Returning Student-Athlete

Pre-Participation Medical Paperwork

Valparaiso University Athletic Department

Dear Student-Athletes and Parents/Guardians,

On behalf of the athletic training staff, we are excited about the upcoming academic year and athletic season. We look forward to working with you. Our staff is committed to maintaining and improving the health and athletic performance our student-athletes.

As part of the athletic department, and under the direction of the team physician, the athletic training staff provides high quality medical care for all student-athletes. Athletic training is an allied health profession recognized by the American Medical Association. All full time staff and graduate assistant athletic trainers are responsible for the evaluation, management, rehabilitation and treatment of injuries/illnesses that may occur during participation in athletic endeavors. The prevention of these injuries/illnesses, where possible, is of utmost concern. The athletic training staff works in conjunction with team physicians, the Health Center staff, surrounding medical facilities, Valparaiso University Athletic Department staff and the student-athletes to carry out these tasks.

As an integral part of our preventative efforts, we ask that you read and complete the paperwork found in this packet. After completion of the entire packet, please mail the forms to the address below. **This information must be received by the specified due date so that your participation can begin immediately upon your arrival.** Student athletes are not permitted to participate until the completed packet is received. We ask that you also read and review our policies and insurance information found on the Sports Medicine web page (www.valpoathletics.com), and acknowledge that you have read them on the Authorization form.

Due Dates

June 1st -Basketball & Summer School Enrollees

July 1st- ALL Sports Fall Enrollees

Medical Form Checklist:

_____ Sports Medicine Services, Medical Authorization, Assumption of Risk & Health Disclosure (A-D)
_____ Health Insurance & Emergency Contact Form
_____ Insurance/Dental/Vision Card Copy (front & back of card please)

If you have questions you may contact us anytime.
Sincerely,

Valparaiso University Sports Medicine
219-464-5236

Mail all forms to:
Valparaiso University
Attn: Sports Medicine
1009 Union St.
Valparaiso, IN 46383

Sports Medicine Services, Medical Authorization, Assumption of Risk & Health Disclosure
Valparaiso University Athletics Department

_____	_____	_____	_____
Student-Athlete's Last Name	First Name	Middle Name	Sports(s)

Note to Parent/Guardian: Please read, sign and return with other Sports Medicine paperwork.
For purposes of this document, I or my shall mean the Student-Athlete and the Parent/Guardian on behalf of the Student-Athlete

A. Sports Medicine Services

I understand that the sport medicine staff's primary focus is preventing injury as well as treating and rehabilitation of injuries. I also understand that they will develop a rehabilitation program to fit the student-athlete's needs for a quick recovery and are assigned to attend practices and competitions with priority given to in-season, collision or high-risk sports. Valparaiso's team physicians do not attend all practices and competitions; however, they are immediately available via cell phone and pagers.

I acknowledge that all athletic injuries and illness are to be reported immediately to the sports medicine staff for evaluation, care, and referral. The Sports Medicine staff assesses the immediate needs and gives authorization to receive medical care from one of the following: Team Physicians, Health Services, and Outside Physicians. No one within the Athletic Department is allowed to authorize any type of care or referral. The Student-athlete is responsible to report back to the sports medicine staff with information regarding the doctors' visit and follow-up care. Failure to do so will result in being withheld from participation.

Student-athlete initials_____

B. Assumption of Risk

In consideration and as a condition of my participation at Valparaiso University in activities with an athletic team, which includes but are not limited to training, trying out, practicing, competing, and traveling, I freely acknowledge that I am aware of and accept the risks associated with such participation and that my participation in such activities is voluntary.

I fully realize the dangers of participating in such activities and fully assume the risk associated with such participation, which may include, but are not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, and which may be caused in whole or in part by numerous factors, including my medical or physical condition, the actions or inactions of other student-athletes, the conditions of premises, and the negligence of entity or individuals released hereby. I waive, release and discharge for myself, my heirs, executors, administrators, legal representatives, assignees and successors in interest any and all rights or claims for injuries or losses of any description that I may have or which may hereafter accrue to me against Valparaiso University, The Lutheran University Association, Inc., either of their directors, employees, or agents, in connection with my participation in activities associated with Valparaiso University athletic teams.

Student-athlete initials_____

C. Medical Authorization

I grant permission to Valparaiso University athletic trainers, physicians, and/or other medical practitioners to render any preventative, emergency, surgical, or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being, and to arrange for my hospitalization where reasonable and necessary, in circumstances connected with my participation in activities with Valparaiso University athletic teams which I am a participant.

Student-athlete initials_____

D. Disclosure of Health Conditions

I authorize the Sports Medicine staff or any such person that they may designate , permission to contact and discuss my health or medical condition with my parents, guardians or immediate family members in the case of a health emergency on my part. A health **emergency** shall include, but is not limited to, experiencing serious physical or mental difficulties, requiring hospitalization or treatment for any serious physical or mental ailment, injury, disorder or other health condition which the Head Athletic Trainer or the Head Coach believes in good faith to be a serious nature.

Student-athlete initials_____

In the event of any injury or emergency medical condition, I hereby authorize Valparaiso University Sports Medicine Staff or Team Physician(s) to contact my parent(s)/guardians(s). □ Agree □ Disagree

By signing below I have read, understand and approve of Part A, B, C, and D above.

_____	_____
Student-Athlete Signature	Date

_____	_____	_____
Parent/ Guardian Signature	Relationship	Date

(Required regardless of Student-athlete's age)

Valparaiso University Sports Medicine Health Insurance & Emergency Contact Information

When completed, return this form to:

Attn: Sports Medicine
Athletic/Rec Center
1009 Union Street
Valparaiso IN 46383
Phone: 219-464-5236 x3

Valparaiso University Athletic Department's accident policy only provides insurance coverage for student-athlete injuries that occur while participating in the play or practice of intercollegiate sports. This policy is considered EXCESS or SECONDARY to any other collectible group insurance benefits. This simply means that any claims must FIRST be filed with any other valid and collectible group insurance policy under which the student-athlete is covered. Only after the student-athlete's PRIMARY carrier has exhausted all available benefits will our athletic insurance company consider the payment of remaining balances, **PROVIDED THE CLAIMS ARE SUBMITTED WITHIN THE SPECIFIED TIME PERIOD (52 WEEKS) AND THE FOLLOWING CLAIM PROCEDURES ARE FOLLOWED WITH THE REQUIRED DOCUMENTATION PROVIDED.** The University's athletic policy covers athletic injuries only and is not a substitute for comprehensive medical coverage.

SEND A COPY OF THE FRONT & BACK OF YOUR HEALTH, PRESCRIPTION, AND/OR DENTAL INSURANCE CARDS WITH THIS FORM.

Student name (Please Print) : _____ Sport: _____
Year in school: ___ Freshman ___ Sophomore ___ Junior ___ Senior ___ 5th Yr ____ Male ____ Female
Social Security No.: _____ or Student ID No.: _____ Date of birth: _____
Current address: _____

EMERGENCY CONTACT INFORMATION:
Primary contact name: _____ Relationship: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Secondary contact name: _____ Relationship: _____
Cell phone: _____ Home phone: _____ Work phone: _____

OTHER INSURANCE INFORMATION:
Father/Guardian's name: _____ Date of Birth: _____
Social Security Number: _____ Employed: Yes ___ No ____
Employer: _____
Address: _____
Phone number: _____ Contact person: _____
Does your father have group Medical Insurance coverage through his employment? Yes ____ No _____
Insurance company: _____
Address: _____ Policy No.: _____
Mother/Guardian's name: _____ Date of Birth: _____
Social Security Number: _____ Employed: Yes ___ No ____
Employer: _____
Address: _____
Phone number: _____ Contact person: _____
Does your mother have group Medical Insurance coverage through her employment? Yes _____ No _____
Insurance company: _____
Address: _____ Policy No.: _____

TYPE OF PLAN:
☐ Health Maintenance Organization (HMO) ☐ Preferred Provider Organization (PPO) ☐ Standard Medical & Hospitalization Coverage
☐ Other (Describe): _____

- If your mother or father has medical insurance coverage and you are not covered, or are only partially covered, due to policy limitations, please explain: _____
- If you have medical insurance coverage as an eligible dependent from a parents' previous marriage, as mandated in a divorce decree, please give details for filing a claim: _____

I hereby authorize any physician, hospital, company, employer or organization to release and/or exchange any information regarding the medical history, treatment, or benefits payable incurred from any intercollegiate athletic accidents. I permit the release of any medical information about me to Valparaiso University and Commercial Travelers Mutual Insurance Company or its authorized benefit Plan Administrator. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or had in the past. The company will use this information to find out if any claim is eligible. A photocopy of this authorization shall be as valid as the original. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. I also authorize the Commercial Travelers Mutual Insurance Company or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service and such payment shall release the Insurance Company from liability as to amounts so paid. Any person who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Signature of policy holder: _____ Date: _____

Printed name: _____

** * * Please inform the Sports Medicine Office of any insurance changes during the course of the year. * * **