SAN DIEGO STATE
ATHLETIC TRAINING

MEMORANDUM

TO: Student-Athletes Trying Out for SDSU Intercollegiate Athletics

FROM: SDSU Athletic Medicine Staff

RE: Medical Information

DATE: July 2024

On behalf of the SDSU Athletic Training Staff, I congratulate you on trying out for a place on one of our intercollegiate teams. In athletic training, our mission is to provide you outstanding sports medicine care if the need arises.

- The following packet of information has critical medical and insurance information: The physical exam: you will need a physical examination completed. The physical exam must be administered by a physician (MD or DO). Please attach a business card or have it stamped by the provider. An exam administered by a chiropractor will not be accepted. As per NCAA guidelines, SDSU cannot pay for this.
- Health History Form: this is a form for you to complete relative to your previous injuries and illnesses.
- Authorization Forms: various forms which allow us to treat your injuries.
- Insurance Forms: forms regarding your insurance information. Also include a copy of the front and back of your medical and dental insurance cards. We will attempt to contact your personal medical insurance company for pre-authorization of medical care as needed. If there is a change in your medical or dental insurance coverage, please contact us as soon as possible.
- Sickle Cell Trait: to comply with NCAA guidelines, we need to know your sickle cell trait status **PRIOR** to working out. Your family physician may have this information. If needed, you can be tested at Student Health Services but SDSU cannot pay for this as part of your tryout.

We will file the medical bills of athletic related injuries with your primary insurance company. We have a secondary insurance policy that will pay any portion not covered by your insurance or if you are without primary medical insurance.

Please review the following check-list as you complete the forms. It is important that you sign the pages where it is indicated. Thank you again for your assistance and we wish you a healthy and successful career.

SAN DIEGO STATE
ATHLETIC TRAINING

Check List

Please complete the following:

- ☐ **Consent to Medical Treatment (Page 1)**
- ☐ **Health History**
  - ☐ SDSU Pre-Participation Health History (Pages 2-6)
  - ☐ Attention Deficit Hyperactivity Disorder Information Form (Page 7)
  - ☐ Attention Deficit Hyperactivity Disorder NCAA Medical Exception Documentation Form (Page 8)
- ☐ **SDSU Athletic Medicine Authorization/Consent for Disclosure of Health Information (Pages 9-10)**
- ☐ **Awareness of Risk Statement (Page 11)**
- ☐ **Insurance Information**
  - ☐ SDSU Intercollegiate Athletic Policy Statement of Understanding (Pages 12-13)
  - ☐ SDSU Insurance Information (Page 14)
  - ☐ Aztec Athletic Medicine Health Insurance Release Authorization (Page 15)
  - ☐ Attach a copy of your MEDICAL INSURANCE CARD (FRONT AND BACK)
- ☐ **Acknowledgment of Receipt of Notice of Privacy Practices (Page 16)**

Please include/provide any other significant medical records, such as MRIs, x-rays, etc.

Please return by mail to:

Athletic Medicine
San Diego State University
5302 55th Street
San Diego, CA 92182-4313

Or fax to:

(619) 594-7654

SAN DIEGO STATE
ATHLETIC TRAINING

CONSENT TO MEDICAL TREATMENT FOR ADULTS (18 years & older)

_____ _____ _____
Student-Athlete's Name (printed) Date of Birth Red ID #

To be read and signed by the Adult Student-Athlete:
I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide diagnostic tests or treatment that is deemed advisable, and is to be provided by medical practitioners of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff and health care professionals to proceed with medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance or any specific diagnosis or treatment that may be required.

_____ _____
Signature Date

PARENTAL CONSENT TO MEDICAL TREATMENT FOR A MINOR

Please choose an option below and sign for Minor Student-Athletes:
☐ I hereby authorize San Diego State University Student Health Services (SDSU SHS) and San Diego State University Athletic Medicine Staff to provide my minor (less than 18 years or age) son or daughter diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or outside physicians or facilities deemed medically necessary. Authorization and consent is granted to San Diego State University, its Athletic Medicine Staff and health care professionals to proceed with medical care or treatment that the professional staff deems medically necessary. This authorization is given in advance or any specific diagnosis or treatment that may be required.

_____ _____
Parent/Guardian Name (printed) Signature of Parent/Guardian

☐ I may choose a person employed at San Diego State University to serve as a "designated agent" to consent for treatment of my minor son or daughter. This person can then sign any consent forms that may be necessary for diagnosis or treatment of my child, whether at SDSU Student Health Services or another medical facility. (This designated agent can be any adult into whose care the minor has been entrusted. You may identify the authorized adult by titles and employer [for example, Director or Patient Services & Medical Records of SDSU Student Health Services] rather than by name.)

The undersigned parent/guardian of _____ a minor authorizes _____ as an agent for the undersigned, to consent to any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of SDSU Student Health Services or any outside physicians or facilities as needed. This authorization is given in advance or any specific diagnosis or treatment that may be required.

_____ _____
Parent/Guardian Name (printed) Signature of Parent/Guardian

FOR STUDENT HEALTH SERVICES USE ONLY

Telephone consent to treat the above named student-athlete was given by:

_____ _____ _____
Name (printed) Relationship to Patient Phone Number

_____ _____
Director of Pt. Services Medical Records or Designee Signature Witness Signature

SAN DIEGO STATE
ATHLETIC TRAINING

SDSU Preparticipation Health History Form

Name:	Sex:	Age:	DOB:
Varsity sport:	Cell Phone:	Email:	
Local Address:			
Red ID:			

EXPLAIN ALL "Yes" answers in the box at the end. Circle questions you do not know the answer to.

	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason? Why?_____	○	○
2. Do you have an ongoing medical condition (like diabetes or asthma)? List:_____	○	○
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicine or pills? List:_____	○	○
4. Do you have allergies to medicines, pollens, foods or stinging insects? If so, what? _____	○	○
5. Have you ever passed out or nearly passed out **DURING** exercise?	○	○
6. Have you ever passed out or nearly passed out **AFTER** exercise?	○	○
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	○	○
8. Does your heart race or skip beats during exercise?	○	○
9. Has a doctor ever told you that you have (check all that apply) □ High blood pressure □ Heart murmur □ High cholesterol □ Heart infection	○	○
10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram, etc)?	○	○
11. Have you ever spent the night in the hospital?	○	○
12. Have you ever had surgery? On what?	○	○
13. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss practice or game?	○	○
14. Have you ever had any broken or fractured bones or dislocated joints?	○	○
15. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, crutches?	○	○
16. Have you ever had a stress fracture?	○	○
17. Have you ever been told you have or have had an x-ray for atlantoaxial (neck) instability?	○	○
18. Do you regularly use a brace or an assistive device?	○	○
19. Do you cough, wheeze, or have difficulty breathing during or after exercise?	○	○
20. Do you currently use an inhaler or take Asthma medicine?	○	○
21. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	○	○
22. Have you had infectious mononucleosis (mono) within the last month?	○	○
23. Do you have any rashes, pressure sores or other skin problems?	○	○
24. Have you ever had a herpes skin infection?	○	○
25. Have you ever had a head injury or concussion? If so, when was your last one? _____ How many have you had? ___ Current problem? _____	○	○
26. Have you been hit in the head and been confused or lost your memory?	○	○
27. Do you have headaches with exercise?	○	○
28. Have you ever had numbness, tingling, or weakness in your arms or legs after a hit or fall?	○	○
29. Have you ever been unable to move your arms or legs after being hit or falling?	○	○
30. When exercising in the heat, do you have muscle cramps or become ill?	○	○
31. Have you ever had any problems with eyes/vision?	○	○

	YES	NO
32. Do you wear glasses or contact lenses?	○	○
33. Do you wear protective eyewear, such as goggles or a face shield?	○	○
34. Are you happy with your weight?	○	○
35. Are you trying to gain or lose weight?	○	○
36. Has anyone recommended you change your weight or eating habits?	○	○
37. Do you limit or carefully control what you eat?	○	○
38. Do you have any concerns that you would like to discuss with a doctor?	○	○
39. Have you ever had feelings or thoughts that you didn't want to live?	○	○
40. Do you currently feel that you don't want to live?	○	○
41. Have you ever tried to kill yourself before?	○	○
42. Have you ever hurt or cut yourself before?	○	○
43. Have you ever been treated for a mental health concern or drug/substance use in the past?	○	○
44. Have you ever been hospitalized or admitted to an inpatient or intensive outpatient therapy program for a mental health concern?	○	○
45. Do you ever hear voices or see things that are not really there?	○	○

Please explain YES answers:

46. What is your current home environment like (family supportive, do you like where you live, etc.)?
    Please explain: _____
47. Who are your main support systems (parents, friends, partner, teammates, coaches, etc.)?
    Please explain: _____

FEMALES ONLY:

	YES	NO
48. Have you ever had a menstrual period?	○	○
49. How old were you when you had your 1st period	_____	
50. How many periods have you had in the last 12 months	_____	

I hereby state that, to the best of my knowledge, my answers are complete and correct

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

Please indicate any personal or family history for the following diseases:

	select a drop down option	
Sudden Death	---	Family Member: _____
Heart Disease	---	Self or Family Member: _____
Hypertension (high blood pressure)	---	Self or Family Member: _____
Stroke	---	Self or Family Member: _____
Autoimmune Disease (Rheumatoid Arthritis, Lupus, Etc.)	---	Self or Family Member: _____
Blood Clot in Legs or Lungs	---	Self or Family Member: _____
Thyroid/Endocrine Disease	---	Self or Family Member: _____
Asthma	---	Self or Family Member: _____
Seizures	---	Self or Family Member: _____
Diabetes	---	Self or Family Member: _____
Kidney Disease	---	Self or Family Member: _____
Tuberculosis (TB)	---	Self or Family Member: _____
Sickle Cell Disease	---	Self or Family Member: _____
Cancer Diagnosis	---	Self or Family Member: _____
Depression or Anxiety	---	Self or Family Member: _____
Bipolar Disorder	---	Self or Family Member: _____
Suicide	---	Self or Family Member: _____
Schizophrenia	---	Self or Family Member: _____
Learning Disorder/ADD/ADHD	---	Self or Family Member: _____
Consumption of Alcohol	---	Self: How much: _____
Used Drugs	---	Self: _____
Addiction	---	Self or Family Member:_____
Marfan Syndrome	---	Self or Family Member: _____

Please select a response from the drop-down boxes for each of the following: I…

		select a drop down option	Score
1.	Am terrified about being overweight	---	
2.	Avoid eating when I am hungry	---	
3.	Find myself preoccupied with food	---	
4.	Have gone on eating binges where I feel that I may not be able to stop	---	
5.	Cut my food into small pieces	---	
6.	Aware of the calorie content of foods that I eat	---	
7.	Particularly avoid foods with high carbohydrate content (i.e. bread, rice, potatoes, etc.)	---	
8.	Feel that others would prefer if I ate more	---	
9.	Vomit after I have eaten	---	
10.	Feel extremely guilty after eating	---	
11.	Am preoccupied with a desire to be thinner	---	
12.	Think about burning calories when I exercise	---	
13.	Other people think that I am too thin	---	
14.	Am preoccupied with the thought of having fat on my body	---	
15.	Take longer than others to eat my meals	---	
16.	Avoid foods with sugar in them	---	
17.	Eat diet foods	---	
18.	Feel that food controls my life	---	
19.	Display self-control around food	---	
20.	Feel that others pressure me to eat	---	
21.	Give too much time and though to food	---	
22.	Feel uncomfortable after eating sweets	---	
23.	Engage in dieting behavior	---	
24.	Like my stomach to be empty	---	
25.	Enjoy trying new rich foods	---	
26.	Have the impulse to vomit after meals	---	

27. Have you gone on eating binges where you feel that you may not be able to stop? (Eating much more than most people would eat under the same circumstance?)
    NO ○ YES ○ How many times in the last 6 months? _____
28. Have you ever made yourself sick (vomited) to control your weight or shape?
    NO ○ YES ○ How many times in the last 6 months? _____
29. Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?
    NO ○ YES ○ How many times in the last 6 months? _____
30. Have you ever been treated for an eating disorder?
    NO ○ YES ○ How many times in the last 6 months? _____
31. Have you ever been diagnosed as having an eating disorder (anorexia, bulimia, or both?)
    NO ○ YES ○
32. Lost 20 pounds or more in the past 6 months?
    NO ○ YES ○ How many times in the last 6 months? _____
33. Exercised more than 60 minutes a day to lose or to control weight?
    NO ○ YES ○ How many times in the last 6 months? _____

Please list your:
Highest weight_____, Lowest weight _____, Goal weight _____

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: (If under 18) _____ Parent Signature: _____ Date: _____

Musculoskeletal History Section:

Please list fractures, sprains, strains, dislocations, cartilage injuries, etc.
If you need more room use lines at the end of the section.

	Type of Injury	Date	Treatment	Fully Resolved?
Ankle	R			○ yes ○ no
	L			○ yes ○ no
Foot	R			○ yes ○ no
	L			○ yes ○ no
Knee	R			○ yes ○ no
	L			○ yes ○ no
Hip/Leg	R			○ yes ○ no
	L			○ yes ○ no
Hand	R			○ yes ○ no
	L			○ yes ○ no
Wrist	R			○ yes ○ no
	L			○ yes ○ no
Elbow	R			○ yes ○ no
	L			○ yes ○ no
Shoulder	R			○ yes ○ no
	L			○ yes ○ no
Chest/Ribs				○ yes ○ no
Neck				○ yes ○ no
Back				○ yes ○ no
Head/Face				○ yes ○ no

Any other significant injury to your body? (please explain) _____

General Questions:

Have you ever been hospitalized overnight? (Please explain) _____

Have you ever had any surgeries? (Please explain)_____

Do you have ANY medical problems you have not yet listed that require regular treatment or medical attention?_____

Have you seen a doctor in the last year? _____

Are you currently experiencing any symptoms or in any way feel not well?_____

I hereby certify that I have completed this questionnaire completely and correctly to the best of my ability and knowledge. I certify that there are no illnesses or injuries, current or previous, that I have not incurred, other than those I have listed on the preceding pages.

Athlete name: _____Athlete Signature: _____Date: _____

Parent Name: _____Parent Signature: _____Date: _____
(If under 18)

Attention Deficit Hyperactivity Disorder Information Form

Please check the appropriate box and sign:

☐ I have never been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). Please print and sign your name below and return this form to us. **You do not need to read or complete the rest of this form.**

☐ I have been diagnosed or treated for Attention Deficit Disorder (ADD or ADHD). **Please read and complete the NCAA medical exemption documentation form (Page 6 of this packet.)** This needs to be done yearly – last year's records are not enough.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

DO NOT COMPLETE THE FOLLOWING FORM IF YOU HAVE NEVER BEEN DIAGNOSED OR TREATED FOR ADHD

SAN DIEGO STATE
ATHLETIC TRAINING

NCAA Medical Exception Documentation Form
To Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
And Treatment with Banned Stimulant Medication

- Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
- Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (See Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting)

To be completed by SDSU Athletic Medicine Staff

Institution Name: San Diego State University

Institutional Representative Submitting Form:

Name:_____

Title:_____

Email:_____

Phone:_____

Student-Athlete Name:_____

Student-Athlete DOB:_____

To Be Completed by Student-Athlete's Medical Provider

Current Treating Physician (print name):_____Specialty:_____

Office Address:_____

Physician's Signature:_____Date:_____

Check off that documentation representing each of the items below is attached to this report

- o Diagnosis
- o Medication(s) and Dosage
- o Blood Pressure and pulse readings and comments.
- o Note that alternative non-banned medications have been considered, and comments.
- o Follow up orders.
- o Date of clinical evaluation:_____

Attach a written report summary of a comprehensive clinical evaluation. Please note this includes the original clinical notes of diagnostic evaluation

The evaluation should include individual and family history. Address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation such as completed ADHD Rating Scale(s) (e.g.) Connors, ASRS, CAARS) scores. The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or part, in reliance upon the accuracy or veracity of the information provided hereunder.

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

Background:
This consent form is designed to inform you of the public nature of your athletic injuries and illnesses and obtain your consent to our release of certain personal health information.

Participating in varsity intercollegiate sports by its nature puts an athlete in the public eye. Television, internet and print media will be following and reporting on the team and sometimes on individual athletes. They are often interested in illnesses or injuries that will result in missed game time or limit performance.

As a varsity athlete you enter into an agreement with the Athletic Department with unique rights and responsibilities as described in the Student Athlete Handbook. Sharing medical information about your injuries or illnesses with coaches and other Athletic Department administrators is helpful (such as when a coach is planning a roster for an upcoming competition) and sometimes necessary (such as when applying for a "medical redshirt"). Personal health information must be sent to the Mountain West Conference when applying for a medical redshirt.

Often other athletes are within hearing distance while you are being treated in the athletic training room or on the field for your athletic injuries and illnesses.

Lastly, concerned parents often request information about your care for athletic injuries and illnesses.

Definitions:
Athletic injuries and illnesses: This may refer to any injury or illness that impacts your ability to play and/or perform for San Diego State University's varsity intercollegiate sports. Medical information that will not be released includes information about psychological/psychiatric illness, substance abuse, eating disorders, obesity, sexually transmitted disease, neuropsychiatric testing, or learning disabilities. If a professional team requests information about your *athletic injuries and illnesses* we will release such information to the team ONLY if you give us specific written consent.

Athletic Medicine Staff: This refers to all persons working under the direction of the Medical Director of Athletic Medicine and/or the Head Athletic Trainer and includes but is not limited to all team physicians, resident physicians, medical students, staff certified athletic trainers, athletic training students, and administrative assistant for medical billing.

Consent:

I, _____, acknowledge that I have read and understand the
Name of Student Athlete

Background and Definitions above.

Student Athlete Authorization/Consent for Disclosure of Health Information Regarding Athletic Related Injuries and Illnesses.

I, _____, hereby authorize San Diego State University and its
Name of Student Athlete
athletic medicine staff (physicians, athletic trainers and health care personnel) to disclose when requested or necessary my protected health information and any related information regarding my *athletic injuries and illnesses* to the following groups/persons:

List A: Groups/Persons

- SDSU Athletic Department Administrators including but not limited to coaches, compliance officer, and Director of Media Relations
- Media outlets and their employees or agents (such as newspapers and television)
- Parents or guardians
- Mountain West Conference and its employees or agents
- NCAA Injury Surveillance System (ISS)

This information may be sent to one or more of the above groups/persons by unsecured electronic means such as e-mail, fax, or text messages.

I understand that the information released may have different purposes and is dependent on to whom the information is released. These purposes may include but are not limited to:

List B: Purposes

- Athletic Department operations
- Answering media questions
- Explaining the typical course of an injury or illness to another athlete
- Informing concerned parents or guardians
- Asking the MWC to grant a medical redshirt (hardship) or exemption
- Allowing the NCAA to track injury statistics

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 (FERPA) 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 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 or conference athletics. I also understand that the media outlets, Mountain West Conference, parents and guardians, and other varsity athletes are not covered by the Buckley Amendment or HIPAA and that this policy does not apply to their use or disclosure of my *athletic injury or illness* information.

The authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending a written notification to the director of athletic medicine at SDSU at the address below. I understand that the revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Athlete name: _____Athlete Signature: _____Date: _____

Parent Name: _____Parent Signature: _____Date: _____
(If under 18)

AWARENESS OF RISK STATEMENT

In an effort to recognize the responsibility for sports safety of administrators, coaches, physicians, athletic trainers and student athletes, I, the undersigned, am aware that there is a certain risk of injury involved in my participation in Intercollegiate Athletics at San Diego State University. I understand that this includes the risk of spinal cord or brain injury that may result in paralysis and the possibility of permanent injury. I accept the responsibility for reporting my injuries and illnesses to San Diego State University's medical staff, including signs and symptoms of concussions.

I have been informed that the San Diego State University Intercollegiate Athletics insurance has provisions which require that I report current and previous injuries to the athletic trainer immediately.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

Intercollegiate Athletic Accident Policy

SDSU, like most NCAA Athletic Departments, provides an athletic insurance policy for its student-athletes. This is the *SDSU Intercollegiate Athletic Accident Policy.* This policy will cover medical costs related to injuries that occur while participating in supervised practice or competition for SDSU. Our athletic accident policy is a secondary insurance. Thus, if a student-athlete is covered by a personal, family or private insurance policy it will be used first. Medical expenses will not be paid by our secondary insurance policy until any existing personal medical insurance is exhausted.

In order for an injury to qualify for coverage under the SDSU athletic accident insurance policy, the student-athlete must have their medical care coordinated and authorized by our Athletic Medicine staff of Athletic Trainers and Team Physicians. The Athletic Medicine staff will coordinate all necessary care for the athletically related injuries. Here are some steps in the process of what happens following an injury:

- Medical claims or expenses for the student-athlete, resulting from an accident injury during supervised scheduled university athletic activity, practice or competition, will be filed first with the student-athlete's primary insurance.
- After the claim is processed by the primary insurance the policyholder (which in most cases is the parent) will receive an "Explanation of Benefits" (EOB) from the insurance company. The EOB is a summary of expenses paid or not paid by the insurance company.
- The EOB needs to be forwarded as soon as possible to SDSU Athletic Insurance Coordinator:

  Athletic Training Room - San Diego State Athletics
  c/o Kristen Paulius
  5302 55th Street
  San Diego, CA 92182-4313

- In the event the primary insurance sends a check for payment of an athletic related expense to the parent or policy holder, it should be sent to Kristen Paulius or to the medical provider as promptly as possible.
- There should be no out-of-pocket expenses for any remaining balances for the injury that occurs during scheduled and supervised university athletic activity, practice, or SDSU competition.
- If the student-athlete has no primary insurance, the medical expenses will be forwarded to SDSU.

The SDSU intercollegiate athletic accident policy will only cover ***authorized*** expenses during the 2 years (104 weeks) following the date of injury. The limit of insurance coverage is $75,000 per injury. Expenses beyond $75,000 will be submitted to the NCAA Catastrophic Injury policy for review.

It is very important to understand that this is not a comprehensive insurance policy. For example, if the athlete requires surgery for an appendicitis or hospitalization for a kidney infection, these expenses would not be covered. It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover expenses which are not managed by the SDSU intercollegiate athletic accident policy.

Student-Athlete & Parent Statement of Understanding

By my signature below I acknowledge that I have read the information listed above and understand and attest to the statements that follow:

1. The Athletic Medicine Staff will coordinate all necessary care for athletic related injuries. The Athletic Department will not bear financial responsibility for medical bills that are not authorized by the Athletic Medicine staff.
2. Failure to report injuries to university athletic medical personnel, obtain authorization for outside medical care, or to meet scheduled medical appointments may void university responsibility for medical expenses resulting from athletic injuries.
3. I understand that the SDSU intercollegiate athletic accident insurance policy will only cover expenses incurred during the 2 years (104 weeks) following the injury date and up to $75,000, whichever comes first.
4. If a student-athlete is covered by a personal, family, or private insurance policy it will be used first. Medical expenses will not be paid under the secondary insurance policy carried by SDSU until any existing personal medical insurance policy is exhausted.
5. I understand that if I do not have personal medical insurance SDSU will ask outside providers to bill SDSU intercollegiate athletic accident insurance policy directly.
6. If these policies are followed there will not be any out-of-pocket expenses for the student-athlete or their family for injuries occurring during SDSU supervised practices and competitions.
7. The SDSU athletic accident insurance policy will only cover medical costs related to injuries that occur while participating in a supervised practice or competition for SDSU. This is not a comprehensive insurance policy.
8. It is highly recommended that every student-athlete at SDSU have personal medical insurance to cover these expenses.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

I hereby grant permission to the Physicians in the Athletic Medicine Department and Student Health Services at SDSU and those professional personnel designated by them to treat my son/daughter in the event of any injury or illness. In the event of a serious injury and if unable to contact me, this consent is to include any and all emergency procedures deemed necessary by the attending physician.

Athlete name: _____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____
(If under 18)

ALLERGIES _____

Insurance Information Form

****ATHLETE'S INFORMATION****

NAME (Last) _____ (First)_____ (MI)_____ SPORT _____

SOC SEC # _____ RED ID #_____ CELLPHONE _____ DOB _____

EMAIL ADDRESS_____

PERMANENT ADDRESS (Street)_____(City)_____(State)____(Zip)_____

LOCAL ADDRESS (Street)_____(City)_____(State)____(Zip)_____

****PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION****

NAME (Last) _____ (First) _____ RELATION _____ PHONE _____

****INSURANCE INFORMATION****

Attach copy of insurance card

PRIMARY Insurance Company _____

Policy Holder Name _____

Policy Holder DOB _____

Policy Holder SS# _____

Policy Holder Employee and Employer's address:

_____

_____

Group # _____

Policy # _____

Phone # _____ Fax # _____

Billing Address (Street, City, State, Zip Code)

_____

HMO (◯Y ◯N) PPO (◯Y ◯N) Military (◯Y ◯N)

Insurance covers prescriptions (◯Y ◯N)

Attach copy of insurance card

DENTAL Insurance Company _____

Policy Holder Name _____

Policy Holder DOB _____

Policy Holder SS# _____

Policy Holder Employee and Employer's address:

_____

_____

Group # _____

Policy # _____

Phone # _____ Fax # _____

Billing Address (Street, City, State, Zip Code)

_____

HMO (◯Y ◯N) PPO (◯Y ◯N) Military (◯Y ◯N)

Insurance covers prescriptions (◯Y ◯N)

Primary Care Physician's Name (if applicable)_____Phone_____

****NOTE TO PARENT/GUARDIAN AND ATHLETE****

I understand this insurance information must be COMPLETELY and ACCURATELY provided and on file with the Athletic Training Department before me or my son/daughter will be allowed to participate in athletics.

Athlete name:_____ Athlete Signature: _____ Date: _____

Parent Name: _____ Parent Signature: _____ Date: _____

SAN DIEGO STATE
ATHLETIC TRAINING

AZTEC ATHLETIC MEDICINE
HEALTH INSURANCE RELEASE AUTHORIZATION

TO: HEALTH INSURANCE CARRIER _____

ADDRESS _____

CITY_____ STATE _____

ZIP_____ PHONE _____ FAX _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE INFORMATION REGARDING MY HEALTH INSURANCE INFORMATION AS LISTED BELOW TO:

Aztec Athletic Medicine - San Diego State
5302 55th Street
San Diego, CA 92182-4313

Telephone (619) 594-5551 Fax (619) 594-7654

THIS RELEASE COVERS ALL HEALTH INSURANCE INFORMATION INCLUDING BUT NOT LIMITED TO:

PRIMARY CARE PROVIDER; ELIGIBILITY & BENEFITS; DEDUCTIBLE LEVEL AND AMOUNT MET; COPAYS; EXPLANATION OF BENEFITS (EOB)

THIS AUTHORIZATION WILL REMAIN VALID UNTIL REVOKED BY ME IN WRITING. A COPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

1. POLICY HOLDER NAME _____ SS#____-____-_____

SIGNATURE OF POLICY HOLDER _____ DATE _____

2. PATIENT NAME_____ SS#____-____-_____

SIGNATURE OF PATIENT_____ DATE _____