Sports Medicine Paperwork Information for Returning Student-Athletes

Dear Binghamton University Student-Athlete & Parent(s)/Guardians:

Welcome back to Binghamton University Intercollegiate Athletics and another year of successful athletics and academics. It is our goal to provide our student-athletes with the best possible athletic health care. To achieve this, we will need your assistance in a variety of matters. We ask each returning student athlete to complete the enclosed medical and insurance forms completely and accurately. This information will be used by the Sports Medicine Department and our providers of care to bill for services and to contact individuals in the event of an emergency. We also request that you include a copy of any insurance identification and/or prescription cards that you may have. All of the following must be completed and on file before being allowed to participate in any activity:

- _____ “Medical Update for Returning Student-Athletes” form
- _____ “Health Insurance Information/Authorization” form
- _____ Completion of Impact Test

Please complete and return the enclosed forms, including all signatures, along with a copy of any insurance cards to the following address by ____________________________:

Department of Sports Medicine  
Binghamton University  
Events Center  
PO Box 6000  
Binghamton, NY 13902

Should you have any questions regarding this matter, please feel free to contact the Sports Medicine Department regarding your concerns at 607-777-5571. Thank you in advance for your prompt attention to the enclosed material. Have a great and healthy summer and we look forward to your return in August.

Sincerely,

The Department of Sports Medicine  
Binghamton University
Student-Athlete’s Name _________________________________ Social Security # ___________________

Gender:  O Male   O Female   O MTF   O FTM   O Non-binary
Date of Birth _____________________________

Class Level:  FR   SO   JR   SR   5TH   B#_____________________ Sport ___________________

Home Address ______________________________________ City __________________________ State
Zip Code ______________ Country ___________________ Home Phone # __________________

School / Campus _____________________________________ Cell Phone # __________________
Address __________________________________________ Email Address: __________________
(if known)

Emergency Contact ________________________________ Relationship __________________________
Home Phone Number __________________________ Work Phone Number __________________________

Medications Currently Taking _____________________________________________________________

Allergies (medications, food, etc.)/Asthma? __________________________________________________

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<th>Father’s/ Guardian’s Information</th>
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Primary Insurance Information

| Policyholder:  O Father  O Mother  O Student-athlete |
| Insurance Company ______________________________|
| Policy/ID # ______________________________________|
| Group # __________________________________________|
| Insurance Co. Address ____________________________|
| Insurance Co. Phone # ____________________________|
| Type of Insurance:  O HMO  O PPO  O Indemnity  O Other ___________________|
| Primary Care Physician ____________________________|
| Physician Phone # ________________________________|
| Is preauthorization required for medical/diagnostic services?
  O YES  O NO  Phone # ____________________________|
| Is your son/daughter covered under this policy?
  O YES  O NO |

Secondary Insurance Information

| Policyholder:  O Father  O Mother  O Student-athlete |
| Insurance Company ______________________________|
| Policy/ID # ______________________________________|
| Group # __________________________________________|
| Insurance Co. Address ____________________________|
| Insurance Co. Phone # ____________________________|
| Type of Insurance:  O HMO  O PPO  O Indemnity  O Other ___________________|
| Primary Care Physician ____________________________|
| Physician Phone # ________________________________|
| Is preauthorization required for medical/diagnostic services?
  O YES  O NO  Phone # ____________________________|
| Is your son/daughter covered under this policy?
  O YES  O NO |

PLEASE READ AND SIGN OTHER SIDE!
PLEASE READ CAREFULLY!!

• Binghamton University Athletic Department's excess athletic insurance policy provides medical insurance coverage for student-athletes with injuries occurring only when participating in the play or practice of intercollegiate athletics. BU's athletic policy is considered “EXCESS” or “SECONDARY” to any other collectible group insurance benefits. Therefore, all claims must first be filed with the student-athletes/parents personal health insurance company. Only after all available benefits have been exhausted will the University's insurance carrier consider payment for any remaining balances.

• I hereby authorize BU's Department of Sports Medicine, team physicians, and/or attending medical providers to furnish information to insurance carriers concerning any illness, injury, & treatments.

• Our policy benefit is limited to charges that are reasonable and customary.

• I agree to supply any & all information requested by my primary insurance, Binghamton University and/or their excess insurance company in a timely manner.

• I hereby authorize BU Sports Medicine Department and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.

• A photostatic copy of this authorization shall be deemed as effective & valid as the original.

• I agree to notify the BU Sports Medicine Department immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I will be responsible for any & all charges incurred.

• I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

Policy Holder's Signature ___________________________ Date ______________________

Student-Athlete's Signature ___________________________ Date ______________________

Please remember to attach a copy of your insurance card!!!
Please complete the following form in regards to your physical health

OVER THE PAST YEAR ONLY.

Please use the provided space on the back page to explain ALL YES answers (Include Question Number)

1. Have you had any major illnesses in the past year? 
   YES  NO

2. Are you currently taking any medications? If YES, please list them: 
   YES  NO

3. Do you have any known allergies (medication, bee sting, food, etc.)? 
   YES  NO

4. Have you been hospitalized in the past year? 
   YES  NO

5. Have you ever been unconscious, passed out or fainted for any reason? 
   YES  NO

6. Have you ever experienced chest pain, tightness, pressure or any discomfort during exercise? 
   YES  NO

7. Have you had any dental work done (excluding routine cleanings)? 
   YES  NO

8. Have you had an injury to any of the following areas in the past year: 

   YES  NO
   Shoulder 
   Pelvis/Hip 
   Foot/Toe 
   Head 
   Thigh 
   Arm 
   Neck 
   Lower Leg 
   Elbow 
   Ribs 
   Knee 
   Wrist 
   Spine/Back 
   Ankle 
   Hand/Finger 

Please use the provided space on the back page to explain ALL YES answers.

9. Have you had any physical problems in the past year that have not been mentioned? 
   If YES, please list them: ________________________________

I, the undersigned, hereby acknowledge, affirm, and represent that all the above answers are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or medical history, I fully understand that Binghamton University disclaim liability, and will not be held liable for any injuries and illnesses not noted.

Student-Athlete’s Signature ____________________________ Date ____________________________
Reviewed By:

BU Sports Medicine Staff  Date

Clearance:

____  Cleared for all athletic activity

____  Limited clearance due to: _________________________________
   May participate in: ____________________________________________

____  No participation due to: _________________________________

Team Physician  Date
At Binghamton University, we use ImPACT online concussion testing to assist us in providing the appropriate care when treating and evaluating head injuries (concussions). In order to maximize the effectiveness of this tool, we collect a baseline measurement of how well you can perform the tests when you are healthy prior to participating in athletics. This test is required for all student-athletes. Thank you for your cooperation and please follow the instructions below.

**IMPACT CONCUSSION ON-LINE TESTING INSTRUCTIONS**

Please make sure of the following before starting your exam:

1) An External mouse must be used throughout the exam. TouchPad and TrackPoint mice (typically found on laptop computers) should NOT be used.

2) If you are taking your exam on a laptop computer, make sure it is plugged into an electrical outlet and is not running on battery power.

3) Please close any applications other than ImPACT that are currently running on this computer.

4) Please choose an environment that is free of noise and other distractions.

To take the IMPACT test online go to the following website:

1) [https://www.impacttestonline.com/colleges/](https://www.impacttestonline.com/colleges/)

2) Select the state in which you go to college  NEW YORK

3) ENTER Code E33FF5DC08  and Click on the Launch Baseline Button

4) Select language and follow the instructions given It should take approximately 20 minutes to complete.

5) TURN OFF POP UP BLOCKER