercollegiate sports. It is the responsibility of every Oakland University student-athlete to have his/her own accident insurance.

CLAIM PROCEDURE:

All medical bills for your son/daughter incurred as the result of an injury in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the 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 to be sent.**

- A. **Submit the bills incurred to your family insurance or employer group insurance plan first.** They will do one of two things:
 - a. Honor the claim and pay all or a portion of the bills incurred.
 - b. 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 insurance, or employer group insurance plan has contributed towards the claim, send an explanation of benefits from the insurance company and a copy of the itemized bills incurred to the 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 Athletic Department. If you have no coverage, a letter from your employer with verification will be necessary.
- C. If the bills incurred are not paid by the family insurance, employer group insurance plan, the claim will be sent from the Athletic Department to our insurance carriers 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 bills incurred are in your name.**

PLEASE KEEP THIS FORM FOR FUTURE REFERENCE

**OAKLAND UNIVERSITY
EMERGENCY INFORMATION**

Student Athlete Information

Name of Athlete _____ Sport _____
Grizzly ID Number _____ Date of Birth _____
College Address _____ Cell/College Phone _____
Home Address _____ Home Phone _____
City _____ State _____ Zip Code _____

Medical History

Diabetes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Epilepsy	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Heart Trouble	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Metal Pins	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Contacts/Glasses	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Blood Type	_____			

Allergies: _____

Medical History: _____

Insurance Information

Parent(s) Name _____
Date of Birth _____
Home Address _____

Home/Cell Phone _____
Work Phone _____
Employer _____
Address _____

Medical Insurance Company _____
Contract / Policy Number _____
Address _____
Insurance Phone Number _____

In case of injury or serious illness, I hereby grant permission for Oakland University to secure medical services for the above named student athlete.

Signature of Parent/Guardian

(Date)

**OAKLAND UNIVERSITY
SPORTS MEDICINE
MEDICAL HISTORY**

PLEASE PRINT

DATE _____

NAME _____ DATE OF BIRTH _____
Last First Middle

CAMPUS ADDRESS _____ PHONE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SPORT _____ G Number _____ YEAR IN SCHOOL 1 2 3 4 5

DO YOU HAVE A FAMILY PHYSICIAN? YES / NO

IF SO, NAME _____ CITY _____

PHONE _____

I. HOSPITALIZATION / SURGERY

Yes / No 1. Are you currently under medical supervision?
Explain _____

Yes / No 2. Have you ever had surgery?
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____

Yes / No 3. Have you ever been hospitalized for a reason other than surgery?
Date _____ Reason _____
Date _____ Reason _____

Yes / No 4. Have you ever been advised to have surgery not yet performed?
If yes, why and when _____

Yes / No 5. I give permission to the Oakland University Sports Medicine Staff to receive my medical records.

II. MEDICATION

Yes / No 1. Do you regularly use any prescription medication (e.g., asthma, seizure, oral contraceptives)?
If yes, List: _____

Yes / No 2. Do you regularly use any non-prescription medication (e.g., Advil, Sudafed)

Yes / No 3. Do you regularly take nutritional supplements?
If yes, describe: _____

Yes / No 4. Do you use narcotics, anabolic steroids or street drugs?
If yes, describe: _____

Yes / No 5. Do you use tobacco products?
If yes, describe: _____

III. ALLERGIES

Yes / No Aspirin
 Yes / No Asthma
 Yes / No Dust, Pollen
 Yes / No Food (specify) _____
 Yes / No Insect Stings (specify) _____
 Yes / No Novocain
 Yes / No Penicillin
 Yes / No Sulfa Drugs
 Yes / No TB Tine Test
 Yes / No Tetanus Serum
 Yes / No Other Drugs (specify) _____

IV. IMMUNIZATIONS

Yes / No Date _____ Flu
 Yes / No Date _____ Hepatitis B
 Yes / No Date _____ Measles
 Yes / No Date _____ Mumps
 Yes / No Date _____ Rubella
 Yes / No Date _____ TB Test
 Yes / No Date _____ Tetanus

V. ILLNESSES (give date if within the past 3 years)

Yes / No Date _____ Chicken Pox
 Yes / No Date _____ Diabetes
 Yes / No Date _____ Headaches (frequent or severe)
 Yes / No Date _____ Hepatitis
 Yes / No Date _____ Measles
 Yes / No Date _____ Mononucleosis
 Yes / No Date _____ Pneumonia
 Yes / No Date _____ Rheumatic Fever
 Yes / No Date _____ Scarlet Fever
 Yes / No Date _____ Stomach Disorder
 Yes / No Date _____ Tuberculosis
 Yes / No Date _____ Other (specify) _____

VI. CARDIOVASCULAR SYSTEM

Yes / No 1. Have you ever fainted during exercise?
 Yes / No 2. Have you ever had chest pains during or after exercise?
 Yes / No 3. Have you ever been told that you might have high blood pressure?
 Yes / No 4. Have you ever been told that you have a heart murmur?
 Yes / No 5. Have you ever had a racing of your heart or skipped heartbeats?
 Yes / No 6. Has anyone in your family died of heart problems or a sudden death from non traumatic causes before age 50?
 Yes / No 7. Does anyone in your family have a history of Marfans Syndrome?
 Additional Information _____

VII. HEAT PROBLEMS

Yes / No Date _____ Have you ever had heat or muscle cramps?
 Yes / No Date _____ Have you ever been dizzy or faint in the heat?
 Yes / No Date _____ Have you ever been given I.V. fluids for heat problems?

VIII. MUSCULOSKELETAL SYSTEM Have you ever injured any of the following that caused you to miss significant playing time (a week or more)?

Date:

Explain:

Yes / No Do you know of or do you believe there is any health reason that should prevent you from participating in intercollegiate athletics?
If yes, explain_____

6. Have you ever been screened for the sickle cell trait?
Yes / No Result: _____

XI. FOR WOMEN ONLY

Date of last menstrual period? _____

Date of last gynecological exam / pap smear? _____

My periods are now: (circle one) Regular (every 24-35 days)
Irregular (every 36 days or more)
Absent (no periods for 3 months)

Yes / No 1. Do you have any gynecological problems (i.e. cramps, PMS, discharge, etc.)
If yes, explain_____

Yes / No 2. Have you ever missed periods for 6 months or more?
If yes, explain_____

Yes / No 3. Do any family members have a history of menstrual problems?
If yes, explain_____

I certify that the answers to the preceding questions are correct and true. I understand that passing the physical exam does not necessarily mean that I am physically qualified to engage in intercollegiate athletics, but only that the examiner did not find a medical reason to disqualify me from participation.

Student - Athlete's Signature Date

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. If in the judgment of any representative of Oakland University the above student-athlete should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and grant permission to the attending physician, Oakland University Sports Medicine Staff, or other medical personnel to proceed with medical or minor surgical treatment, x-ray examination and immunizations. In the event of serious injury or illness, I understand that an attempt will be made by the appropriate medical personnel to contact my parents or legal guardian. If medical personnel are not able to communicate with the responsible party, the treatment necessary for my health may be provided. I do hereby agree to indemnify and save harmless the University and any Oakland University representative from any claim by any person whomsoever on account of such care and treatment of said athlete.

Student - Athlete's Signature Date

Parent / Guardian's Signature Date

**OAKLAND UNIVERSITY
PHYSICAL EXAMINATION**

Examination Date _____

NAME _____ DATE OF BIRTH _____ SEX M or F
SPORT _____ ATHLETIC SHOE SIZE _____ MEN OR WOMEN

HEIGHT _____ WEIGHT _____ BODY COMP _____ PULSE _____ BP ____/____

VISION R 20/____ L 20/____ CORRECTED Y N GLASSES _____ CONTACTS _____

MEDICAL:	NORMAL	ABNORMAL FINDINGS	INITIALS
APPEARANCE			
SKIN			
EYES (PUPILS: EQUAL / UNEQUAL)			
EARS / NOSE / THROAT			
LYMPH NODES			
DENTAL			
HEART (MURMUR / RHYTHM)			
LUNGS			
ABDOMEN (HERNIA, MASSES, TENDERNESS, SCARS)			
GENITALIA: MALES ONLY (HERNIA, TESTICLES)			

MUSCULOSKELETAL:

NECK			
BACK			
POSTURE			
SHOULDERS / ARMS			
ELBOW / FOREARM			
WRIST / HAND			
HIP / THIGH			
KNEE			
LOWER LEG / ANKLE			
FOOT / ARCHES			
FLEXIBILITY			
STRENGTH			

CLEARED _____

RESTRICTIONS: _____

NOT CLEARED FOR: _____ REASON: _____

RECOMMENDATIONS: _____

NAME OF PHYSICIAN (PRINT / TYPE): _____

ADDRESS: _____ PHONE: _____

SIGNATURE OF PHYSICIAN: _____

Oakland University Department of Athletics
Parent/Guardian/Student Athlete Information Form

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

**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).
Please include a copy of the front and back of your insurance card.**

Student Athlete Information

Name of Athlete _____ Sport _____
Grizzly ID Number _____ Date of Birth _____
College Address _____ Cell/College Phone _____
Home Address _____ Home Phone _____
City _____ State _____ Zip Code _____

Father/Guardian Information

Name _____
Address _____

Date of Birth _____
Home/Cell Phone _____
Work Phone _____
Employer _____
Address _____

Medical Insurance Company _____
Policy Number _____
Address _____

Is this plan: HMO PPO
Is pre-authorization required to obtain treatment?
YES NO
Is a second opinion required before surgery?
YES NO

Mother/Guardian Information

Name _____
Address _____

Date of Birth _____
Home/Cell Phone _____
Work Phone _____
Employer _____
Address _____

Medical Insurance Company _____
Policy Number _____
Address _____

Is this plan: HMO PPO
Is pre-authorization required to obtain treatment?
YES NO
Is a second opinion required before surgery?
YES NO

I certify that the above information given by me is true and correct.

To any medical care provider, medical care facility, insurer, government-sponsored health plan or employer:

I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives including reinsuring companies and other persons or groups performing business or legal services to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which would be given to me by the company upon my request) will be valid as this one.

Name of Claimant (please print)

Signature of Claimant (If claimant is 18 or older)

Date

Name of Parent or Guardian (please print)

Signature of Parent or Guardian

Date

OAKLAND UNIVERSITY SPORTS MEDICINE
INFORMATION RELEASE AUTHORIZATION

I, _____, give consent for my medical records to be released to any Oakland University Team Physician involved in the care of my illness or injury; or to a physician appointed by the Oakland University Sports Medicine Staff.

Athlete's Signature _____ Date ____ / ____ / ____

I also give consent for the Oakland University Sports Medicine Staff to release the following information to the sports information department, media or a scout / representative of any professional or amateur athletic organization seeking information (for employment purposes).

- Body part affected by injury or illness
- Nature of the injury (sprain, fracture, etc.)
- Status of the athlete for same day and future competition

Athlete's Signature _____ Date ____ / ____ / ____

THIS RELEASE REMAINS VALID UNTIL REVOKED IN WRITING BY THE ABOVE SIGNED