To be eligible, the student-athlete participant must fulfill the following requirements:

1) Complete a pre-participation medical examination administered by a licensed health care provider (MD, DO, PA, or CNP) and complete all insurance and medical history information forms.

   ***(These must be handed in prior to participation !!!!  No exceptions !!!!!)***

2) Prior to participating in any intercollegiate sports activity, the student-athlete must disclose full information concerning illnesses and injuries sustained prior to matriculation at Eastern University to the examining physician, team physician(s), or athletic trainer(s).

3) The student-athlete must report all injuries sustained in the course of university athletic activities as defined above, or otherwise, at the time of their occurrence to an athletic trainer or a coach.

4) The student-athlete must report to a Health Services physician, Hospital, or Sports Medicine Clinic as directed by the athletic trainer or supervisor in 2) above.

5) The student-athlete agrees to look solely to the benefits provided and described in this statement after all other insurance coverage maintained by the student-athlete is exhausted.

6) The student-athlete and policyholder must sign this document to signify that he/she has read and understood the terms and conditions under which he/she will be permitted to participate in intercollegiate athletic activities at Eastern University.

<table>
<thead>
<tr>
<th>Print Student-Athlete’s Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Parent/Guardian/Father Name</td>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Print Parent/Guardian/Mother Name</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

**PLEASE NOTE:**

Your signatures must appear where indicated on all the forms.
Send all forms to the address listed under the Parent Information Sheet (next page).

Please contact the Athletic Training Services Office at (610)341-1316 with any questions.
Thank you for your cooperation. We are looking forward to a healthy and successful year!
PARENT INFORMATION FORM

Parent/Guardian to complete. Return all forms to:

   Eastern University Athletic Department
   1300 Eagle Road
   St. David’s, PA  19087
   ATTN:  John Post, MBA, LAT, ATC

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: ______________________  Sport: ______________________
   Social Security #:_____________________ Date of Birth: ____________
   College Address: _____________________ Cell Phone: (___) _________
   City: _______________ State: _________ Zip: __________________
   Home Address: ______________________ Home Phone: (___) _________
   City: _______________ State: _________ Zip: __________________

II. Father/Guardian: ___________________ Mother/Guardian: ______________
    Date of Birth: _______________ Date of Birth: _______________
    Address: _____________________ Address: _____________________
    City: _______________ City: _______________
    State: _______ Zip: _________ State: ________ Zip: __________
    Phone: (___) _______________ Phone: (___) _______________

III. Employer: _________________________ Employer: ______________________
     Address: _________________________ Address: ______________________
     City: _______________ City: _______________
     State: _______ Zip: _________ State: ________ Zip: __________
     Phone: (___) _______________ Phone: (___) _______________

   We/I have elected to purchase the Eastern University Student Health Plan as the primary insurance for our/my son/daughter and will not keep him/her under our family plan (please go to Section V). **(Recommended for all, especially if out-of-state.)**

   We/I have elected to waive the Eastern University Student Health Plan and will remain under our/my family plan as the primary insurance for our/my son/daughter (please fill out information on next page). Make sure you waive the Eastern University Student Health Plan

   We/I have elected to remain under our/my family plan as the primary insurance for our/my son/daughter but have also purchased the Eastern University Student Health Plan as the secondary insurance for costs not covered by our/my family plan (please fill out information on next page).
IV. Insurance Company Name: _______________________________________
Address: ________________________________________________________
Policy Holder: ____________________________________________________
Policy #: __________________________ Group #: ______________________
I.D. #: ______________________________ Phone #: ___________________
Effective Date of Policy: _______________ Expiration Date: ____________
Policy Limit: _______________ Deductible: _____________ Co-Pay: ______

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)?
HMO: Yes _____ No _____ If yes, you must fill in physician information below:
PPO: Yes _____ No _____ If yes, you must fill in physician information below:

Primary Physician: _____________________________________________
Address: __________________________ Phone: ________________
_________________________________ Fax: ________________
City: _____________________________ State: ________ Zip: ________

Does your policy require a referral from your primary physician? Yes ____ No ____
Does your policy require pre-authorization for specialty care? Yes ____ No ____
Does your policy require a second opinion before surgery? Yes ____ No ____
Does your policy cover athletically related injuries? Yes ____ No ____

V. We/I understand my son/daughter must have personal accidental/medical insurance coverage to be eligible to participate in intercollegiate athletics at Eastern University and attest that my son/daughter has a current, in-force policy for all injuries that occur while he/she is participating in intercollegiate athletics at Eastern University. Also, we/I agree to notify Eastern University of any material change in coverage in order to update all coverage files immediately.

We/I hereby authorize Eastern University to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We/I understand and agree that Eastern University or its insurance agency, BMI Benefits, LLC., will assume no responsibility whatsoever for the payment of medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Eastern University if procedures set forth by the primary and secondary carriers are not followed as required.

Parent/Guardian/Father Signature ___________________________ Date __________

Parent/Guardian/Mother Signature ___________________________ Date __________

Student-Athlete Signature ___________________________ Date __________
TO: Eastern University Student-Athletes and Their Parents  
FR: The Athletic Training Services Program and Department of Athletics  
RE: Insurance Verification for 2019-2020 Academic Year as per NCAA Requirements

Please note, all Eastern University student-athletes must provide evidence of insurance that includes coverage for athletically related injuries. This is a pre-requisite for all practices and competitions. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the Eastern University Department of Athletics. The enclosed “Acknowledgement of Insurance Requirements” form and an insurance card (photocopy of both sides) must be on file before a student-athlete can participate in his or her sport.

Insurance coverage must have a limit of at least $90,000 and cover athletically related injuries. If your insurance does not meet these requirements, Eastern University will review the individual circumstances to determine if the insurance meets the coverage requirements.

Eastern University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Eastern University.

If you have questions regarding the terms of your insurance coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions to your policy regarding athletically related injuries, particularly out-of-network benefits.

The NCAA Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all terms and conditions). The policy has a $90,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Eastern University. It is supplemental coverage in the event of a catastrophic injury. More information on this program may be found on the NCAA’s web site at www.ncaa.org.

**NOTE - this form here is not the Eastern University Health Insurance Waiver**
(All students must either waive or enroll in the general Eastern University medical insurance plan prior to Sept. 15th annually. Go to www.FirstStudent.com to waive. Failure to waive this insurance will result in automatic enrollment with no refund.)

If you have any questions regarding this requirement, please contact us at your convenience at (610) 341-1736 or (610) 341-1316.
ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

I, ____________________________________________, as parent, guardian or legal representative, attest that __________________________________ has insurance coverage under a current, in-force insurance policy for all injuries that occur while he/she is participating in intercollegiate athletics at Eastern University.

If there is a material change in coverage or expiration of coverage, I agree to notify Eastern University of this development and update the insurance information I have on file with Eastern University immediately.

I understand and agree that Eastern University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Eastern University.

_______________________________________________
(signature)  ____________________________
(date)

THIS FORM MUST BE SIGNED AND RETURNED TO THE EASTERN UNIVERSITY DEPARTMENT OF ATHLETICS PRIOR TO THE START OF YOUR SON’S/DAUGHTER’S SPORT SEASON.

Return to:

Eastern University
Department of Athletics
1300 Eagle Road
St. Davids, PA  19087-3696
ATTN: John Post, MBA, LAT, ATC

Or send via FAX:  610-341-1317
EASTERN UNIVERSITY
INSURANCE INFORMATION VERIFICATION FORM

Name: ___________________________________________________________________
Date of Birth: ___________________ Sport: ___________________
SSN: ___________________ Year: ___________________

The Acknowledgement of Insurance Requirements must be read and understood and this form completed \textbf{PRIOR} to the student-athlete participating in practice and/or competition.

Parent/Guardian Name(s): ___________________________________________________________________
Home Address: ___________________________________________________________________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________ Work Phone: ______________

Policy Holder Name: ___________________________________________________________________
DOB: ___________
Relationship to Student-Athlete: ___________________________
Address: __________________ Home Phone: __________________
________________________ Work Phone: __________________

Insurance Company Name: ___________________________________________________________________
Address: ___________________________________________________________________
Group#: __________________ I.D.#: __________________
Phone: __________________
Effective Date of Policy: ______________ Expiration Date: ______________
Policy Limit: __________________
Policy Deductible: __________________ Policy Co-Pay: __________________

Primary Physician: __________________
Address: __________________________
Office Phone: __________________ Office Fax: __________________

Does your policy cover athletically related injuries? __________________
Does your policy require a second opinion before surgery? __________________
Does your policy require a referral from your primary physician? __________________

\textbf{DID YOU WAIVE THE EASTERN UNIVERSITY STUDENT HEALTH POLICY?}
\textbf{MAKE SURE YOU DID IF YOU DO NOT WANT IT!}
(See Page 4!)
MEDICAL HISTORY FORM

Medical History & Injury Questionnaire – to be filled out by student-athlete

**Personal Injury History**
Please take your time and complete each area carefully and accurately. Your description of each injury should be in as much detail as possible. Include dates, if possible, and the exact diagnosis by the physician. If you are unsure, please consult the treating physician. List any surgical procedure performed.

1. **History of Concussions?**
   - ___ Yes
   - ___ No
   Dates: __________________________
   If Yes, were you hospitalized?
   - ___ Yes
   - ___ No
   Have you ever lost consciousness?
   - ___ Yes
   - ___ No
   Have you experienced any amnesia?
   - ___ Yes
   - ___ No
   Time loss before returning to play?
   - ___ Yes
   - ___ No
   If Yes, how long? _________________________

2. **Neck Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

3. **Back Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

4. **Pinched Nerves?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

5. **Shoulder Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

6. **Elbow Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

7. **Wrist/Forearm Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

8. **Hand/Finger Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:

9. **Hip/Thigh Injury?**
   - ___ Yes
   - ___ No
   Dates: _________________________
   Details:
   Details: ____________________

11. Lower Leg/Shin?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

12. Ankle Injury?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

13. Foot/Toe Injury?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

14. Fractures?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

15. Non-Orthopedic Problems or Surgeries?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

16. Have you ever had a Cortisone Injection?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

17. Have you ever been advised or told that you should not compete in a sport because of a medical condition?  ___ Yes  ___ No  Dates: ____________________
   Details: ____________________

1) It is my responsibility to consult with a licensed/certified athletic trainer before taking ANY medication (prescription and/or over-the-counter) or nutritional supplement to be certain it is not banned by the NCAA.  ____ Initials

2) Failure to do so risks loss of NCAA-and/or Eastern University eligibility.  ____ Initials

3) It is my responsibility to update this form as it becomes necessary.  ____ Initials

4) I certify that the medical history/injury history information I have provided above is complete and accurate to the best of my knowledge. I understand the information given may be relied on to determine my fitness and ability to participate in an athletic environment.

________________________________________
Signature of Student-Athlete

Date
I, an Eastern University Student-Athlete:
   A) Understand that injuries are an inherent part of athletics and that participation in sport requires an acceptance of risk of injury.
   B) Understand that I must refrain from practice or play while ill or injured until cleared by appropriate medical practitioners (physicians) and/or their designated representatives (certified athletic trainers) whether receiving medical treatments or not.
   C) Understand that having passed the physical examination does not necessarily mean that I am physically qualified to participate in athletics, but only that the evaluator did not find a medical reason for disqualification from participation.
   D) Certify that the answers to the questions above are correct and true.

_____________________________________________________________________________________
Signature of Student-Athlete

_____________________________________________________________________________________
Date

All forms reviewed by:

_____________________________________________________________________________________
Certified/Licensed Athletic Trainer Signature

_____________________________________________________________________________________
Date

_____________________________________________________________________________________
Team Physician’s Signature

_____________________________________________________________________________________
Date

Return To:

Eastern University
Department of Athletics
1300 Eagle Road
St. Davids, PA 19087-3696
ATTN: John Post, MBA, LAT, ATC

This entire packet must be completed and returned by:

August 1 (Fall Sports) or August 15 (Winter/Spring Sports)