



Chadron State College Athletic Insurance Policy

Dear Student-Athlete and Parents/Guardian:

Welcome to Chadron State College and Chadron State Athletics. We are excited to have you participating in intercollegiate athletics at Chadron State College.

Due to the rising cost of insurance Chadron State College will now require all student athletes to carry health/medical insurance while participating in intercollegiate athletics. Chadron State College carries a secondary policy to help defray some of the medical costs associated with athletic injuries. Please thoroughly read the insurance information included in this packet for details.

If you have any questions regarding personal insurance requirements or CSC insurance coverage please contact Melissa Miskimins, athletic administrative assistant, at 308-432-6344. I have listed below an insurance option that would provide a monthly plan for your son/daughter. Please feel free to research other insurance plans and providers We look forward to working with you during your intercollegiate athletic career at Chadron State College.

Sincerely,

Brad Smith
Director of Athletics

INSURANCE OPTION

Barney Insurance Company—Kearney NE

Contact is Tracy Pritchard—800-927-7562

18-23 year old Male and Female (short term policy)

\$500 deductible \$78.10 per month

18-23 year old Male (permanent policy)

\$500 deductible \$99.31 per month

18-23 year old Female (permanent policy)

\$500 deductible \$137.00 per month



Chadron State College Athletics

Student-Athlete Participation Packet Checklist

Please complete all of the attached documents and returned them to the Chadron State College Athletics Department no later than **August 1, 2009.**

Please detach the student-athlete participation packet checklist and retain it for your records.

- _____ 1. Emergency Contact Information (page 2)
- _____ 2. Medical Insurance Authorization/Information (page 3)
- _____ 3. Insurance Information Sheet (page 4)
- _____ 3. Medical Consent Form (page 5)
- _____ 4. Football Helmet Warning (page 6)
- _____ 5. Medical History Form (page 7&8)
- _____ 6. Physical Exam Form (completed by a certified physician) (page 9)
- _____ 7. A front and back photocopy of your insurance, dental and prescription card.



Emergency Contact Information

PLEASE PRINT

Student-Athlete's Name: _____ Sport: _____

Date of Birth: _____ Gender: MALE / FEMALE

Student-Athlete's Permanent Address:

Permanent Telephone: _____

Father/Guardian Information

Father's Name: _____

Address (Street): _____

(City, State Zip): _____

Work Telephone: _____

Home Telephone: _____

Cell Phone: _____

Mother/Guardian Information

Mother's Name: _____

Address (Street): _____

(City, State Zip): _____

Work Telephone: _____

Home Telephone: _____

Cell Phone: _____

In case a parent/guardian cannot be reached, please enter a third emergency contact.

Name: _____

Address (Street): _____

(City, State Zip): _____

Work Telephone: _____

Home Telephone: _____

Cell Phone: _____

Relationship to Student-Athlete: _____



Medical Insurance Information/Authorization

Primary coverage for any intercollegiate athletic-related injuries is the responsibility of the student-athlete's personal or family insurance policy. The student-athlete must show proof of insurance before participating in any intercollegiate activity. The coverage CSC provides for the student-athlete is for injuries sustained while participating or competing in intercollegiate athletics is a secondary coverage or **EXCESS** coverage. This secondary policy has a **\$5,000 deductible per injury which has to be met by either you or your insurance company.** Chadron State College does not have the option of waving this provision.

A brief summary of the Chadron State College secondary insurance policy is as follows:

1. All claims must be first submitted to your personal insurance company prior to sending them to the CSC Athletic Department.
2. The student athlete must see a Chadron State College approved doctor to be eligible for the claim. If the student-athlete wishes to see any other physicians, dentists, optometrists, etc. the Head Athletic Trainer must approve this prior to scheduling an appointment.
3. All claims must be filed within 120 days of the injury date or date of service.
4. The student-athlete must report the injury to the CSC athletic training staff in a timely manner so a record can be made in order to file a claim.
5. Covered injuries include: participation during a scheduled varsity event, practice or conditioning workout supervised by a coach. This does not include non-supervised workouts or injuries/illnesses that prevent participation in athletics if they were not directly caused by participation in athletics.
6. In the event that the CSC insurance denies the claim for whatever reason, the remaining balance is considered your responsibility.
7. The CSC insurance policy has a **104 week** statute of limitation from the date of the injury.

The procedure for filing a claim with the Chadron State College secondary insurance policy is:

1. All claims will be first submitted to your personal insurance to be processed.
2. After your insurance had paid its portion, you will receive a bill from the provider with the remaining amount owed. Send this bill to the CSC athletic office and it will be submitted to our insurance company.
3. Processing a claim can take up to 4-6 weeks. This necessitates bills being submitted in a timely manner as we do not have the ability to negotiate with collections agencies. *If a claim is approved after you have paid a bill, the insurance company may authorize reimbursement.*
4. We recommend that you make a copy of this form for your records. We also recommend that you make a copy of all bills you send to the CSC Athletic Department.

For more information please contact the Chadron State Athletic Office at 308-432-6344.

I have read and understand the CSC summary of its supplemental athletic insurance policy and the procedures for filing a claim that may affect me as a parent/guardian and/or student-athlete.

Student-Athlete Printed Name

Student-Athlete Signature

Date



Parent/Guardian Signature Required

Date



Insurance Information Sheet

Please complete the following form completely. **Also include with the information a front/back copy of the following items that apply: health insurance card, dental insurance information and/or prescription cards. The following information is updated annually.**

Student-Athlete Information

Student-Athlete's Name: _____ Sport: _____

Date of Birth: _____ Gender: MALE / FEMALE

Health Insurance Information

Primary Policy:

Policy Holder's Name: _____ Relationship to Athlete: _____

Insurance Company: _____

Effective Date of Policy _____ Expiration Date of Policy _____

Policy #: _____ ID #: _____ Group #: _____

Is this an HMO Policy: YES / NO Is this a PPO Policy? YES / NO

Address for Insurance Company's Claim Office:

Phone: _____ FAX: _____

Secondary Policy (if applicable):

Policy Holder's Name: _____ Relationship to Athlete: _____

Insurance Company: _____

Effective Date of Policy _____ Expiration Date of Policy _____

Policy #: _____ ID #: _____ Group #: _____

Is this an HMO Policy: YES / NO Is this a PPO Policy? YES / NO

Address for Insurance Company's Claim Office Address:

Phone: _____ FAX: _____

If a change or lapse of insurance occurs, parents and/or student-athletes will be responsible for the \$5,000 deductible to be paid prior to submission of the claim to the CSC Secondary Policy.

I, _____, verify that the above primary and/or secondary policies are viable, major medical policies. Any athletic injury expenses would be covered under these policies.

Student-Athlete Signature

Date

Parent/Guardian Signature Required

Date



Medical Consent Form

Athlete Name _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above-named student-athlete. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student-athlete may be given. NO surgery, other than surgery for major **life-threatening** injuries, will be performed without prior medical opinions being given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents/legal guardians/spouse as soon as possible. Permission is also granted to the athletic training staff to provide the needed emergency treatment and first aid to the student-athlete prior to his/her referral to the attending physician or admission to the medical facilities.

STATEMENT OF RISK

While benefits derived from intercollegiate athletic participation are great, there are also calculated risks involved in such competition.

Intercollegiate student-athletes need well-conditioned bodies to perform in a successful manner. No matter how well-conditioned the human body is, injuries may and will occur. These injuries range from very minor injuries to major injuries that may require minor or major surgery. Some injuries could possibly cause permanent damage or even be life threatening.

The coaches working in our programs are well-qualified, professional people. Fundamentals related to their specific sport will be emphasized repeatedly on and off the field or court. These fundamentals are designed to help prevent injury. But even with the best of fundamentals, the risk of injury still exists.

Both participants and parents are hereby advised that an element of risk is present in all intercollegiate athletic participation.

I hereby affirm that I have read the above information and understand that the risk of injury exists in all intercollegiate athletic participation.

Signature of Student-Athlete

Date

Signature of Parent/Guardian

Date



Football Helmet Warning

The football helmet issued to you by Chadron State College has warning label(s) attached inside and/or outside of the shell which read as follows:

WARNING – DO NOT strike an opponent with any part of this helmet or face mask. This is a violation of football rules and may cause you to suffer severe brain and/or neck injury, including paralysis or death. Severe brain and/or neck injury may also occur accidentally while playing football. NO HELMET CAN PREVENT ALL SUCH INJURIES. YOU USE THIS HELMET AT YOUR OWN RISK.

On some helmets the label reads as follows:

WARNING – NO HELMET CAN PREVENT ALL HEAD OR NECK INJURIES A PLAYER MIGHT RECEIVE WHILE PARTICIPATING IN FOOTBALL. DO NOT use this helmet to butt, ram, or spear an opposing player. This is in violation of football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent.

Other helmet labels may read:

WARNING – DO NOT use this helmet to butt, ram, or spear an opposing player. This is in violation of football rules and can result in severe head, brain, or neck injury, paralysis, or death to you and possible injury to your opponent.

There is a risk these injuries may also occur as a result of an accident without intent to butt, ram, or spear.

NO HELMET CAN PREVENT ALL SUCH INJURIES!!

Furthermore, I understand that participating in football may result in my accidental death, paralysis (or not being able to move my arms and/or legs), or possible brain and neck injury that may lead to permanent dysfunction for the rest of my productive life.

I/We, the undersigned, have read the above and foregoing helmet warning(s) and understand the statements therein.

Signature of Student-Athlete

Date

Signature of Parent/Guardian

Date



Medical History Form

Name _____ Age _____ Date of Birth _____ Sex _____

Instructions: Please circle "Y" for YES or "N" for NO. If you reply "Y" to any statement, please attach a separate sheet of paper explaining your condition, date of occurrence and the anatomical site of your injury (i.e. left or right). Please keep in mind that these documents are kept confidential and reviewed only by the Head Athletic Trainer.

Diseases and Illnesses

- 1. Y N Have you ever experienced an epileptic seizure or been informed that you may have epilepsy?
- 2. Y N Have you ever been diagnosed as having high blood pressure?
- 3. Y N Have you ever experienced chest pain during or after exercise?
- 4. Y N Have you ever experienced any of the following problems during or immediately after exercise?
Fainting, or near fainting; unexpected, excessive or unexplained shortness of breath; or excessive or unexplained fatigue?
- 5. Y N Have you ever been told you have a heart murmur, heart disease or heart trouble?
- 6. Y N Have any of your parents, siblings or grandparents died prematurely from a heart attack or stroke?
Any prior to the age of 50?
- 7. Y N Have any close relatives younger than age 50 had any disability from cardiovascular (heart) disease?
- 8. Y N Have you ever had hepatitis?
Which type and when?
- 9. Y N Have you been treated for any infections disease(s) in the past 12 months?
- 10. Y N Do you, or an immediate family member have a systemic (diabetes, etc) disease?
- 11. Y N Do you, or an immediate family member have a progressive disease (multiple sclerosis) or cancer?
- 12. Y N Have you ever had an ulcer?
- 13. Y N Have you ever had asthma?
- 14. Y N Have you ever had tuberculosis?
- 15. Y N Have you ever had appendicitis or an appendectomy?
- 16. Y N Have you ever had arthritis?
- 17. Y N Have you ever had a hernia or rupture?
- 18. Y N Have you ever had any allergies?
a. Hay Fever _____ Specify _____
b. Drugs _____ Specify _____
c. Foods _____ Specify _____
d. Poison Ivy or Oak _____ Specify _____
e. Other _____
- 19. Y N Are you allergic to bee stings or insect bites?

Head and Neck

- 20. Y N Have you ever had (a) head injury/injuries or concussion(s)?
- 21. Y N Have you ever had to go to a hospital, emergency room or clinic for a head or neck injury?
- 22. Y N Have you ever been knocked out or unconscious?
- 23. Y N Have you ever had a "stinger" or a "burner"?
- 24. Y N Have you ever had whiplash, a pinched nerve, or severe headaches?
- 25. Y N Do you wear a mouthpiece during athletic participation?
- 26. Y N Do you wear a dental appliance (other than a mouth guard) when you participate in athletics?
- 27. Y N Have you ever had a problem with your vision?
- 28. Y N Do wear glasses, contacts, or protective eyewear?
- 29. Y N Do you have loss of sight in either eye?
If yes, which one?

Bone and Joint



- 30. Y N Have you ever been unable to participate in athletics due to a shoulder injury?
- 31. Y N Have you ever been advised to have surgery to correct a shoulder condition?
If yes, has the surgery been performed? Give date:
- 32. Y N Have you ever sprained, dislocated, had repeated swelling, and/or repeated pain in any joints/bones?
- 33. Y N Do you have any pins, screws, wires, plates or other hardware implanted in you as a result of a surgical repair?
- 34. Y N Do you use any protective equipment (braces, neck roll, etc) while participating in athletics?
- 35. Y N Have you ever had a fracture?
- 36. Y N Have you ever injured your neck, back or vertebral disks?
- 37. Y N Have you ever had surgery to correct a bone or joint problem?
- 38. Y N Has a medical practitioner given you any special instructions or placed any restrictions on you?
- 39. Y N Have you ever been told that you injured the ligaments/cartilage in either knee joint?
- 40. Y N Have you ever been advised to have surgery to a knee to correct a condition?
If yes, has the surgery been performed? Please provide dates.
- 41. Y N Have you had a severe sprain of either ankle during the past two years?
- 42. Y N Have you ever had a bone graft or spinal fusion?
If yes, please indicate site and date.
- 43. Y N Have you ever had synovial fluid (water in the knee or elbow) removed? Indicate date.

General Medical

- 44. Y N Are you currently under a doctor's care?
- 45. Y N Do you have any other medical conditions not mentioned above?
- 46. Y N Have you had any heat-related illnesses (heat cramps, fainting, heat exhaustion, heat stroke)?
- 47. Y N Are you currently taking any medications (birth control, pain killers, insulin, etc.) either prescribed by a physician or over the counter?
- 48. Y N Are your immunizations up to date?
- 49. Y N Have you recently had a tetanus shot. Please give the date (month/year)
- 50. Y N Do you have any problems with or are you missing any paired organs (kidneys, eyes, etc)?
- 51. Y N Have you ever been diagnosed with a kidney or bladder infection?
- 52. Y N Have you had any operations during the last five years?
If yes, indicated anatomical site and date:
- 53. Y N Have you been advised by a medical doctor not to participate in sports?
If yes, for what reasons?
- 54. Y N Have you ever had an eating disorder?
- 55. Y N Have you ever been hospitalized?
If yes, give date and condition?
- 56. Y N Have you ever had a problem with dehydration?

Females Only

- 57. Y N Do you experience any problems with menstruation?
If yes, please describe.
- 58. Y N Do you have irregular menstrual cycles?

By signing below, you certify that to the best of your knowledge all of the above information is correct.

Signature of Student-Athlete

Date

Signature of Parent/Guardian

Date



Physical Exam Form

Name: _____ Date of Birth: _____ Today's Date _____
Sport: _____ Age (years): _____ Height: _____ Weight: _____ Pulse (bpm): _____
Blood Pressure: _____ Vision: R/20 _____ L/20 _____ Both 20/ _____ Corrected: Y N

Check off normal finding and indicate abnormal findings and where follow-up is recommended.

Table with 4 columns: System, Normal, Abnormal Findings, Needs Follow-Up. Rows include Appearance, Eyes/Ears/Nose/Throat, Hearing, Lymph Nodes, Heart, Lungs, Abdomen, Genitourinary (males), and Skin.

Table for joint mobility with columns for NORMAL and ABNORMAL. Rows include Neck (Forward Flexion, Extension, R Side Flexion, L Side Flexion, R Rotation, L Rotation, Axial Comp), Shoulder (Abduction, Adduction, Flexion), Trunk (Flexion, Extension, Side Bending, Rotation), Hip (Flexion, Extension, Abduction, Adduction), and Knee (Flexion).



	<input type="checkbox"/>	Extension	_____		<input type="checkbox"/>	Extension	_____
	<input type="checkbox"/>	Int. Rot.	_____				
	<input type="checkbox"/>	Ext. Rot.	_____	Ankle	<input type="checkbox"/>	Dorsiflexion	_____
					<input type="checkbox"/>	Plantarflexion	_____
Elbow	<input type="checkbox"/>	Extension	_____		<input type="checkbox"/>	Inversion	_____
	<input type="checkbox"/>	Flexion	_____		<input type="checkbox"/>	Eversion	_____
Wrist	<input type="checkbox"/>	Extension	_____	Posture	<input type="checkbox"/>	Head	_____
	<input type="checkbox"/>	Flexion	_____	Symmetry	<input type="checkbox"/>	Shoulders	_____
	<input type="checkbox"/>	Radial Deviation	_____		<input type="checkbox"/>	Back	_____
	<input type="checkbox"/>	Ulnar Deviation	_____		<input type="checkbox"/>	Hips	_____
					<input type="checkbox"/>	Knees	_____
Hand	<input type="checkbox"/>	Grip Strength	_____	Balance	<input type="checkbox"/>	R leg 30 secs	_____
	<input type="checkbox"/>	Pinch Strength	_____		<input type="checkbox"/>	L leg 30 secs	_____
	<input type="checkbox"/>	Finger Abd/Adduction	_____				

I certify that the above named student-athlete is (check one):

cleared to participate cleared, but restricted from contact sports NOT cleared to participate at all

Physician's Signature _____ Date _____