

**Ohio Valley University Athletic Department
Medical Information & Health Insurance Information Packet**

CHECKLIST

- Physical Examination Form (p.2):
 - This is the only physical exam form we will accept.
 - Your physical must be performed annually and will remain in effect for 365 days. To ensure that their physicals cover the entire academic year, most student-athletes will schedule their exams in the summer prior to the beginning of the school year.
 - **Take the form with you to your physical exam appointment.**
 - Make sure the form is signed by the physician.

- Student-Athlete Health Record (pp. 3-5):
 - Make sure all information is complete, accurate and signed by you before you see your physician.
 - **Bring these 3 pages with you to your physical for the physician to review.**

- Athletic Injury and Health Insurance Information (pp. 6, 7)
 - Contains information regarding what the student-athlete and subscriber (typically the parent) need to do if an athletic injury occurs. Please **read carefully and keep pages 6 & 7 for future reference.**
 - ***PLEASE NOTE: ALL STUDENT-ATHLETES MUST BE COVERED BY HEALTH INSURANCE IN ORDER TO PARTICIPATE. IF YOU DO NOT HAVE INSURANCE YOU MUST PURCHASE IT PRIOR TO ARRIVING ON CAMPUS. CONTACT THE ATHLETIC OFFICE AT 304.865.6046, IF YOU HAVE QUESTIONS.***

- Injury/Insurance Questionnaire (p.8)
 - Fill out forms completely.
 - Provide your insurance information.
 - ***Student-athletes*** and ***parents*** (if student is covered by parent's insurance) must initial and sign.
 - Submit two copies of the front and back of your insurance card.

- Student-Athlete/Emergency Contact Information (p.9)
 - Provide complete contact information.

- Student-Athlete Consent/Disclosure Authorization (p.10)
 - If you are under 18, parent or guardian must sign.

- Consent to Treat (p.11)
 - If you are under 18, parent or guardian must sign.

- Retain copies of all forms for your own records.**

- Mail ALL forms to the address below by **August 1, 2011.**
 - To: ATTN: Carissa Bucklin
 - OVU Athletic Department**
 - 1 Campus View Drive
 - Vienna, WV 26105-8000

**Ohio Valley University
Physical Examination**

TO BE COMPLETED BY A PHYSICIAN ONLY

Name _____

General Appearance _____

Vitals: Pulse _____ B/P _____ WGT _____ HGT _____

Date of last Tetanus _____

Allergy History

Please list allergy and reaction: _____

Bee Sting Allergy? YES NO

Females: Date of last menstrual period _____

<u>Assessment</u>	WNL	ABNORMAL (please explain)
Neurological	_____	_____
Cardiovascular	_____	_____
Mouth	_____	_____
Lymph	_____	_____
Respiratory	_____	_____
Abdominal	_____	_____
Musculoskeletal	_____	_____
ENT	_____	_____
Eyes	_____	_____

After reviewing the history provided to me on pages 3 – 5, along with my evaluation of the patient, it is my recommendation that this athlete *may* participate in intercollegiate athletics.

Name of Physician _____ Phone _____

Signature of Physician _____ Date _____

NO OTHER FORM IS ACCEPTABLE FOR NCAA COMPLIANCE

STUDENT-ATHLETE HEALTH RECORD

This information is strictly for the use of the OVU Athletic Training Staff. Information will not be released without your knowledge and written consent or as required by law. Your Health Record will be destroyed 10 years after your last date of attendance.

Student Information: Please Print

First Name:	Middle Name:	Last Name:	Gender:
Address:		City	State/Zip
Student email address:		DOB (mm,dd,yyyy)	Student cell phone:
Parent/Guardian First Name:	Parent/Guardian Last Name:	Home Phone:	Cell Phone:

Family History

	Age	State of Health	If deceased, list cause	Have any of your relatives ever had any of the following?	No	Yes	Relationship
Father				Alcohol/Drug Problem			
Mother				Asthma's, Allergies			
Brother				Cancer			
Brother				Depression			
Sister				Diabetes			
Sister				Heart Disease/Stroke			
				Stomach Disease, Ulcer			

Student's Health History

___Acne	___Depression	___Hernia	___Murmur
___ADD/ADHD	___Diabetes	___High Blood Pressure	___Pain in chest
___Allergy-Food_____	___Dizziness/Fainting	___Insomnia	___Palpitations
___Allergy to Penicillin	___Ear/Nose/Throat Problems	___Joint, disease/injury	___Psoriasis
___Allergy to Sulfa	___Eating Disorder	___Learning Disability	___Sinusitis, frequent
___Allergy, other_____	___Epilepsy/Seizures	___Liver/Kidney Problems	___Stomach: GERD, ulcer
___Anxiety	___Eye Problems	___Measles	___Thyroid Disorder
___Asthma	___Gallbladder Problems	___Measles, German	___Tumor, cancer/cyst
___Back Problems	___Headaches	___(females)Menstrual Problems	___Weight, recent gain/loss
___Chicken Pox	___Headaches, Migraine	___Mononucleosis	Continued on Back
___Dental Problems	___Head Injury/concussion	___Mumps	Turn page over

All OVU Athletes Must Complete Form

Name (print) _____ Sport _____

Please answer all of the following questions and sign below. If you answer "yes", explain in the space provided.	Yes	No
1. Have you had any recent illnesses? Explain:		
2. Have you ever been told to give up sports because of a health problem? Explain:		
3. Do you wish to discuss a specific problem with the Athletic Trainer? Explain:		
4. Has anyone (under the age of 50) in your close family died suddenly? Explain:		
5. Has anyone (under the age of 50) in your close family had a heart attack? Explain:		
6. Has anyone in your immediate family had high blood pressure? Explain:		
7. Do you get chest pain with exercise? Explain:		
8. Do you have faintness or dizziness with exercise? Explain:		
9. Heart trouble or a heart murmur? Explain:		
10. Heat illness (dehydration with exercise)? Explain:		
11. Coughing after strenuous exercise? Explain:		
12. Do you exercise continuously for at least 30 minutes, three or more times a week? Explain:		
13. Do you eat any special foods or follow a special diet during the sports season? Explain:		
14. Is your pregame meal a special part of you game preparation? Explain:		
15. Have you ever taken any supplements or vitamins to help you lose or gain weight or improve performance? Explain:		

Hospitalization History

Please list all medical, surgical, or other hospitalizations including dates and diagnosis.

Dates: Month/Year	Hospitalization History	Diagnosis

Additional Health Information

Please answer the following questions.	Yes	No	Please provide details or list.
Has your physical activity been restricted during the past four years?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you received treatment/counseling for alcohol or other drug abuse, an eating disorder, depression, anxiety, or any other reason?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any significant illness or injury other than what you already listed?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any medications routinely?	<input type="checkbox"/>	<input type="checkbox"/>	

In the space below add any recent or significant information about your health you think we need to know. If necessary, staple an additional page to the form.

I affirm that to the best of my knowledge the above information is correct.

Athlete's Signature

Date

OVU Athletically-Related Injury and Health Insurance Information

The NCAA and Ohio Valley University require all student-athletes to maintain adequate primary medical insurance coverage for athletically related injuries. If you are not covered by an individual health plan, you cannot participate in intercollegiate athletics at OVU. If you need to purchase an individual health plan and are seeking assistance in locating an insurer, call the Athletics Administration Office at (304) 865-6046.

Many student-athletes and their parents assume that OVU carries insurance on each of its student-athletes. As is typical with most NCAA member schools, the University provides secondary coverage only for athletically-related injuries. **This secondary insurance provides coverage in excess of the student-athlete's individual primary health insurance and is limited to covering related expenses for one year after the initial date of the injury.**

Secondary coverage is subject to the following limitations:

1. To be able to receive benefits from secondary coverage, the student-athlete/parent must first file a claim with the primary insurance company. Student-athletes must report all injuries to the Head Athletic Trainer within 24 hours of the occurrence.
2. Only athletically related injuries, suffered during a game or supervised practice, will be covered.
3. Covered treatments are limited to those referred by the team physician or certified athletic trainer. Non-referred visits will not be covered. Expenses incurred as a result of a non-referred treatment or office visit will be the responsibility of the student-athlete.
4. HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) members must use an authorized medical provider. Secondary coverage is available only for expenses related to the use of an authorized medical provider. It is recommended in such cases that the student-athlete contact the primary insurance company to change the registered primary care physician to a physician in the immediate Parkersburg/Vienna area.
5. Student-athletes must notify the Head Athletic Trainer of any changes in primary insurance coverage that occur during the school year. Failure to do so could cancel potential benefits of secondary coverage.
6. Submit copies of medical bills and primary insurance company Explanation of Benefits (EOB) forms within 10 days of their receipt to the Athletic Insurance Coordinator (Barbara Ogden). Failure to do so will result in a cancellation of secondary coverage benefits.

Insurance Claims Procedure

1. The student-athlete's primary insurance information must be given to the medical provider at the time of treatment. The provider will bill the insurance company which will do either of the following:
 - Honor the claim by paying some or all of the charge
 - Send you a denial of payment letter
2. Forward a copy of the bill/denial letter from the medical provider to the OVU Athletic Insurance Coordinator.
3. Forward copies of all EOBs to the Athletic Insurance Coordinator.
4. Once copies of the final medical statement and Explanation of Benefits have been received and reviewed by the Athletic Insurance Coordinator, a claim for secondary coverage payments will be submitted.
5. Secondary insurance coverage will take effect only after the primary insurance benefits have been exhausted.

Inquiries regarding insurance payment and processing should be directed to:

Barbara Ogden
Athletic Insurance Coordinator
Ohio Valley University
1 Campus View Drive
Vienna, WV 26105-8000

304.865.6079
barabara.ogden@ovu.edu

Additional Note to Parents: If your primary insurance coverage is an HMO plan, we recommend that you contact the company to change your student-athlete's primary care physician to a physician in the Parkersburg-Vienna area. If your insurance is a PPO plan, you must follow the proper procedures required by the plan so that the university's secondary insurer can complete its portion of the claim. Note that many PPO plans require pre-authorization for some treatments or for treatment outside the plan's service area. Also, many HMO plans do not provide adequate coverage for student-athletes requiring non-emergency treatment while attending college out of state. You should contact your insurer to see what modifications to your plan you will need to make in order to provide qualified coverage for your student-athlete. **Remember, only student-athletes with adequate primary insurance coverage are eligible to participate in athletically related activities at Ohio Valley University.**

OVU Student-Athlete Injury/Insurance Questionnaire

Once you have carefully reviewed the OVU Athletically-Related Injury and Health Insurance information, initial each of the statements below as an indication that you understand that:

Parent	Student	
_____	_____	Secondary insurance coverage is limited to injuries sustained during a game or approved practice.
_____	_____	Medical expenses cannot be covered by secondary insurance unless the athlete is referred by the athletic trainer or an approved physician.
_____	_____	HMO policies require treatment by an approved primary care physician.
_____	_____	PPO policies provide maximum coverage only for in-network medical care providers.
_____	_____	The athletic trainer must be informed immediately in the event of a change in primary insurance coverage.
_____	_____	Copies of all EOB forms from the primary insurance company must be submitted to the Athletic Insurance Coordinator within <u>10 days</u> of receipt.
_____	_____	If proper procedures are not followed, the athlete (or athlete's parents) will be responsible for any unpaid medical bills.
_____	_____	Ohio Valley University is not responsible for any remaining balances not paid by the primary insurer and/or the University's secondary insurer.

PRIMARY INSURANCE:

Insurance Co. Name _____ Policy # _____

City: _____ State: _____ Zip: _____ Group#: _____

Phone: _____ Employee ID #: _____

Primary Care Physician: _____ **Phone #:** _____

THIS FORM IS TO BE COMPLETED AND SIGNED BY STUDENT-ATHLETE AND PARENT PRIOR TO AN ATHLETE'S PARTICIPATION IN SPORTS AND WILL BE KEPT ON FILE IN THE ATHLETIC OFFICE.

I/We agree that all information provided in this document is accurate to the best of my/our knowledge.

_____	_____	_____
Print full name of student-athlete	Signature of student-athlete	Date
_____	_____	_____
Print full name of parent	Signature of parent	Date

NOTE: Please submit two copies of your insurance card (front and back) with this packet. If you are not able to copy your card, bring it to the athletic office and we will make copies for you.

Student-Athlete Information Form 2011-12

Name: _____ DOB: _____

Sport: _____

Athlete's College Address: _____ Phone #: _____

Athlete's Home Address: _____ Phone #: _____

Father

Mother

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Employer: _____

Employer: _____

Work phone: _____

Work phone: _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name: _____ Relationship to you: _____

Home #: _____ Cell: _____

**Ohio Valley University
Student-Athlete Authorization/Consent
For Disclosure of Protected Health Information**

I hereby authorize the physicians, athletic trainers, sports medicine staff, and other Health Care personnel representing Ohio Valley University and the Ohio Valley University Athletic Department to disclose my personal health information relating to injury or illness during my training for and participation in intercollegiate athletics. My personal health information includes my medical status, medical condition, injuries, prognosis, or diagnosis. My personal health information may be released to other health care providers, my parents/guardians, hospitals, and/or service companies, academic counselors, athletic and/or college administrators, chaplains and/or clergy members, sports information staff and members of the media.

I understand that my authorization/consent for the disclosure of my personal health information is a condition for participation as an intercollegiate athlete for Ohio Valley University. I understand that my personal health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment.

I understand that I may revoke this authorization/consent at any time by notifying, in writing, the Head Athletic Trainer or the Athletic Director. Such revocation shall not apply to any use of disclosure of my protected health information allowed prior to receipt of the written revocation. I have read and understand this authorization. This authorization/consent expires 24 months from the date it is signed.

Print Name of Student-Athlete

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian *(if athlete is under 18 years of age)*

Date

Ohio Valley University Consent to Treat

I hereby authorize the athletic training staff, and any medical personnel designated by them, to evaluate and treat any injuries that occur during my participation in athletics at Ohio Valley University. I understand that the Team Physician or Head Athletic Trainer have the authority to declare me ineligible for intercollegiate athletic participation due to injury.

Athlete's Signature

Date

Parent or Legal Guardian *(if athlete is under 18 years)*

Date