

Dear Parents,

It is that time of year again to fill out the necessary insurance paperwork for your son/daughter. Please read through this information carefully as some of our policies have changed. Please find enclosed the following:

Physical Examination Form

This is the only form accepted. Be sure your son/daughter gets their physical after July 1 along with a **TB test** or **chest x-ray** before returning to Mount Olive College. All student-athletes are required to have a TB test or chest x-ray each year. This form can be mailed separately.

Department of Athletics Information Brochure *-For you to read and keep for your reference.*

This brochure will explain to you our policies and procedures for insurance procedures as well as NCAA Clearinghouse and filing of the FAFSA.

Mount Olive College Athletic Department Consent Form

For you to sign acknowledging that you have read and understood. If your son/daughter is not around we can obtain their signature in the fall when they arrive back on campus.

Insurance Information Form

For you to fill out, sign, and return with a *copy of the front and back of your insurance card.*

Return Envelope

Please use this envelope to return all green forms along with a current *copy of the front and back of your insurance card.* All forms must be received no later than **July 15, 2009.**

If you have any questions, please feel free to email me cparks@moc.edu or call 919-658-7759.

Sincerely,

Tina Parks

Tina Parks

Administrative Assistant

Mount Olive College Physical Examination Form
(Must be completed in English)

Name: _____

Academic year _____

Date of Birth _____ **SS#** _____

Sport(s) _____

- History:**
- a. Frequent Colds No/Yes: _____
 - b. Hay Fever No/Yes: _____
 - c. Allergies No/Yes: _____
 - d. Asthma No/Yes: _____
 - e. Diabetes/Thyroid/Endocrine No/Yes: _____
 - f. Serious Disease or Injury No/Yes: _____
 - i. Back No/Yes: _____
 - ii. Knee/Hip No/Yes: _____
 - iii. Foot/Ankle No/Yes: _____
 - iv. Hand/Wrist No/Yes: _____
 - v. Neck No/Yes: _____
 - g. Drugs or Medicine Regularly No/Yes: _____
 - h. As Needed Medications No/Yes: _____
 - i. Tuberculosis/Recent contact No/Yes: _____
 - j. Surgeries No/Yes: _____
 - k. Seizures No/Yes: _____
 - l. Hospitalizations No/Yes: _____

Physical Examination: Height _____ Weight _____ B/P _____ Pulse _____

Urinalysis: SPGR _____ PRTN _____ GLUC _____ BLD _____ Other _____

Vision: Right _____ Left _____ Corrected _____ PPD or Chest X-ray and results (within past year)

Date: _____ Results: _____

- a. Ears, Eyes, Nose, Throat Normal/Abnormal: _____
- b. Thyroid/ Lymph glands Normal/Abnormal: _____
- c. Chest Normal/Abnormal: _____
- d. Heart Normal/Abnormal: _____
- e. Lungs Normal/Abnormal: _____
- f. Abdomen Normal/Abnormal: _____
- g. Hernia Normal/Abnormal: _____
- h. Deformities Normal/Abnormal: _____
 - (circle and explain) Normal/Abnormal: _____
 - Head /Neck / Shoulder _____
 - Spine / Hip / Knee / Ankle _____
 - Elbow / Wrist / Hand _____

Do you know of any specific reasons why this student could not participate in physical education, intramurals, or athletics?

No/Yes: _____

Has this student experienced any emotional problems requiring assistance by a psychiatrist or counselor that might affect their adjustment to and performance at college? No/Yes: (if Yes, give name and address of Professional) _____

Additional Remarks: _____

Physician's name: _____ **Signature:** _____

Address: _____ **Telephone:** _____

MOUNT OLIVE COLLEGE ATHLETIC DEPARTMENT CONSENT FORM

This form must be completed and on file with the Athletic Department prior to participation in intercollegiate athletics. Please read all sections of this form. Student-Athlete and Parent/Guardian must sign at the bottom.

PRE-PARTICIPATION EXAMINATION REQUIREMENTS. I understand that Mount Olive College requires a physical examination prior to participation in Mount Olive College athletics. The results of the physical must be recorded by a physician on a Mount Olive College Physical Examination Form. I am also responsible for notifying the Athletic Department if I encounter any medical or orthopedic conditions that would alter or prohibit participation in athletics at Mount Olive College.

ASSUMPTION OF RISK AND SPORTS SAFETY. I understand that participation in intercollegiate athletics requires a personal acceptance of risk of injury. In order to minimize the risk, it is necessary that I am aware of and abide by certain safety rules and guidelines. Any abuse of equipment relating to sport could cause serious injury to teammates, my opponents, or myself. I understand that participation in intercollegiate athletics at Mount Olive College may result in injury/illness, permanent physical or mental impairment, or even death. These injuries may be minor or may be career or life threatening. I also understand that Mount Olive College cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques that are made known to me by my coaching staff, athletic training, or strength and conditioning personnel or are otherwise known to me from another source including but not limited to medical personnel of the college. I acknowledge the fact that these risks exist and I am willing to assume responsibility in preventing potential injuries, complying with the treatment plan of Mount Olive College medical staff, reporting all injuries to my coach and/or athletic training staff, and accepting the risk of such injuries.

MEDICAL CONSENT. I hereby grant permission to the Mount Olive College team physicians at Mount Olive Family Medicine and Wilson Orthopaedics and/or other team or consulting physicians (e.g. Wayne County Emergency Room Attending Physician) to render treatment deemed reasonably necessary to my health and well-being. I also hereby authorize the Mount Olive College athletic training staff, operating under direction and guidance of the Mount Olive College team physicians, to render any emergency, first aid, preventative or rehabilitative treatment that they may deem reasonably necessary to my health and well-being.

INSURANCE. I understand that it is required by Mount Olive College that I have primary insurance coverage either through personal or family health insurance that covers athletic related injuries in order to participate in intercollegiate athletics at Mount Olive College. I also understand that I must demonstrate proof of insurance coverage before participation may begin. The insurance must have a limit of at least \$12,500 per injury and the coverage must be continuous and cover me from August 1, 2009 through May 31, 2010. If I do not have coverage that covers athletic injuries, I will be required to purchase a policy. I also understand that Mount Olive College has a secondary insurance policy which covers all student-athletes only for injuries sustained during official practices and competitions. I understand I am responsible for the cost of any co-pays and the deductible on my personal or family health insurance and all other medical bills will be filed with my personal or family insurance first and those claims will be filed with the college's insurance after my insurance has paid in full, in part, or denied the initial claim. The college's policy will pay the unpaid portion of medical fees within the policy limits. The College will not make any payments beyond those limits. I also understand that second opinions and physical therapy will be submitted to the college's insurance company only in limited circumstances, and pre-existing or non-athletic related injuries and illnesses will not be covered by the college's insurance. I also understand that I will be totally responsible for any bills not paid by the college's insurance.

AUTHORIZATION- TO PERMIT USE AND DISCLOSURE OF HEALTH INFORMATION. This authorization was prepared by First Agency, Inc., the provider of the Mount Olive College insurance policy, 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, government 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 advise, 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 First Agency's 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 my authority to act on his/her belief 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 the above address. I understand that a revocation will not be effective to the extent First Agency had relied on the use or disclosure of 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 pursuant to this authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law. This authorization is valid from the date signed for the duration of the claim and is applicable to First Agency, Inc. or any other insurance carrier that provides insurance to Mount Olive College.

By signing below, I acknowledge that I have read, understood, and will comply with all of the policies and procedures. I also acknowledge that if I did not understand, I have contacted Mount Olive College to clarify any issues that I did not understand. This signed form and the completed Physical Examination, Disclosure of Health Information and Insurance Information forms, along with a copy of my insurance card (front and back), are required to be delivered to the Mount Olive College Athletic Department prior to participation in intercollegiate athletics at Mount Olive College.

Signature of Student-Athlete

Date

Signature of Parent/Guardian

Date

Mount Olive College Athletic Department Insurance Information

This form must be completed and signed by a parent/guardian. Incomplete forms will not be accepted. It will only delay the process of clearing your son/daughter for participation.

Date: _____ Date of Birth: _____ Social Security #: _____

Athletes Name: _____ () New Athlete () Returner () Transfer

Home Address: _____ City: _____ State: _____ Zip: _____

Year in Sport: FR SO JR SR 5th Year Sport(s): _____

Father / Guardian

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (H) _____ (C) _____

Employer: _____

City: _____ State: _____ Zip: _____

Work Phone #: _____

Mother / Guardian

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (H) _____ (C) _____

Employer: _____

City: _____ State: _____ Zip: _____

Work Phone #: _____

Parent information should be listed below UNLESS you have your own policy, then list your insurance information.

Name of insurance company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Group #: _____

Policy #: _____

***Deductible (not co-pay) Amount: _____

Is this an HMO? Y N Is this a PPO? Y N

Is a referral necessary for non-emergency treatment? Y N

What is your policy limit per injury?: _____

_____ My son/daughter is covered under this policy

Will this policy cover your son/daughter in all 50 states? Y N

Name of insurance company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Group #: _____

Policy #: _____

***Deductible (not co-pay) Amount: _____

Is this an HMO? Y N Is this a PPO? Y N

Is a referral necessary for non-emergency treatment? Y N

What is your policy limit per injury?: _____

_____ My son/daughter is covered under this policy

Will this policy cover your son/daughter in all 50 states? Y N

*****You are responsible for payment of any deductible before the secondary insurance policy that Mount Olive carries can be filed for consideration of payment.**

Please list all surgeries that your son/daughter have had: _____

Please list all medications that your son/daughter are currently taking: _____

Please list any allergies that your son/daughter might have: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY – OTHER THAN PARENTS

NAME: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

The above information is correct and complete to the best of my knowledge. Failure to notify the athletic department of any changes in the student-athlete's insurance policy could result in me being 100% responsible for any medical bills not covered by their insurance policy.

Parent's/Guardian's Signature: _____ Date: _____

FOR OFFICE USE ONLY Missing: _____
 Date Received: _____ Date Posted: Spreadsheet: _____ Sports Ware: _____ CAI: _____