To: Parent/Guardian of Loras College Student-Athlete

From: Loras College Athletic Training Staff

The 2015-2016 athletic seasons will soon be upon us and there is some information that must be completed prior to your son or daughter beginning participation this year at Loras College. There are several forms that must be completed and returned to Chris Kamm, to ensure proper eligibility. The forms are online at www.duhawks.com. You will find a box called athletic links at the bottom left hand side of the webpage. Click on the athletic training tab and it will bring you to a page where all the forms can be printed. Each student-athlete needs to fill out the following forms. Please ensure that each form is filled out in its entirety.

Acceptance of Risk Form
Consent Form
Medical History Form
Parent HIPPA Form
Parent Info Form
Student HIPPA Form
Physical Form

First year student-athletes, including transfer students, must have ALL the lab work indicated on the physical form completed, including the sickle cell trait testing. NCAA is now mandating this testing among all DIII institutions, so please make sure this test is completed along with the other lab work. Most individuals are tested for sickle cell at birth, in which case we will accept a copy of these results if they can be located. All athletes are encouraged to check their birth records to determine if they were tested. Please note that the doctor that cared for the athlete as an infant might not have these records on file. In this case, we recommend calling the hospital in which the athlete was born and checking the athlete’s neonatal records for a test result. Again, if you find the sickle cell results, we will accept a copy of these results. However, all other blood work and lab work will still need to be completed. If a sickle cell test result cannot be found, the athlete will need to be tested. **NCAA is mandating that we have an actual copy of the sickle cell results in the athlete’s file on campus, so please make sure these results are sent with the physical. We cannot accept a physician’s note; we need the actual lab results showing a positive or negative result. If needed, the results can be faxed to us at 563-557-4087.** The other lab work can be simply filled out on the physical form.

All student athletes are also required to provide a copy of an updated insurance card. Please copy the front and back of the card and send it in with the rest of the completed forms. If you have a separate card for prescriptions, please send a copy of this card as well. All forms and insurance cards are kept in private files and only used if a student athlete needs to be seen by a physician. Please note that if your insurance coverage changes during the academic that we will need an updated copy.
The NCAA does not permit Loras College to provide insurance or pay bills for expenses related to any illness or condition not directly attributable to participation in an intercollegiate practice or game. The athletic accident insurance at Loras College provides excess or secondary coverage to your son/daughter for accidents occurring while participating in an intercollegiate game or practice including sponsored authorized team travel. Injuries sustained prior to entrance to Loras College or having been diagnosed as a chronic or over-use injuries, will not be covered by the college’s athletic insurance provider. This is a limited excess or secondary policy only. Under the terms of the insurance, the first $1,000 for each claim must be paid by the student, the student’s personal health insurance and/or another responsible party. The coverage afforded by the College is not in lieu of any other insurance plan maintained by the student. The plan will not pay for HMO denied claims; health insurance denied claims, non-athletic related injuries, or other such items. Claims are encouraged to be filed within 60 days of the injury occurrence. Any claims filed past this timeframe have an increased risk of not being approved, therefore student-athletes are encouraged to see a physician within this timeframe to document the injury is a claim might be needed.

If at any time through this process you have questions, please feel free to call Chris Kamm at 563-588-7408 or email questions to christopher.kamm@loras.edu. All forms should be sent to the following address:

Loras College
Attn: Chris Kamm, ATC
1450 Alta Vista CB #212
Dubuque, IA 52001

Fax: 563-557-4087
PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO Name of College/University Loras College

Attention Chris M. Kamm, ATC, LAT, CSCS

Address 1450 Alta Vista Street

City Dubuque State IA Zip 52001

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete ___________________________ Sport ___________________________

Social Security No or Passport No ___________________________ Date of Birth ___________________________

College Address ___________________________ College Phone (____) ___________________________

Home Address ___________________________ Home Phone (____) ___________________________

City ___________________________ State ______ Zip ______

FATHER/GUARDIAN INFORMATION

Father's Name ___________________________ Mother's Name ___________________________

Date of Birth ___________________________ Date of Birth ___________________________

Address ___________________________ Address ___________________________

Address ___________________________ Address ___________________________

Employer ___________________________ Employer ___________________________

Address ___________________________ Address ___________________________

Telephone (____) ___________________________ Telephone (____) ___________________________

Medical Insurance Company or Plan ___________________________

Address ___________________________ Address ___________________________

Policy Number ___________________________ Policy Number ___________________________

Telephone (____) ___________________________ Telephone (____) ___________________________

Is this plan an HMO or PPO? □ Yes □ No Is this plan an HMO or PPO? □ Yes □ No

Is pre-authorization required to obtain treatment? □ Yes □ No Is pre-authorization required to obtain treatment? □ Yes □ No

Is a second opinion required before surgery? □ Yes □ No Is a second opinion required before surgery? □ Yes □ No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM
AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Claimant (please print)  Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)  Date  Signature of Authorized Representative of Next of Kin  Date

Relationship of Authorized Representative or Next of Kin to Claimant
Student-Athlete Authorization/Consent for Disclosure of Protected Health Information to the National Collegiate Athletic Association for Monitoring and Research of Sports Injuries/Illnesses

I, ____________________________ hereby authorize Loras College and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness or participation related to my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my participation and protected health information will be used by the NCAA’s Injury Surveillance System (ISS), a longitudinal surveillance database maintained by the NCAA, for the purpose of monitoring injuries resulting from training for or participation in athletics. The ISS provides NCAA committees, athletic conferences and individual schools and NCAA approved researchers with injury and participation information that does not identify individual athletes or schools. The data provide the Association and other groups with an information resource upon which to base and evaluate the effectiveness of health and safety rules and policy, and to study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations may not apply to the NCAA’s use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information and any personal identifiers will be encrypted while being transmitted from my institution to the NCAA and that all data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana. I further understand that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete ____________________________

Signature of Student-Athlete ____________________________ Date_________________

Printed Name of Parent/Guardian (If student is under 18)____________________________

Parent/Guardian Signature (If student is under 18):_____________________________ Date_________________
Student-Athlete Authorization/Consent for Disclosure of Protected Health Information to Parents/Guardians

I, ____________________________ hereby authorize Loras College and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness or participation related to my training for and participation in intercollegiate athletics to my parents/guardians listed below.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the Loras College athletics director. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Telephone Numbers Where Parent(s)/Guardian(s) can be reached:

Mother’s Name: _________________________________________________

Father’s Name: _________________________________________________________

Home Number: ________________________________

Mother Office: __________________________________________________________

Father Office: _________________________________________________________

Cellular of Mother/Guardian: __________________

Cellular Father/Guardian: _________________________________________________

Name of Family Physician: ________________________________________________

Physician Telephone Number: _____________________

Student Athlete Signature:________________________ Date_______________

Parent/Guardian Signature (If student is under 18):________________________ Date___________
Participation in sport requires an acceptance of risk of injury. I understand that the risk of serious physical injury including catastrophic injury resulting in permanent paralysis, brain injury, or death does exist. I can rightfully assume that those who are responsible for the conduct of sport have taken reasonable precautions to minimize the risk of significant injury. I understand that I must refrain from practice or play while ill or injured, until I am discharged from treatment or until the team physician or athletic trainer gives permission to restart participation, despite ongoing treatment. I also understand that passing the physical exam does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me. I understand that I am responsible for immediately reporting injuries and illnesses of any kind including the signs, symptoms, and behaviors consistent with a concussion to the team physician and/or athletic trainer. I understand that I must refrain from practice or play while ill or injured, until I am discharged from treatment and the team physician or athletic trainer gives permission to restart participation, by following the concussion management policy held by the NCAA and Loras College.

Drug Testing Consent Statement

By signing below I understand that I will be asked to provide urine for drug analysis. I consent to any such testing conducted as a part of the university’s athletic drug policy and agree that I will not refuse to take any such test or otherwise dispute the right of the university to perform such tests on me. I understand that the university will take every precaution to maintain the confidentiality of all matters related to the tests to be performed as pursuant to this policy. I also authorize the athletic department to contact my parent(s), or legal guardian(s) with information relating to test results.

Acknowledgement of Receipt

By signing below I certify that I have received and reviewed a copy of the brochure outlining the various athletic department policies at Loras College. I also understand that the descriptions in the brochure are only summaries of the formal policies and that a detailed explanation of each policy is contained in the student handbook. I also certify that I have read and understand the signs, symptoms, and behaviors consistent with a concussion and the policies and management plan for concussions at Loras College. I also understand that a baseline assessment will be conducted prior to the first practice to use for comparison with post injury tests.

Authorization to Release and/or Obtain Medical Information

By signing below I give my consent for the team physician, athletic trainer, and/or Loras College administrators to obtain and/or release such information regarding my health care, record of injury or surgery, record of serious illness, and rehabilitation results as they deem reasonable and appropriate. I also authorize any insurance company, physician, hospital, or any other person who has examined or attended to me, to disclose when requested to do so, all or any portions of the following: Hospital or medical records; x-ray readings and reports; laboratory records and reports; all tests of any type and character and reports thereof; statements of charges; any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense, and any other health care records pertaining to me.

My signature below indicates that I have read this entire document, understand it completely, and agree to be bound by its terms.

Athlete Signature:______________________________________________ Date____________

Parent Signature (If Under 18):____________________________________ Date____________
Loras College
Athletic Training Department

Healthcare Consent Form

Student Athlete: ________________________________ Date of Birth: ______________

In the event that, in the judgment of an attending physician, the above-described Student Athlete is unable to make healthcare decisions due to age or otherwise, permission is hereby granted to any healthcare provider to provide necessary healthcare services to him/her including by way of illustration but not limitation, medical or surgical treatment, blood and/or blood products, and other procedures or tests. When necessary for executing such care, permission to hospitalize is hereby granted.

In the event that an emergency arises during competition or at a practice session, permission is also granted to Loras College, including its athletic trainers and physical therapists, to provide such preventative, first aid, rehabilitative or emergency care and treatment as they deem reasonably necessary.

The undersigned further authorizes Loras College to notify the person(s) identified below of the physical or mental condition of the above-described Student Athlete if Loras College deems it to be in his/her best interest.

Contact Information: ______________________________________________________

Name(s): __________________________________________________________________

Telephone Number(s): __________________________________________________________________

Address(es):

Student Athlete Signature: ________________________________ Date __________

Parent/Guardian Signature (If student is under 18): __________________________ Date __________
Loras College Athletic Training Department
Pre-Participation Medical History

Name: _________________________________ Social Security Number: __________________________

Date of Birth: _______________ Sex: _________________ Sport: ______________________________

Parent’s Address: _____________________________________________________________________

Parent’s Telephone: ____________________

EXPLAIN YES ANSWERS BELOW

1. Have you ever been hospitalized? ______ NO ______
2. Have you ever had surgery? ______ NO ______
3. Are you presently taking any medications or pills? ______ NO ______
4. Do you have any allergies (medications, insects, or foods)? ______ NO ______
5. Have you ever passed out during or after exercise? ______ NO ______
6. Have you ever been dizzy during or after exercise? ______ NO ______
7. Have you ever had chest pain during or after exercise? ______ NO ______
8. Have you ever had high blood pressure? ______ NO ______
9. Have you ever had a positive sickle cell trait test? ______ NO ______
10. Have you ever been told that you have a heart murmur? ______ NO ______
11. Has anyone in your family died of heart problems or a sudden death before age 50? ______ NO ______
12. Do you have any skin problems (itching, rashes, acne)? ______ NO ______
13. Have you ever had a head injury? ______ NO ______
14. Have you ever been knocked out or unconscious? ______ NO ______
15. Have you ever had a seizure? ______ NO ______
16. Have you ever had a stinger, burn, or pinched nerve? ______ NO ______
17. Have you ever had heat or muscle cramps? ______ NO ______
18. Do you have trouble breathing, cough during or after activity, or have asthma? ______ NO ______
19. Do you use any special equipment (pads, braces, mouth or eye guards, etc.)? ______ NO ______
20. Have you had any problems with your eyes or vision? ______ NO ______
21. Have you ever suffered or been diagnosed with an eating disorder? ______ NO ______
22. Have you ever suffered or been diagnosed with depression? ______ NO ______
23. Do you wear glasses or contacts or protective eye wear? ______ NO ______
24. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ______ NO ______
25. Have you had any other medical problems (mono, diabetes, loss of paired organ, etc.)? ______ NO ______
26. Have you had a medical problem or injury since your last evaluation? ______ NO ______
27. When was your last tetanus shot? _____________________________
28. When was your last measles immunization? _____________________

Females Only:
29. When was your first menstrual period? _________________________
30. When was your last menstrual period? _________________________
31. When was your longest time between periods last year? __________

Please explain any “yes” answers: ____________________________________________________________________________
_____________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________________

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Athlete: ___________________________________________________________ Date_________________

Signature of Parent/Guardian (if student is under 18)_________________________________________ Date_________________
Required Laboratory Procedures for 1st year athletes (transfers, freshman, 1st year participants)

Urinalysis: Protein: _____ Sugar: _____ Micro: _____

Blood: Hgb/Hct: _____/

NCAA mandated Sickle Cell Trait: If the student-athlete can’t provide lab results from a neonatal test, the athlete must be re-tested and provide the college with the actual lab results per NCAA rules

_____ Athlete was tested today and the lab results are attached _____ Athlete will provide their neonatal results

Vision: OK _______ Needs investigation _______ Glasses _______ Contacts _______

Without corrective wear R 20/____ L 20/______ With corrective wear R 20/______ L 20/______

Medical Examination: Remarks:
1. Head, neck and scalp
2. Dental and mouth
3. Ears- general (audiometric if apparent loss)
4. Nose
5. Throat
6. Eyes/ fundus
7. Skin
8. Chest: Heart rhythm ______ Murmur _______ Marfan’s _______
   If Marfan’s Syndrome or Mitral Valve Prolapse: ECG results: 
   Lungs 
   Breasts 

9. Abdomen and viscera
10. Lymphatic (cervical, Axillary, femoral)
11. Hernia
12. Genitalia
13. Neurological

General Orthopedic Examination (instability, strength, ROM):
1. Neck and shoulder
2. Elbow, wrist, & hand
3. Back
4. Knee
5. Ankle
6. Feet
7. Flexibility

Other:
1. Recommendations for follow-up of diabetics, hypertensives, epileptics, asthmatics, etc.: 

2. Hypersensitivities (Drugs, pollens, foods, etc)

Is the athlete/patient physically able to participate in intercollegiate athletics? _______ YES _______ NO

Are there any exceptions? If so, specify

Are you the patient’s family physician? 

How long have you known the patient?

Signed: ____________________________ (Please circle) MD DO PA ARNP

Date: _____________________________ Address: ________________________

Telephone: ______________________ Fax: _____________________________