



*All medical forms are due by July 20th of 2009.
Return forms to Athletic Training Department/5151 Park Avenue/Fairfield, CT 06825
DO NOT RETURN TO HEALTH SERVICES.*

Dear Student-Athlete and/or Parent/Guardian:

April 27, 2009

Sacred Heart University provides excess insurance coverage to protect all of our intercollegiate athletes against medical claims from accidental injury during your participation in all school sponsored and supervised athletic events, whether at the school or away. This coverage is provided by AIG and is administered by Bob McCloskey Insurance.

This insurance plan is Excess coverage: i.e. you must submit all bills to your own insurance first, and the school policy will pick up the unpaid balances, deductibles, and co-insurance amounts, up to the limits of the policy.

Although this coverage is very broad, there are restrictions, limitations, and exclusions in any insurance policy. In some situations, medical bills may not be covered in full. Athletes should understand that medical expenses are their own responsibility, not those of the university, although we are certainly here to help. Some of the important benefits and limitations of the plan are:

1. The Maximum Medical Benefit is \$75,000, after which the claim would be submitted to the NCAA Catastrophic Insurance carrier.
2. Claims must be submitted and treatment must commence within 90 days of the date of injury or there will be no coverage.
3. Benefits are payable for up to 2 years from the date of injury.
4. Student-athletes must obtain care from a SHU Sports Medicine Physician, if they choose to obtain care from a physician outside of our sports medicine team; the student-athlete must have primary insurance coverage accepted by that physician. *

All injuries must be immediately reported to a SHU Certified Athletic Trainer. Claim forms will be completed and filed by the athletic training department, but it is the student-athletes' (or parents') responsibility to:

1. Submit all itemized bills (monthly statements will not do).
2. Submit the statement (EOB-Explanation Of Benefits) received from your own insurance company showing amounts paid and balances due, or, a letter of denial stating the claim is not covered. One of these letters is required for any payments to be made.

*If you want to see a physician other than one referred by our staff, please see me for approval – it is imperative that if you are not using our physicians that you use a physician who is in your own network. Medical care by physicians other than those included in our sports medicine team will not be covered unless the athlete's primary insurance covers 50% or more. This is to aid in insuring that you have appropriate insurance coverage and minimal out of pocket expenses.

If you have no other medical insurance, you may receive a letter from Bob McCloskey Insurance requesting employer information and verification of insurance coverage or lack thereof. Fill this out and return it to the company immediately and the claim will be processed. Failure to return this letter will result in a delay or denial of the claim.

It is your responsibility, and to your benefit, to submit the necessary papers as soon as possible, as the claim cannot be paid until all papers are submitted. Only one claim form per accident is required. All claim forms, bills, and the letters from other insurance companies are to be forwarded to, and questions regarding the coverage answered by:

BOB McCLOSKEY INSURANCE / P.O. BOX 511, MATAWAN, NJ 07747 / 800-445-3126

Insurance coverage is subject to change. Changes that occur after this letter is received will be provided on www.sacredheartpioneers.com under the compliance and eligibility link.

Sincerely,

Julie G. Alexander, MEd, LAT, ATC, CSCS

Head Athletic Trainer / Assistant Athletic Director

(203) 365-7672 or alexanderj@sacredheart.edu

**SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS
MEDICAL CLEARANCE FORMS
2009-2010**

*MEDICAL FORMS SHOULD BE PROVIDED TO ALL STUDENT-ATHLETES IN APRIL of 2009.
MEDICAL FORMS ARE DUE IN THE ATHLETIC TRAINING ROOM BY **JULY 20, 2009.**
**FORMS SHOULD BE RETURNED TO THE ATHLETIC TRAINING ROOM - DO NOT RETURN TO
HEALTH SERVICES DEPARTMENT.***

MEDICAL FORMS

Enclosed you will find the appropriate medical forms for intercollegiate athletics. All forms should be filled out completely and legibly. Missing or incomplete forms will delay the participation of the student-athlete in their chosen sport. After returning the forms, athletes will be ineligible for participation for up to 2 weeks. This gives our staff adequate time to input information into our database and evaluate medical information. Also, be aware that any student-athlete without completed medical forms will not be covered by our insurance policy and cannot be treated by our staff. All forms should be completed before any participation in intercollegiate athletics. 2009-2010 forms will be available on www.sacredheartpioneers.com . This will assist in avoiding large summer mailings and ensure that all athletes will have access to forms. **Please remember that signatures are necessary, so the student-athletes must send these forms back to us via U.S Mail, not email.**

FORM A INSURANCE FORM

Must be completed by all athletes yearly.

FORM B PHYSICAL FORM

Required for all freshmen, juniors, transfers, and athletes who have not participated within the last 12 months.

FORM C MEDICAL HISTORY FORM

Must be completed by all athletes yearly.

**FORM D RELEASE/VERIFICATION/
PERMISSION FORM**

Must be completed by all athletes yearly.

FORM E SUPPLEMENTAL FORM

Must be completed by all athletes prescribed stimulant for ADHD or any other condition.

PREPARTICIPATION ORTHOPEDIC SCREENING Required for all first and third year athletes. The Athletic Training staff will set up screening sessions as early as possible in the academic year. Sacred Heart University Certified Athletic Trainers and athletic training staff will perform screenings. This is a large undertaking, which is being put in place to create more thorough health care for our student-athletes. Coaches will be provided with the time and date of team orthopedic screenings, usually the day the team arrives for pre-season for fall athletes, or within a few weeks of returning to campus for winter/spring sport athletes.

PRIMARY INSURANCE

Parents/guardians are responsible to be sure that their insurance company provides coverage to their son/daughter while in college. It is also their responsibility to obtain referrals from the primary physician (if required by their insurance). It is the athlete's responsibility to alert the parent/guardian of any injuries that occur during athletic participation. It is also their responsibility to report all injuries to the athletic training staff. As student-athletes, these young men and women assume the responsibility of reporting to the athletic training room for consistent treatment, rehabilitation, and communicating progress. If an athlete is evaluated by a physician without our consent, our secondary insurance will not cover the medical expenses incurred due to that injury.

SECONDARY INSURANCE

Bob McCloskey Insurance is the claims payer for our secondary athletic accident insurance company, AIG. All medical claims can be submitted directly to them at PO Box 511/Matawan, NJ 07747. The phone number is (800) 445-3126 and the contact person is Sarah.

MEDICAL CLEARANCE

An athlete is considered medically cleared if all medical forms and orthopedic screenings are completed, signed and on file in the Athletic Training Room. **If forms are not turned in by July 20th, they need to be submitted no later than 2 weeks prior to the first date of practice or the student-athlete will not be medically cleared for their sport.**

For Athletic Department Use Only:

FORM A

Allergies to medications: _____
Current medications: _____
Medical history: _____

2009-2010

**SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS MEDICAL CLEARANCE
INSURANCE INFORMATION FORM**

NAME: _____ SPORT(S): _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX: _____
ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)
HOME PHONE #: _____ CELL PHONE #: _____ CAMPUS PHONE #: _____
YEAR OF EXPECTED GRADUATION: _____ TODAY'S DATE: _____
PRIMARY CARE PHYSICIAN (PCP): _____ PCP PHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO ATHLETE: _____
WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____
NAME: _____ RELATIONSHIP TO ATHLETE: _____
WORK PHONE: _____ HOME PHONE: _____ CELL PHONE: _____

MEDICAL INSURANCE INFORMATION

PLEASE COMPLETE ALL INFORMATION - INCORRECT INFORMATION COULD LEAD TO INSURANCE DENIAL

FATHER/GUARDIAN NAME: _____
ADDRESS (IF DIFFERENT FROM ABOVE): _____
TELEPHONE: _____
FATHER EMPLOYED? Y / N (If yes, fill out section below.)

MOTHER/GUARDIAN NAME: _____
ADDRESS (IF DIFFERENT FROM ABOVE): _____
TELEPHONE: _____
MOTHER EMPLOYED? Y / N (If yes, fill out section below.)

EMPLOYER: _____
EMPLOYER ADDRESS: _____
TELEPHONE: _____

EMPLOYER: _____
EMPLOYER ADDRESS: _____
TELEPHONE: _____

INSURANCE COMPANY NAME: _____
POLICY NUMBER: _____
GROUP NUMBER: _____
TELEPHONE: _____

INSURANCE COMPANY NAME: _____
POLICY NUMBER: _____
GROUP NUMBER: _____
TELEPHONE: _____

REFERRAL REQUIRED? Y / N

REFERRAL REQUIRED? Y / N

Is the athlete covered by parent / primary insurance? Y / N

Is the athlete covered by parent / primary insurance? Y / N

YOU ARE REQUIRED TO PROVIDE A COPY OF ALL INSURANCE CARDS. PLEASE INCLUDE COPIES OF CARDS FRONT AND BACK OF PRIMARY INSURANCE, SECONDARY INSURANCE AND/OR DENTAL INSURANCE CARDS AS WELL AS PROOF OF ANY OTHER MEDICAL INSURANCE COVERAGE.

2009-2010
**SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS MEDICAL CLEARANCE
 PHYSICAL FORM**

NAME: _____ SPORT(S): _____

DATE OF BIRTH: _____ CELL PHONE #: _____

ADDRESS: _____
 (STREET) (CITY) (STATE) (ZIP CODE)

-----DO NOT WRITE BELOW THIS LINE-----

PHYSICIAN EXAMINATION

- | | |
|--|---|
| <p>1. HEIGHT: _____</p> <p>2. WEIGHT: _____</p> <p>3. BLOOD PRESSURE: _____</p> <p>4. PULSE: _____</p> <p>5. SKIN: _____
 RASHES: _____
 OTHER: _____</p> <p>6. HEAD: _____</p> <p>7. EYES: _____
 EOM: _____
 PUPIL SIZE: _____
 LIGHT REFLEX: _____
 OTHER: _____</p> <p>8. EARS: _____
 TYMP. MEM.: _____
 CANAL: _____
 OTHER: _____</p> <p>9. NOSE: _____
 SEPTAL DEFECT: _____
 OBSTRUCTION: _____</p> <p>18. LOWER EXTREMITIES: _____
 _____</p> <p>19. UPPER EXTREMITIES: _____
 _____</p> <p>20. SPINE/TORSO: _____
 _____</p> <p>21. RESTRICTIONS & LIMITATIONS: _____
 _____</p> <p>22. MEDICATIONS: _____
 _____</p> <p>23. ADD/ADHD DIAGNOSIS (Please include form E) _____</p> <p>24. COMMENTS: _____
 _____</p> | <p>10. THROAT/MOUTH: _____</p> <p>11. TEETH: _____</p> <p>12. LYMPH NODES: _____</p> <p>13. LUNGS: _____
 BREATH SOUNDS: _____
 OTHER: _____</p> <p>14. HEART: _____
 SIZE: _____
 RHYTHM: _____
 MURMUR: _____
 OTHER: _____</p> <p>15. ABDOMEN: _____
 LIVER: _____
 SPLEEN: _____
 MASSES: _____
 TENDERNESS: _____
 OTHER: _____</p> <p>16. HERNIA: _____</p> <p>17. GENITALIA: _____</p> |
|--|---|

 (EXAMINING PHYSICIAN'S NAME)

 (SIGNATURE)

 (DATE)

 (PHONE #)

2009-2010 SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS MEDICAL CLEARANCE MEDICAL HISTORY QUESTIONNAIRE

Name: Sport: Local Phone: Date of Birth: SS#: Date of Exam:

Allergies and Medications

- 1. Are you currently taking any non-prescription/over the counter medications? Brand and dosage:
2. Are you currently taking any prescribed medication on a permanent or semi-permanent basis? Brand and dosage:
3. Are you allergic to any medication (anesthetics, aspirin, sulfa, codeine, penicillin, etc.)? Brand:
4. Are you allergic to any foods? (Explain if yes:)
5. Are you allergic to any insect bites including bees?
Notes:

Diseases and Illnesses

- 1. Have you ever suffered from heat stroke/heat exhaustion? (Date:)
2. Have you ever had (please list the date each illness occurred: leave blank if never had it):
Hepatitis Infectious Mononucleosis
Chicken Pox Viral Pneumonia
Rheumatic Fever Diabetes
Measles Sickle Cell Trait
Mumps Marfan's Syndrome
3. Have you ever had the following symptoms of heart problems (check all that apply)?
Chest pains Shortness of breath
Fatigue easily Frequent awareness of heart beat
Heart murmur/Irregular heart beat Racing or skipped heart beats
4. Have you ever passed out during exercise?
5. Do you have a history of lung problems?
a. Asthma (How many times per week do you use your inhaler?)
Please list what medication you use for asthma:
b. Bronchitis
6. Do you have a history of high or low blood pressure?
7. Have you ever had episodes of dizziness or fainting spells?
8. Do you have a history of epilepsy or seizures?
9. Have you ever been diagnosed with ADD/ADHD or any other learning disability?
If yes, are you currently on any medication for it?
Notes:

Eyes and Dental:

- 1. Do you have loss of sight in either eye?
2. Do you wear glasses, hard lens contacts, or soft lens contacts?
3. Do you wear glasses/contacts during athletic competition?
4. Do you wear any dental appliances?
5. Have you ever had any cavities or had to have a root canal?
Notes:

Head, Neck, Back Injuries:

- Y N 1. Have you ever been “knocked out,” had your “bell rung,” or had a concussion/head injury?
Dates: _____
- Y N 2. Have you ever had a facial fracture?
- Y N 3. Have you ever had an injury to the neck or back?
- Y N 4. Do you suffer from recurrent headaches?
- Y N 5. Have you ever experienced a “burner” or pinched nerves?
- Y N 6. Do you have a loss of hearing in either ear?
- Y N 7. Have you ever had an injury to your chest/thoracic, or abdominal area?

Notes: _____

Upper Extremities:

- Y N 1. Have you ever had a shoulder dislocation, subluxation, AC sprain or other shoulder injury?
- Y N 2. Have you ever been advised to have surgery or rehabilitation to correct a shoulder condition?
Y N a. Has the surgery been completed?
- Y N 3. Have you ever suffered any type of an elbow injury?
- Y N 4. Have you ever suffered any type of a wrist injury?
- Y N 5. Have you ever suffered any type of a finger/hand injury?

Notes: _____

Lower Extremities:

- Y N 1. Have you ever sustained a hip pointer or other hip injury?
- Y N 2. Have you ever sustained a groin, hamstring, or quadriceps pull, strain, or tear?
- Y N 3. Have you experienced a sprain of either knee?
- Y N 4. Have you ever been told that you injured the cartilage or meniscus in either knee?
- Y N 5. Have you ever had general knee pain, or been told you had patellofemoral problems on either knee?
- Y N 6. Have you ever been advised to have surgery or rehabilitation on a knee to correct a condition?
Y N a. Was it completed?
- Y N 7. Have you ever been treated for Osgood-Schlatter’s disease?
- Y N 8. Have you ever experienced a severe sprain or twist or other injury to the the ankle?
- Y N 9. Have you ever experienced an injury to your foot?
- Y N 10. Have you ever been diagnosed with a stress fracture?

Notes: _____

Other Conditions:

- Y N 1. Do you have any physical disabilities?
- Y N 2. Have you lost a lung or lung function?
- Y N 3. Have you lost a kidney or kidney function?
- Y N 4. Have you lost either a testicle or ovary?
- Y N 5. Do you have stomach or intestinal trouble?
- Y N 6. Have you ever been treated for depression?
- Y N 7. Have you ever been treated for anxiety?
- Y N 8. Have you ever been advised by a medical doctor not to participate in any sport?
- Y N 9. Do you have a metal screw, plate, or rod anywhere in your body as a result of surgery?
- Y N 10. Have you ever been told that you have a hernia?
Y N a. Was it surgically repaired?
- Y N 11. Have you ever undergone surgery (tonsillectomy, appendectomy)?

Notes: _____

General Health

- Y N 1. How many meals do you eat each day? _____
- Y N 2. How many snacks do you eat each day? _____
- Y N 3. List what you have eaten over the last 24 hours? _____
 Y N _____
- Y N 4. Are there any foods or food groups that you refuse to eat?
 Y N Please list. _____
- Y N 5. Have you ever been on a diet?
- Y N 6. Are you happy with your weight?
 If not, how much do you want to weigh? _____
- Y N 7. Has your weight fluctuated by more than 20 pounds in the last year?
 If so, please explain. _____
- Y N 8. Have you ever tried to control your weight by vomiting, diet pills, laxatives, or diuretics?
- Y N 9. Do you feel as though you are preoccupied with calories, food, body weight?
10. How many times per day do you exercise? _____
- Y N 11. Do you feel anxious if you can't exercise?
- Y N 12. Do you frequently experience fatigue or lethargy?
- Y N 13. Do you avoid eating in groups?
- Y N 14. Have you had your body fat percentage tested? Results? _____
- Y N 15. Do you worry about what you eat?
- Y N 16. Do you lie about what you eat?
- Y N 17. Have you ever missed school, work or classes because of your weight or eating habits?
- Y N 18. Have you ever eaten large amounts of food in a short time without being able to stop?
- Y N 19. Have you ever been diagnosed with an eating disorder?
 If so, provide details. _____
- Y N 20. Have you ever tried any weight gain methods, such as creatine or androstine?
 If so, provide details. _____
- Y N 21. Have you ever used anabolic steroids or any other performance enhancing supplements?
 If so, provide details. _____
- Y N 22. Are you currently taking any supplements?
 If so, provide details. _____

Family History

1. Does anyone in your family have a history of:

- | | |
|-------------------------------|-------------------------|
| _____ Diabetes | _____ Sickle Cell Trait |
| _____ Marfan's Syndrome | _____ Heart Disease |
| _____ High/Low Blood Pressure | _____ Asthma |
| _____ Cardiomyopathy | _____ Epilepsy/Seizures |

Y N 2. Has anyone in your family ever died before the age of 50 because of heart disease?

Notes: _____

FEMALE STUDENT-ATHLETES ONLY

- Y N 1. Do you have regular menstrual periods?
 How often do you menstruate? _____
 How long do your menstrual periods last? _____
 How many menstrual periods have you had in the last 12 months? _____
 When was your last menstrual period? _____
 Do you suffer from severe cramps or heavy bleeding? _____
- Y N 2. Have you ever been told that you are/were anemic?
 If so, provide details. _____
- Y N 3. Do you currently take birth control pills or hormone therapy?
 If so, what? _____

2009-2010

SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS MEDICAL CLEARANCE
PERMISSION FOR MEDICAL TREATMENT / ASSUMPTION OF RISK / INSURANCE VERIFICATION / HIPAA STATEMENT

PERMISSION FOR MEDICAL TREATMENT AND ASSUMPTION OF RISK

I, _____ give permission for the athletic training staff to administer medical treatment to myself. I understand that I am involved in intercollegiate athletics activities that could lead to the possibility of injury and need for medical attention. I understand that the Athletic Training Staff at Sacred Heart University will perform only those procedures that are within their training, credentialing and scope of their practice to prevent, care for and rehabilitate athletic injuries. I understand that Sacred Heart University is a CAAHEP Accredited Athletic Training Education institution. I understand that I will have contact with athletic training students who will be under the direct supervision of Certified Athletic Trainers. I understand that it is my responsibility to inform the Athletic Training Staff of any injury, illness, and increase in pain, medication, or abnormal responses to treatment and / or rehabilitation. I understand that it is my responsibility to be present for all treatment and rehabilitation sessions in order to best treat an athletic injury. I understand that it is my right to seek physician evaluation from Sacred Heart University's physicians. I understand that it is my right to seek physician evaluation and/or rehabilitation services outside of the athletic training session, but that I must inform the Athletic Training Staff in writing in advance and that charges may not be fully covered by the university's secondary athletic accident insurance policy. I understand that my Certified Athletic Trainer may refer me to a physician, physical therapist, counselor, wellness coordinator or other member of the student-athlete health care team in order to aid care of my injury/illness.

(SIGNATURE OF STUDENT ATHLETE)_____
(DATE)_____
(SIGNATURE OF PARENT/GUARDIAN IF UNDER 18)_____
(DATE)

VERIFICATION OF INSURANCE POLICIES AND PROCEDURES

I hereby acknowledge that I have been provided with written insurance policies and procedures. I am aware of the type of coverage, the benefits of the coverage, and the exclusions of the university's insurance policy. I understand my responsibilities in being sure that claims are submitted properly and efficiently.

(SIGNATURE OF STUDENT ATHLETE)_____
(DATE)_____
(SIGNATURE OF PARENT/GUARDIAN IF UNDER 18)_____
(DATE)

CONFIDENTIALITY STATEMENT (HIPAA)

HIPAA refers to the Health Insurance Portability and Accountability Act. This act includes a "Privacy Rule" which refers directly to intercollegiate athletes. This rule creates national standards to protect individuals' personal health information (PHI) and gives patients increased access to and control over their medical records. There are several parts to this rule and they are as follows:

1. **Authorization to release information** – All intercollegiate athletes must provide permission for non-routine uses and disclosures of PHI (individuals not directly part of the chain of health care providers). We assume that this includes release of information to media, however, we ask you to sign consent for the Certified Athletic Trainers (ATC) to release information to coaches, administrators, parents, physicians, etc. as well. These communications are considered part of the chain of health care providers. Each time you are injured, you will be asked to sign a privacy statement on your written injury report. This is for your protection and allows us the minimum freedom necessary to provide adequate health care for you as an intercollegiate athlete. This permission expires when you are discharged from treatment/rehabilitation for the injury in question. You are allowed to revoke this authorization, but it must be done in writing and submitted to the Head Athletic Trainer. If media approaches us, you will be asked to sign authorization for a statement to be made regarding PHI. We will not discuss your condition with media without your authorization.
2. **Minimum necessary rule** – This rule was added to the HIPAA Act to ensure that minimum disclosures are made to accomplish the intended purpose of adequate health care.
3. **Incidental uses and disclosures** – This act explicitly permits certain incidental uses and disclosures that occur as a byproduct of a use or disclosure otherwise permitted by the Privacy Rule. For example, PMI being overheard by a passerby, charts being viewed accidentally, and use of sign-in and appointment sheets.

(SIGNATURE OF STUDENT ATHLETE)_____
(DATE)_____
(SIGNATURE OF PARENT/GUARDIAN IF UNDER 18)_____
(DATE)

2009-2010

**SACRED HEART UNIVERSITY INTERCOLLEGIATE ATHLETICS MEDICAL CLEARANCE
STANDARD ASSESSMENT OF STUDENT-ATHLETES TAKING STIMULANT MEDICATION**

- The NCAA requires documentation of diagnosis and treatment of ADHD requiring prescription of stimulant medication.
- The NCAA requires documentation of diagnosis and treatment of any condition requiring prescription of stimulant medication.

DATE: _____

NAME: _____

DATE OF BIRTH: _____

DATE OF EVALUATION: _____

NAME OF PHYSICIAN: _____

DIAGNOSIS: _____

CURRENT MEDICATION(S): _____

ADHD EVALUATION CONSISTED OF THE FOLLOWING (MARK ITEMS COMPLETED/AVAILABLE):

_____ Comprehensive clinical evaluation (DSM-IV criteria) **

_____ Adult ADHD Rating Scale (ASRS, CAARS) **

_____ Alternative medications have been considered and the current stimulant medication regimen is appropriate for this patient. **

_____ Blood pressure and pulse being monitored through regularly scheduled follow-up. **

**** Minimum recommended evaluation criteria, please attach documentation**

_____ Reporting of ADHD symptoms by other significant individual(s)

_____ Physical exam (including blood pressure/pulse reading)

_____ Psychological testing
Results: _____

_____ Laboratory testing

_____ Previous documentation of ADHD diagnosis

_____ Other/comments: _____

Physician Name: _____

Title: _____

Address: _____

Phone: _____

Physician signature: _____