Saint Bonaventure University Student Athletes: The enclosed documents must be fully completed and returned before the athlete will be allowed to participate in University Athletics.

Instructions for completing Athletic Information Forms

1. Enclosed are five (5) important documents:
    - #1 Health Insurance Policy Statement
    - #2 Secondary Insurance Waiver/Verification Form
    - #3 Athletic/Primary Insurance Information Form
    - #4 Acceptance of Risk Release and Agreement
    - #5 Athletic Physical Examination Summary

2. Please read carefully all enclosed forms. Be sure to complete ALL information including all necessary signatures. **RETURN FORMS 2, 3, 4, & 5 to the address below**.

3. #5 Athletic Physical Examination Summary:
    - PLEASE NOTE: The athletic physical is SEPARATE from the physical Health Services requires for incoming students. The athletic physical may NOT be used as a substitute and vice versa. All incoming and transfer students will be required to complete both an athletic physical and Health Services physical form. You will receive information from Health Services in August.

    Read carefully and complete the following information:
    - Basic information (name, gender, age, SS#, sport, year in school, today's date).
    - Read Medical History and circle either Yes (Y) or No (N) to every item.
    - List any medication(s) currently prescribed. **If the athlete is currently taking Adderall, Ritalin, or a generic equivalent please enclose a letter from your primary care physician explaining the condition and prescribed medications for treatment.** These, and similar, medications will result in a positive drug test. Although this information will be kept confidential, proper documentation is necessary to absolve the athlete in the case of a positive drug test.
    - DO NOT COMPLETE orthopedic evaluation, medical examination, team physician's statement. The SBU Sports Medicine Staff will complete these 3 sections during pre-season physicals.
    - Athlete must read and <u>SIGN</u> at the bottom of column 2.
    - PLEASE RETURN THIS FORM

RETURN FORMS #2, #3, #4, #5 *BEFORE* JULY 31, 2006 to:

ST. BONAVENTURE UNIVERSITY SPORTS MEDICINE
Box G, Reilly Center
St. Bonaventure, NY 14778

HEALTH INSURANCE POLICY STATEMENT

The Department of Intercollegiate Athletics requires that all student athletes complete and return the enclosed **Waiver/Verification Form**.

The POMCO/Markel Insurance Policy is optional for the student athlete. However, we *strongly* urge you to purchase this policy for several reasons:

- The cost (approximately $339) is automatically included in tuition (no additional costs)
- $100 deductible waived if seen at the Olean Medical Group
- Will help defray costs not covered by primary insurance carrier (deductibles and final 10%-20%)
- Allows coverage up to $150 for prescription medication
- Allows the student athlete greater access to a physician in a non-emergency (some primary carriers require significant advance notification prior to approval)
- Provides supplemental coverage for illnesses and accidents
- Provides supplemental coverage 12 months a year (even at home)
- Provides coverage of athletic injuries up to $2000

**** ALL international students and all students who are not covered under their parent/guardian insurance are REQUIRED to accept POMCO/Markel ****

If you choose to **WAIVE** the Health & Accident Policy from POMCO/Markel **ALL medical costs incurred by the student athlete are the sole responsibility of the student athlete.**

⇒ It should be noted that the POMCO/Markel policy **excludes** provisions for **DENTAL** and **OPTICAL** expenses (except for athletic trauma). The Athletic Department suggests that you review your primary policy in order to insure coverage for your student athlete. The Athletic Department only covers costs for dental/optical injuries if:

- The injury is athletic related (i.e. practice, game or conditioning supervised by the coach).
- If a mouth guard is required, the student athlete must be wearing a mouth guard or the Athletic Department WILL NOT pay for treatment.

⇒ Other dental injuries that are not a result of athletic competition (i.e. wisdom teeth, toothache) CANNOT be paid for by the Athletic Department. Any structural repair or cosmetic work done in addition to emergency care is the financial responsibility of the student athlete.

⇒ Second opinions and/or surgery by any other physicians other than the St. Bonaventure Team Physicians without prior approval will be the sole responsibility of the student athlete.
All students of St. Bonaventure University are enrolled in the Athletic Accident Insurance Policy in coordination with the NCAA Lifetime Catastrophic Insurance program.

PROCEDURE FOR SUBMITTING ATHLETIC RELATED INSURANCE CLAIMS

- Submit all bills incurred to your family coverage first. This will result in one of more of the following actions:
    - Your insurance company may ask for more information regarding the patient, injury, treatment, hospitalization etc. If this is the case it is your responsibility to forward this information to your insurance company
    - Your insurance company may honor the claim and pay all or a portion of the bills incurred
    - Your insurance company may not honor the claim and send you a denial of benefits letter.

- If a balance remains after your family insurance group has contributed towards the claim, send a copy of all the bills and the explanation of benefits from your insurance company to Renee Kleszczynski at St. Bonaventure University Athletic Department.
    - If you receive a denial of benefits letter from your insurance company then send the denial of benefits letter and a copy of the bills incurred to Renee Kleszczynski at the St. Bonaventure University Athletic Department.

- St. Bonaventure will submit the remaining bills and explanation of benefits (denial letter) to Markel Insurance Company. There is a $2000 deductible for each athletic injury, this deductible is waived if the student-athlete has purchased the Markel Insurance. ***THIS POLICY, HOWEVER, IS SECONDARY TO, OR IN EXCESS OF, PERSONAL FAMILY MEDICAL INSURANCE COVERAGE,*** and covers only injuries resulting in direct participation in the intercollegiate athletic program during the dates of the primary competitive season and designated off-season as approved by the Director of Athletics according to NCAA regulations

* It is the student-athletes and his/her parent(s) / guardian(s) responsibility to understand the conditions that apply to their policy and comply with the requests for information, etc. from the insurance company. Any delinquent bills resulting in bad credit due to non-compliance with insurance companies requests may be the responsibility of the student-athlete and/ or his/her parent(s) / guardian (s)

* All claims must be resolved with in 2 years (104 weeks) from the date of injury

Comprehensive information regarding POMCO/Markel will be sent to all parents from Health Services in August. At that time, you will officially waive or accept POMCO/Markel. However, the Athletic Department needs to have this information on file before student athletes arrive on campus. *****Please understand that the POMCO/Markel Policy is secondary to your primary insurance carrier at all times.***

*If you have any questions regarding the insurance policy or the procedures for submitting claims, contact Renee Kleszczynski, Head Athletic Trainer at (716) 375-4098.

St. Bonaventure University Sports Medicine
POMCO/Markel Secondary Health Insurance

Waiver/Verification Form

I have read and understand the St. Bonaventure University Department of Athletics Insurance Policy Statement. I understand I will receive comprehensive information regarding POMCO/Markel from Health Services in August. At that time, I will officially waive or accept POMCO/Markel. However, the Athletic Department needs to have the following information on file before student athletes arrive on campus.

**** I understand that ALL international students and all students who are not covered under their parent/guardian insurance are REQUIRED to accept POMCO/Markel.**

I understand that if I **ACCEPT** the Health & Accident Policy from POMCO/Markel:

- The projected premium of approximately $339.00 is automatically included in the tuition statement and there will be NO additional billing
- The parent's insurance policy is primary
- POMCO/Markel insurance is secondary
- All medical bills must first be submitted to the parent's primary policy before any claims are considered by POMCO/Markel

Some HMO's do not participate with the Olean Medical Group. Please call your primary insurance company and ask if they participate and, if so, are there any restrictions.

I understand that if I choose to **WAIVE** the Health & Accident Policy from POMCO/ Markel ALL medical costs incurred by the student athlete are the sole responsibility of the student athlete.

Please choose (X) ONE:

_____ I choose to **ACCEPT** POMCO/Markel

_____ I choose to **WAIVE** POMCO/Markel

Parent/Guardian Signature ________________________________ Date ___________

**** Please enclose a photocopy of the FRONT and BACK of your primary insurance card**

ST. BONAVENTURE UNIVERSITY SPORTS MEDICINE

The following information must be fully completed before the athlete will be allowed to participate.

Sport: ____ Date: ___________________________

ATHLETE INFORMATION

Name: ____ Date of Birth: _________________

SS #: ____________________ Age: ________ Sex: M F Athletic Year: 1 2 3 4 5

Home Phone #:________________ Campus Phone: ___________ Cell #: _________________

Home Address: ____

____

____

____

School Address: ____

PARENT INFORMATION

Father/Guardian: ____ Date of Birth: ___________

Home Address: ____
Street # City State/Zip

Home Phone #: ______________ Cell Phone #:________________ Work #:_______________

Mother/Guardian: _______________________________________ Date of Birth: ___________

Home Address: ____
Street # City State/Zip

Home Phone #: ______________ Cell Phone #:________________ Work #:_______________

Name of family physician: ____
Phone #: ______________

** Please be sure to complete all information on the back of this form

INSURANCE INFORMATION

**** Please enclose photocopy of front and back of all insurance cards ****

Primary Insurance:

Company Name: ____

Address for Claims:
____

Policy #: ______________________________ Group #: _____________________________

Phone#: ___________________________

*** Is your dependent son/daughter covered under this policy? YES / NO
*** Is this HMO or PPO? YES / NO
*** Is pre-authorization required for services? YES / NO

Secondary Insurance:

Company Name: ____

Address for Claims:
____

Policy #: _______________________________ Group #: ____________________________

Phone: ____________________________

*** I choose to ACCEPT / WAIVE (circle one) POMCO/Markel secondary health

insurance offered through St. Bonaventure University.

**** NOTE: If the athlete is currently taking Adderall, Ritalin, or a generic equivalent please enclose a letter from your primary care physician explaining the condition and prescribed medications for treatment.** These, and similar, medications will result in a positive drug test. Although this information will be kept confidential, proper documentation is necessary to absolve the athlete in the case of a positive drug test.

I hereby state that, to the best of my knowledge, the above information is correct

Athlete's Signature: ____

Date: ______________

ST. BONAVENTURE UNIVERSITY SPORTS MEDICINE

Athlete Name: ______________________________ Sport:_____________________________

STUDENT ATHLETE ACCEPTANCE OF RISK
RELEASE AND HOLD HARMLESS AGREEMENT

I understand the risk of injuries and losses that can occur as a result of participation in intercollegiate athletic activities and assume all such risks. I hereby further consent to St. Bonaventure University's obtaining whatever medical treatment and/or care is deemed necessary by University Staff for health and well-being of the student athlete and I consent to have administered to the athlete any emergency medical or surgical treatment recommended by any licensed physician.

Whereas, I am about participate upon my own initiative and assumption of risk, in an activity sponsored by St. Bonaventure University's intercollegiate athletic program, I do hereby waive and release all future claims, rights and courses of action accruing in my favor as a result of personal injuries or property loss during travel to and from athletic contests, and while participation in said activity against St. Bonaventure University, and/or authorized agents of the above described; and further, hereby covenant and agree with them that no suit or action at law shall be instituted for the above reasons by me or others in my behalf or in my right.

Having read and understood the above, I accept the risk of possible tragic injury, while trying out or participating in athletics at St. Bonaventure University and freely sign this release and hold harmless agreement.

Parent/Guardian Signature:____ Date: _______

Student Athlete Signature: ____ Date: _______

To Parents and Guardians of student athletes <u>under 18 years of age</u>:

I, ____,

pursuant to the authority vested in me as ____________________________________
Parent-Guardian

of____
Student Athlete's Full Name

Do hereby authorize the St. Bonaventure University Staff, upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetic, medicines and hospitalization, including care and treatment by any hospital, staff surgeon, physician or radiologist which they deem necessary for emergency care of my child.

Parent/Guardian Signature:____ Date: _______

St. Bonaventure University Athletic Physical Examination Summary

NAME____________________ **M F AGE:** _______ **SS#:** ________________________ **SPORT:**_________________________ **FR SO JR SR**

MEDICAL HISTORY (circle Y or N)

1. Has a doctor ever denied or restricted your Participation in sports for any reason? Y N
2. Do you have an ongoing medical condition? (like diabetes or asthma) Y N
3. Are you currently taking any prescription or Nonprescription (over the counter) medicines or pills? Y N
4. Do you have allergies to medicines, pollens, foods or stinging insects? Y N
5. Have you ever passed out or nearly passed out DURING exercise? Y N
6. Have you ever passed out or nearly passed out AFTER exercise? Y N
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N
8. Does you heart race or skip beats during exercise? Y N
9. Has a doctor ever told you that you have (check all that apply):
   - ☐ High blood pressure ☐ Heart murmur
   - ☐ High cholesterol ☐ Heart Infection
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) Y N
11. Has anyone in you family died for no apparent reason? Y N
12. Does anyone in you family have a heart problem? Y N
13. Has any family member or relative died of heart problems or of sudden death before the age of 50? Y N
14. Does anyone in your family have Marfan syndrome? Y N
15. Have you ever spent the night in a hospital? Y N
16. Have you ever had surgery? Y N
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? Y N
18. Have you had any broken or fractured bones or dislocated joints? Y N
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical Therapy, a brace, a cast, or crutches? Y N
20. Have you ever had a stress fracture? Y N
21. Have you every been told that you have or have you had an x-ray for antantoaxial (neck) instability)? Y N
22. Do you regularly use a brace or assistive device? Y N
23. Has a doctor ever told you that you have asthma or allergies? Y N
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? Y N
25. Is there anyone in your family who has asthma? Y N
26. Have you ever used an inhaler or taken asthma medicine? Y N
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N
28. Have you ever had infectious mononucleosis (mono) within the last month? Y N
29. Do you have any rashes, pressure sores, or other skin problems? Y N
30. Have you had a herpes skin infection? Y N
31. Have you ever had a head injury or concussion? Y N
32. Have you been hit in the head and been confused or lost your memory? Y N
33. Have you ever had a seizure? Y N
34. Do you have headaches with exercise? Y N
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Y N
36. Have you ever been unable to move your arms or muscle cramps or become ill? Y N
37. When exercising in the heat, do you have severe muscle cramps or become ill? Y N
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N
39. Have you had any problems with your eyes or vision? Y N
40. Do you wear glasses or contact lenses? Y N
41. Do you wear protective eyewear, such as goggles or a face shield? Y N
42. Are you happy with your weight? Y N
43. Are you trying to gain or loose weight? Y N
44. Has anyone recommended you change your weight or eating habits? Y N
45. Do you limit or carefully control what you eat? Y N
46. Do you have any concerns that you would like to discuss with a doctor? Y N

FEMALES ONLY

47. Have you ever had a menstrual period? Y N
48. How old were you when you had your first period? __________
49. How many periods have you had in the last 12 months? __________

EXPLAIN YES ANSWERS: ____

____

____ **MEDICATION**: ____

BELOW TO BE FILLED OUT BY TEAM PHYSICIAN

HEIGHT: **WEIGHT:** **BODY FAT%** **BP:** **PULSE:** **RESP:**

URINALYSIS: PROTIEN: Neg Trace + ++ +++ GLUCOSE: Neg. Trace + ++ +++

	NORMAL	ABNORMAL	INITIALS
Eyes	☐	☐	
Ears, Nose, Throat	☐	☐	
Cardiovascular	☐	☐	
Abdominal	☐	☐	
Genitalia / Hernia	☐	☐	
Chest / Lungs	☐	☐	
Skin & Lymphatic	☐	☐	

	NORMAL	ABNORMAL	INITIALS
Neck	☐	☐	
Back	☐	☐	
Shoulder/arm	☐	☐	
Elbow/forearm	☐	☐	
Wrist/hand/ fingers	☐	☐	
Hip/thigh	☐	☐	
Knee	☐	☐	
Leg/ankle	☐	☐	
Foot/ toe	☐	☐	

Approved for sports: YES With limitation:______________________ Disapproved:_________________ DATE: _________ Physician Signature :_________________________________

The above information is correct and current. I have not knowingly or willing with held information which would affect my ability to participate in athletics at St. Bonaventure University

Athletes Signature:__________________________________ **DATE:**___________________