

Baker Athletes and Parents,

Welcome from Baker University Sports Medicine. Please take a minute to review this letter and the enclosed materials that together embody your Athletic Participation Packet. Within this packet, you should find a Baker Sports Participation Physical, an Insurance Questionnaire, an Assumption of Risk/Liability Waiver and an Insurance Information sheet. All enclosed information **must** be completed and returned to the Sports Medicine Department **before** you will be allowed to participate in any athletic practices or competitions.

The Insurance Questionnaire includes a request for a **legible copy of your medical insurance card**. Please attach the copy to the insurance form. This information will be kept in each student's medical record and kept confidential. Please read all forms carefully before signing, especially **section I** on your Acceptance of Risk/Liability Waiver. Every Baker athlete must have a new physical examination on file each year of competition. **All physical examinations must be completed and signed by a licensed doctor of medicine or doctor of osteopathy. Physical examinations signed by a medical provider other than a licensed MD or DO will NOT be accepted.** The athletic training staff and the Student Health Center will NOT set up or provide physicals for athletes who do not have them at the time of reporting. All athletes are responsible for obtaining their personal information. Junior College transfers should contact their former school of attendance and request the transfer of athletic and health information to Baker University. This may also require you to fill out a medical information release.

Please take time to fill out all of these forms as thoroughly as possible. **Please review with your physician your immunizations' status and have all documented on the physical examination form. All new incoming students are required to show proof of a meningitis vaccine.** When completed, mail or fax all components of your Athletic Participation Packet to the attention of the **Sports Medicine Department by August 1st, 2009.** Please call with any additional questions.

Thank you,

Lynn C. Bott, MS, LAT, ATC

Director of Sports Medicine

(P) 785-594-8424

(F) 785-594-8465

Lynsey Payne, MS, LAT, ATC

Assistant Athletic Trainer

(P) 785-594-8499

(F) 785-594-8465

Revised 04.08

Baker University Student-Athlete Athletic Accident Secondary Insurance

For this 2009-2010 sports' seasons, Baker University Athletics will again purchase an excess or secondary athletic accident insurance policy. This policy is effective only after the student-athlete's (S-A) primary health insurance has paid its full portion and after the S-A has paid incurred charges to meet the secondary insurance disappearing deductible of \$500.00. The \$500.00 deductible is per accidental incident. A disappearing deductible is defined as follows: the covered person may use covered expenses paid under another health care plan to satisfy the deductible under this policy. See examples below.

Please note that athletics requires all S-A to document insurance coverage, through parent, spouse, or personal policy, and must be primary coverage when an athletic accident occurs. Baker University does not pay medical bills or out of pocket expenses. Also, note that this is insurance and insurance is not designed to cover all services in full, such as devices (braces) used by the S-A to play post-injury. Please, be aware that secondary insurance **will not** pay everything in full.

Upon referral to a physician, S-A provides the physician's office with his/her medical insurance. In most cases, insurance will be directly billed by the physician's office. After primary insurance has paid the provider, any remaining balance is sent to the student-athlete. This comes as an explanation of benefits (EOB) and an invoice. These two documents should be presented to Connie Deel, Assistant Director of Human Resources, Constant 3. If the physician's office is already aware of the secondary insurance, they will file the secondary claim directly with Connie, before billing the S-A for any balance. Once the athletic accident insurance deductible, up to \$500.00, has been paid by the student-athlete, the athletic accident insurance will provide excess payment as long as proper documentation is presented.

EXAMPLES

S-A incurs a \$2,000 charge and S-A primary health insurance pays 50% or \$1,000. The \$500 secondary insurance deductible has disappeared in the \$1,000 paid by the primary. The remaining balance of \$1,000 will be filed with the secondary accident insurance.

S-A incurs \$12,000 charge and S-A primary health insurance pays 80% or \$9,600. The \$500 secondary insurance deductible has disappeared in the \$9,600 paid by the primary. The remaining balance of \$2,400 will be submitted to secondary accident insurance.

S-A incurs a \$100 charge and S-A primary health insurance pays a portion or denies payment. The secondary accident insurance deductible has not been met and payment is the responsibility of the S-A.

If you have any questions, please contact Lynn Bott or Lynsey Payne in the Athletic Training Room or Connie Deel in Human Resources (connie.deel@bakeru.edu).

Insurance Questionnaire

This form should be completed **in full** by the parents or the primary insurance provider prior to participation in athletics at Baker University and kept on file in the Sports Medicine Department in the event of a serious injury or medical insurance claim.

Name of Student _____ Sport _____ Soc. Sec. No. _____
Date of Birth _____

Father / Mother

Name _____ Please Copy and Attach the Student Athlete's
Soc. Sec. No. _____ Insurance Card:

Employed _____ Yes _____ No

Address _____

Phone (____) _____

Do you have GROUP medical insurance coverage
through your employment? _____ Yes _____ No

Ins. Co. _____

Address _____

Policy/Group No. _____

Claims Phone (____) _____

Pre-Auth. Required? _____ Yes _____ No

2nd Opinion/Surgery? _____ Yes _____ No

Type of Plan:

_____ Health Maintenance Organization (HMO)

_____ Preferred Provider Organization (PPO)

_____ Standard Medical/Hospital Coverage

_____ Other:

FRONT

BACK

If you have medical insurance coverage, and your son/daughter is NOT covered or is PARTIALLY covered due to policy limitations, please explain:

If your son/daughter has medical insurance as an eligible dependent from your previous marriage, as mandated in a divorce decree, please give details for filing a claim:

I/we agree that all information provided in this document is accurate and complete to the best of my/our knowledge. I/we understand that any incorrect or undisclosed information can result in duplicate billing/payment. The responsibility of such overpayment will be the obligation of the undersigned to reimburse in full, upon request, all amounts deemed refundable.

Parent/Guardian _____ Date _____

Student Athlete _____ Date _____

Revised 4/2009

BAKER UNIVERSITY SPORTS PARTICIPATION HISTORY & PHYSICAL

Name _____ Date _____ Date of Birth _____

Social Security# _____ Sport _____

This Section is to be filled out by Athlete

I. Put an "X" in the blank if you have now or have ever had the following:

- | | | | | |
|-------------------------------------|--------------------------------------|---|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High/Low Blood Sugar | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles | <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Birth Deformities | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heat Exhaustion/Stroke | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Disease |

II. Put an "X" in the blank if you have ever had an illness/injury involving the following:

- | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|-------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Calf | <input type="checkbox"/> Hand | <input type="checkbox"/> Hip | <input type="checkbox"/> Thigh | <input type="checkbox"/> Abdomen/Pelvis |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Knee | <input type="checkbox"/> Wrist | <input type="checkbox"/> Chest/Breast |
| <input type="checkbox"/> Back | <input type="checkbox"/> Foot | <input type="checkbox"/> Heart | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder | |

III. Females Only: Menstrual History:

Age of Onset Interval Between Periods Duration

IV. Put an "X" if you have a family history of:

- Sudden Death at a Young Age
- Syncope (Passing Out)
- Sickle Cell Disease or Trait
- High Blood Pressure

VI. Circle the appropriate answer to the following.

- Yes or No 1. Have you ever been "knocked out" or experienced a concussion? If yes, how many times? ____
- Yes or No 2. Have you ever been hospitalized due to a concussion?
- Yes or No 3. Have you ever had a "Burner" or "Stinger"? If yes, how many? _____
- Yes or No 4. Have you ever passed out?
- Yes or No 5. Have you ever been withheld from participating in a sport for medical reasons?
- Yes or No 6. Do you wear Glasses or Contacts? While playing? Yes or No
- Yes or No 7. Do you have any dead, missing, chipped, or broken teeth?
- Yes or No 8. Do you wear dental appliances?
- Yes or No 9. Have you had any injuries to the neck or back nerves, vertebrae (bones) or vertebral discs?
- Yes or No 10. Have you had any surgery on your neck or back?
- Yes or No 11. Have you had any fractures within the last two years?
- Yes or No 12. Have you had surgery within the last two years?
- Yes or No 13. Are you taking any medication?
- Yes or No 14. Are you allergic to any medication?

Explain any "X" or "Yes" answers in the space below or on the back of the page.

SIGNATURE

DATE

PHYSICAL EXAMINATION (To be filled out by Physician)

Name _____ Sport _____ Height _____ Weight _____ Date _____
 Immunizations: Tetanus (date) _____ TB (date) _____
 MMR (dates) _____ Hepatitis B (dates) _____ Meningitis (date) _____

Normal	Abnormal	General Medical Information
		Eyes: Vision
		Ears: Hearing, Canals, Drums
		Nose: Septum, Obstructions
		Mouth: Membranes, Throat, Tonsils, Teeth
		Abdomen/Pelvis: Viscera Scars, Hernia
		Heart: Chest: Lungs:
		Pulse: Blood Pressure:

Cardiac Health

Rhythm: _____ Marfanoid? Yes / No
 Murmurs: Supine: _____
 Standing: _____
 Pulses: Radial: R _____ L _____ Femoral: R _____ L _____
 O-Absent D-Diminished N-Normal H-Hyperactive

Normal	Abnormal	Musculoskeletal Exam
		Spine
		Shoulders: Left: Right:
		Elbows: Left: Right:
		Wrists: Left: Right:
		Hands: Left: Right:
		Hips: Left: Right:
		Thighs: Left: Right:
		Knees: Left: Right:
		Ankles: Left: Right:
		Feet: Left: Right:

Athletic participation approved without limitation: Yes / No
 If no, specify participation limitations: _____

 Specify actions needed for clearance: _____

Physician's Name: _____ **Signature** _____
 Address: _____ City _____ State _____ Zip _____
 Telephone Number: _____ Fax Number: _____

Acceptance of Risk/Liability Waiver

- A. The undersigned hereby certifies that the answers to the attached Baker University Sports Participation Physical and Insurance Questionnaire are correct, true, and honest.
- B. Understands that having passed the physical examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.
- C. Understands that he/she must refrain from practices or games during medical treatment until he/she is discharged from treatment by both the Team Physician and the Athletic Trainer, and/or supervising Physician in respect to the current medical condition or injury.
- D. Understands that the university's Team or Campus Physician and Athletic Trainers may review this questionnaire and physical examination, and if necessary, require additional testing or examinations before clearing and athlete to participate.
- E. Understands and accepts the risks of injury, permanent disability, and/or death inherent to their sport. By signing below he/she pledges to do their best to reduce risks by using proper techniques in play and conditioning, keeping in the best possible condition, and following the advice of the Team or Campus Physician, Athletic Trainers, and Coaches concerning the prevention, treatment, and rehabilitation of athletic injuries and illnesses.
- F. Will promptly notify the sports medicine staff of any changes in his/her health status, including injuries, illnesses occurring during the off-season and summer.
- G. I/the parent/the legal guardian, by signing below, grant permission to the Sports Medicine and/or Coaching staff to secure treatment, ambulance transportation or Emergency Medical Care in the event of a severe/catastrophic athletic injury.
- H. I grant permission to the Sports Medicine staff and Baker University Student Health Services to communicate to one another, written and/or orally, any athletic related information concerning injuries and illnesses that affect my athletic involvement.
- I. I/We, understand that the secondary insurance that Baker University provides for athletic injuries is not all inclusive and that the student/parent may be liable for the deductible and the cost of services not considered medically necessary. Though Baker University provides this coverage at no cost to the student athlete, Baker University does not pay out of pocket expenses for any student injury.
- J. I/We, by signing below, understand that each athlete must have proof of insurance effective **August 4th 2009** or prior to the start of the athletic season. This "full coverage" insurance must be carried current throughout the schedule of athletic practices (in and out of season) and participation. **Any insurance lapse will result in the removal from team roster and the loss of continued athletic scholarship assistance. Additionally, the student's eligibility for secondary athletic insurance benefits will be CANCELLED without proof of a primary insurance carrier.**

I/We, the undersigned, have read and understand the preceding Acceptance of Risk/Liability Waiver and agree to follow its procedures. We also hereby release Baker University, its agents and employees from any liability caused by, or arising out of, the athlete's participation in the University's athletic programs.

Print Name & Sport

Spouse/Parent/Guardian Signature

Athlete's Signature

Date

Date

Revised 4/09