

**MUST BE RECEIVED ASAP**

**EMERGENCY AND INSURANCE INFORMATION FORM**

Please carefully **READ, COMPLETE, SIGN and RETURN** with a copy (front and back) of your primary insurance card to Health Services

**If this form is not returned and the information given is incomplete or a copy of your insurance card is not received, you will be unable to participate in your sport.**

Please write legibly and complete all blanks with appropriate information or N/A if not applicable. The information you provide on this form will be what is used in the event of an accident or emergency.

**Should any of this information change over the year, notify Barbara Michal or Yvonne Terney at 706- 419-1275.**

**ATHLETE'S NAME** \_\_\_\_\_ **SPORT** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **S.S.#** \_\_\_\_\_ **CLASS LEVEL** \_\_\_\_\_

**HOME ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **ST** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**STUDENT'S CELL #** \_\_\_\_\_ **PARENT'S CELL #** \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**PRIMARY INSURANCE COMPANY NAME** \_\_\_\_\_

**INS. CO. ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**POLICY or ID #** \_\_\_\_\_ **PLAN/GROUP** \_\_\_\_\_

**POLICY EFF DATE:** \_\_\_\_\_ **CO-PAY AMOUNT** \_\_\_\_\_ **DEDUCTIBLE AMOUNT** \_\_\_\_\_

**LENGTH OF INSURANCE COVERAGE - (Circle one):** 3MOS / 6MOS / 9 MOS / 1 YR

**POLICY HOLDER NAME** \_\_\_\_\_

**RELATIONSHIP TO ATHLETE** \_\_\_\_\_

**POLICYHOLDER'S S.S.#** \_\_\_\_\_ **POLICYHOLDER'S DOB** \_\_\_\_\_

**POLICYHOLDERS'S EMPLOYER NAME** \_\_\_\_\_

**EMPLOYERS ADDRESS** \_\_\_\_\_

**EMPLOYERS PHONE** \_\_\_\_\_

**All student athletes are required to have primary insurance and should take a copy of their primary insurance card or information with them if referred for medical treatment..**

**Intercollegiate Athletic Injury** insurance provided through Covenant College is considered excess coverage and is secondary to any primary insurance coverage.

**Procedure for insurance coverage for an Intercollegiate Athletic Injury:**

1. Any injury expenses from medical providers will **first** go to the athlete's **primary insurance for payment**. Parents and/or student athlete is responsible for the **primary insurance deductible and co-payment**. Be sure to take your medical insurance card or information with you to the hospital or doctor's office. **Covenant College should not be shown as the responsible party for medical expenses.**

**In addition, be sure the hospital, doctor's office, laboratory, etc. has the following information about the Athletic Insurance (secondary insurance) The athletic trainer will give the athlete this information to give the provider.**

Insurance name:	AIG
Policy #	9108499
Participant Number	1770-11-AICS
Address	Diversified Group Administrators P.O. box 6540 Harrisburg, PA 17112
Phone	1-800-877-6490
FAX	717-652-8328

2. **Complete an Athletic Injury Insurance Claim Form** obtained from the athletic trainer or Health Services **ASAP. Return the athletic insurance claim form to the athletic trainer or Health Services for mailing. The Claim Form must be completed and filed within a year of the injury to be considered.**

- **If this is not done in a timely manner the Athletic Injury insurance will deny the claim.**

3. **If the Primary insurance denies the claim and will not pay the providers, the Athletic Injury Insurance will pay, once the deductible of \$2500 has been paid.**

**If the Primary insurance denies payment, this deductible becomes your responsibility.**

4. After the Athletic Injury Insurance has paid a claim for the injury they will send an EOB from **AIG – GIVE THIS EOB** (from AIG) to Health Services along **with any bills** you continue to receive.
5. Covenant College will pay bills owed after this procedure is followed.
6. This process needs to be completed **within a year of being released from your doctor** in order for the secondary insurance or the college to pay for any claims.

Timeliness in filing claims will result in prompt claim processing. Your assistance is appreciated.

**I give Health Services permission to contact my parents, doctor, other care providers, primary medical insurance company, and/or pharmacy about any athletic injury should the need arise.**

Parent's e-mail address \_\_\_\_\_

Student Athlete's Signature \_\_\_\_\_ Date \_\_\_\_\_

For your information:

*Student Athletes are covered by the Athletic Injury Insurance during participation in scheduled games, supervised practice sessions and authorized group or team travel in connection with such games or practice sessions.*

*Covenant's Athletic Injury Insurance coverage provides benefits up to \$25,000 with a \$2,500 deductible per accident or injury. The deductible is integrated. Which means that any benefits paid by a primary insurance plan would reduce the \$2,500 deductible. The athletic department will pay the balance of any deductible of this insurance due (up to \$2,500) per injury. Catastrophic insurance is in place should a claim exceed \$25,000.*

We have read this form and understand **that any medical expenses associated with any athletic injury not covered by the primary insurance will be the financial responsibility of the student or the parent(s) of the student if this procedure is not followed.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Athlete Signature \_\_\_\_\_ Date \_\_\_\_\_

## INSURANCE QUESTIONNAIRE

Name of Athlete	
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Please review your primary insurance coverage with your son or daughter.

Your son or daughter is responsible to follow the procedures outlined below prior to seeing the health care provider. At the risk of being redundant, an emergency situation IS NOT the best time to find out about your insurance benefits and requirements. This review will require a call to your insurance agent or company to get some answers.

Please ask the following and fill in all information below.

Explain you will be attending Covenant College, 14049 Scenic Highway, Lookout Mountain, GA 30750 in northwest Georgia, with Chattanooga, TN being the nearest city.

Does my insurance have PPO or HMO requirements?	
What are they?	
Ask them what procedure to follow in case of injury or illness.	
Who are my preferred health care providers for <b>non-emergency</b> visits in the Chattanooga/Northwest Georgia area?	
<b>Please provide a list of doctors you can see in the Chattanooga, TN area if they are not listed below.</b>	
Can I use: <b>Dr. David Bruce, Dr. John Nash, Dr. Martin Redish, or Dr. Kurt Chambliss</b> Chattanooga Bone & Joint, 1809 Gunbarrel Rd., Chattanooga, TN	Circle Yes or No
Can I use: <b>Dr. Glen Beasley,</b> #2 Northgate Park, Suite 104, Chattanooga, TN	Circle Yes or No
<b>Can I use: Dr. Bill Moore Smith;</b> 1200 Pineville Rd.; Chattanooga, TN	Circle Yes or No
<b>Can I use: Dr. Richard Alvarez,</b> 725 Glenwood Dr., Chattanooga, TN	Circle Yes or No

Must I get pre-authorization? If yes, what is the pre-authorization phone number?	Circle Yes or No
Where can I go for outpatient diagnostic tests?	
What must I do in case of an <b>emergency</b> ?	
Must I get pre-authorization?	Circle Yes or No
If yes, what number do I call?	
Must I contact my primary physician?	Circle Yes or No
If yes, what number do I call?	
How soon must they be called post emergency?	
For emergency or inpatient, what <b>hospital</b> can I use if not listed below?	
Erlanger Medical Center, Chattanooga, TN 37403	Circle Yes or No
Hutcheson Medical Center, Ft. Oglethorpe, GA 30742	Circle Yes or No
Parkridge Medical Center, Chattanooga, TN 37404	Circle Yes or No
Memorial Hospital, Chattanooga, TN 37404	Circle Yes or No
What if <b>surgery</b> is required? Must I return to my home state?	Circle Yes or No
Is Pre-authorization needed?	Circle Yes or No
If so, what is the number to call?	



**COVENANT**  
ATHLETICS

Athletic Training  
New Student Athletes  
Pre-Participation Health History

Date \_\_\_/\_\_\_/\_\_\_ Sport \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Men's or Women's

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Campus Phone \_\_\_\_\_  
Student Cell \_\_\_\_\_

<p><b>In case of emergency, notify:</b></p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Cell phone _____</p>
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Date of last health exam by a doctor \_\_\_\_\_

**Family Medical History**

**Y N**

1. Has anyone in your immediate family ever had:

- Diabetes (high blood sugar)
- Stroke
- Epilepsy
- Sickle cell anemia (trait)
- Osteoporosis
- High blood pressure
- Enlarged heart
- Hypertrophic Cardiomyopathy
- Marfan's Syndrome
- Abnormal heart rhythm
- Long QT Syndrome
- Other heart problems \_\_\_\_\_
- Has anyone in your family, under age 50, died suddenly? explain: \_\_\_\_\_

**Y N**

- Osteoporosis
- High blood pressure
- Tendency to bruise easily
- Anemia
- Thyroid trouble
- Mononucleosis (Mono)
- Hepatitis
- Tuberculosis
- Viral infection
- Malaria
- Measles
- Mumps
- Pneumonia
- Bronchitis
- Rheumatic Fever
- Scarlet Fever
- Myocarditis

**General Medical**

- 1. Date of last tetanus booster \_\_\_\_\_
- 2. Have you had or do you now have:
  - Diabetes (high blood sugar)
  - Hives or rash
  - Stroke
  - Epilepsy
  - Sickle cell anemia (trait)

3. Have you had or do you now have:

- To wear glasses or contacts
- Impaired vision in one eye
- Temporary loss of vision
- Unequal pupils
- Hearing loss
- Perforated eardrum
- Recurrent ear infections
- Wear a hearing aid

Name \_\_\_\_\_

**General Medical cont.**

**Y N**

- Broken nose
- Sinus infections
- Frequent nose bleeds
- Wear Braces, retainer or protective mouth gear

4. Have you had or do you now have:

- Kidney problems
- Loss of a kidney
- Missing paired organ (eye, kidney etc)
- Stomach or peptic ulcer
- Bleeding ulcer
- Acid reflux / stomach indigestion
- Bladder disease
- Weight problems
- Disordered eating
- Dieting problems
- Fungus infection
- Athlete's foot
- Skin infection
- MRSA/Staph infection  
explain: \_\_\_\_\_  
\_\_\_\_\_

**Allergies**

1. Have you had or do you now have:

- Hay Fever / Allergies to pollen
- Allergies to bites/stings
- Do you use an Epi Pen
- Do you use adrenalin shots

2. Are you allergic to:

- Penicillin
  - Other Medications
  - Latex
  - Any Food
  - Other Substances  
explain yeses: \_\_\_\_\_  
\_\_\_\_\_
- If yes, check type of reaction
- Rash       Hives
  - Breathing or other anaphylactic reaction

**Breathing/Asthma**

1. Have you had or do you now have:

- Asthma or athlete induced asthma
- Use an inhaler
- Take asthma medication
- Cough, wheeze or have trouble breathing during or after activity?

Ever been dizzy during or after exercise?

**Heart**

1. Have you had or do you now have:

**Y N**

- High Blood Pressure
- Heart murmur
- Enlarged heart
- Hypertrophic cardiomyopathy
- Marfan's syndrome
- Abnormal heart rhythm?
- Heart infection
- Other heart problems? \_\_\_\_\_
- Tendency to faint
- Dizziness/faintness with exercise
- Have you ever passed out during exercise
- Chest pain/discomfort with exercise
- Difficulty breathing
- Do your lips turn blue during exercise?
- Do you tire more quickly than your friends do during exercise?
- Have you ever had racing of your heart or skipped heartbeats?
- Have you ever had an electrocardiogram (EKG)?  
explain: \_\_\_\_\_  
\_\_\_\_\_
- Has a doctor ever ordered a test for your heart?  
explain: \_\_\_\_\_  
\_\_\_\_\_
- Has a doctor ever restricted you from playing sports / exercising due to a heart condition?  
explain: \_\_\_\_\_  
\_\_\_\_\_

**Head Injuries / Concussion**

1. Have you ever:

- Had a Concussion / head injury / "bell rung"  
If yes how many \_\_\_\_\_  
When was your last concussion \_\_\_\_\_
- Had a skull fracture or face fracture
- Had memory loss
- Knocked out /lost consciousness
- altered level of consciousness or felt "Confused" "Fuzzy", "In the Clouds" or "Loopy"
- Had a seizure
- Had fuzzy or blurry vision
- Had sensitivity to light
- Frequent or severe headaches / (with or without exercise)?  
If you take medication for your headaches  
What do you take? \_\_\_\_\_  
How often? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Heat Illness**

1. Have you ever:

Y N

- Had heat or muscle cramps?
- Been dizzy in the heat?
- Become ill/sick in the heat?
- Had fatigue or headache due to heat?
- Passed out or had altered consciousness in the heat?
- Had Heat exhaustion (cool, clammy, damp skin)
- Had Heat stroke (hot, red, dry skin)?

**Neck / Back injuries**

1. Have you had or do you now have:

- A Neck injury
- A Back injury
- Upper back pain
- Lower back pain
- Fracture, stress fracture, or broken bones in neck or back?
- A Stinger, burner, pinched nerve
- Numbness, tingling or weakness in your arms, hands, legs, or feet after being hit or falling?
- Been unable to move your arms, hands, legs, or feet after being hit or falling?

**Other**

- 1. Has a doctor ever denied or restricted your participation in sports because of a health problem? explain: \_\_\_\_\_  
\_\_\_\_\_
- 2. Do you use any special equipment (pads, braces, mouth guards, eye guards etc)? explain: \_\_\_\_\_  
\_\_\_\_\_
- 3. Are you taking any prescription medications on a regular basis? explain: \_\_\_\_\_  
\_\_\_\_\_
- 4. Are you taking any over the counter medications on a regular basis? (ibuprofen, Tylenol, Tums etc.) explain: \_\_\_\_\_  
\_\_\_\_\_
- 5. Are you taking any vitamins or supplements on a regular basis? explain: \_\_\_\_\_

6. Have you ever had surgery?  
(NOT orthopedic/bone or joint related)

explain: \_\_\_\_\_  
\_\_\_\_\_

7. Do you require a special diet (vegetarian, gluten free, etc.)

explain: \_\_\_\_\_  
\_\_\_\_\_

8. \*\*Do you wish to talk to a doctor about ANY health problem?\*

**Males Only:**

1. Have you ever had or do you now have:

- Swelling or pain in your testicles or groin?
- A hernia / sports hernia
- If yes did you require surgery to repair the Hernia / sports hernia?  
When was date of last surgery? \_\_\_\_\_

**Females Only:**

Age at the onset of menstruation \_\_\_\_\_

1. Have you ever had or do you now have:

- Amenorrhea (loss or missed menstruation)
- Oligomenorrhea (irregular menstruation)
- Dysmenorrhea (very painful menstruation or cramping)
- Do you currently use birth control?  
1. Type (pill, depo-shot, etc.) \_\_\_\_\_

2. How often do you take birth control (daily, monthly, every 3 months etc.)  
\_\_\_\_\_

Name \_\_\_\_\_

**Orthopedic / Bone / Joint / Muscle Injuries**

For the following questions, be as specific as possible. Detail WHAT happened, WHEN it happened, RIGHT OR Left, Fracture, Stress Fracture, Dislocation, Separation, Muscle or Tendon Strain, Ligament sprain, X-rays, MRI, CT scan, Surgery, Injections, Casted or Immobilized, how long, any Rehabilitation or Physical Therapy, Cleared to play or Not cleared to play.

**USE BACK OF PAGE FOR MORE SPACE.**

**Have you had an injury to:**

1. Finger, hand or wrist \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The forearm or elbow \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Shoulder \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Hip or pelvis area \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Knee \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Foot or ankle \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Upper or lower back? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Do you experience pain in your back? Seldom Occasionally Frequently \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do you wear orthotics in your shoes? Why? Who prescribed them and when? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Have you had any problems with muscles strains or pulls? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Have you had any other significant injuries? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Are you currently under the care of a physician? Give length of time and reason for care. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HAVE READ AND ANSWERED ALL OF THE ABOVE QUESTIONS COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## Pre-Participation Physical Examination Form

Athlete's Name: \_\_\_\_\_ Date of Exam \_\_\_\_\_

Sport: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

**USE BACK IF NEED MORE SPACE**

Medical	Normal	Abnormal Finding	Initials
Appearance			
Eye/Ear/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Musculoskeletal	Normal	Abnormal Finding	Initials
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee / Leg			
Ankle / Foot			

Cleared without restrictions

Cleared after completing evaluation/rehab for:

Cleared with the following recommendations:

Not cleared / fail (please specify reason):

**Physician Name (print/type):** \_\_\_\_\_ **contact #:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Signature of Physician/Provider:** \_\_\_\_\_

**Circle One: MD DO PA**