SAN DIEGO STATE
ATHLETIC TRAINING

MEMORANDUM

TO: Incoming Aztec Student Athletes

FROM: SDSU Athletic Training Staff

RE: SDSU Intercollegiate Athletic Accident Policy

DATE: May, 2019

Congratulations on becoming an Aztec and we look forward to you contributing to your team's success. In athletic training, our mission is to provide you outstanding sports medicine care if the need arises.

This packet of information has critical information regarding SDSU's Intercollegiate Athletic Accident Policy. We will file the medical bills of your 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.

It is critically important that you complete these forms and return them to us as soon as possible. **ALSO, PLEASE INCLUDE A COPY OF YOUR MEDICAL INSURANCE CARD.** We will attempt to contact your personal medical insurance company for pre-authorization of medical care as needed. In addition, please be certain to review the ADD/ADHD diagnosis and treatment forms if necessary.

If you are a student-athlete from outside the San Diego area:

- We recommend that you establish a local Primary Care Provider (PCP). If you need assistance with this process please let us know.
- If you are a member of Kaiser Permanente, please contact your provider to establish a Southern California Member Number/Card if needed.

Please review the following check-list as you complete the forms. It is important that you sign and date forms where needed. If you have any questions, please contact our Athletic Insurance Coordinator, **Nora Dawson at 619-594-7651**.

Thank you again for your assistance and we wish you a healthy and successful career as an SDSU Aztec!

SAN DIEGO STATE
ATHLETIC TRAINING

SDSU Intercollegiate Athletic Accident Policy

Check List

Please complete the following:

___Parental Consent to Medical Treatment for a Minor, if athlete is under 18 (Page 1)

___ Health History

___ SDSU Pre-Participation Health History (Pages 2-5)

___ Attention Deficit Hyperactivity Disorder Information Form (Page 6)

___ Attention Deficit Hyperactivity Disorder NCAA Medical Exception Documentation Form (Page 7)

___SDSU Athletic Medicine Authorization/Consent for Disclosure of Health Information (Pages 8 and 9)

___ Awareness of Risk Statement (Page 10)

___ Insurance Information

___ SDSU Intercollegiate Athletic Policy Statement of Understanding (Pages 11-12)

___SDSU Insurance Information Form (Page 13)

___ Aztec Athletic Medicine Health Insurance Release Authorization (Page 14)

___ MEDICAL INSURANCE CARD COPY (FRONT AND BACK)

When you come to campus, please bring significant medical records, MRI films, etc.

Please return by mail to:

Athletic Medicine
San Diego State University
5500 Campanile Dr.
San Diego, CA 92182-4313

Or fax to:

(619) 594-7654

SAN DIEGO STATE
ATHLETIC TRAINING

PARENTAL CONSENT TO MEDICAL TREATMENT FOR A MINOR

_____ _____
Student's Name (printed) and **Date of birth** **Red ID Number**

Please choose and option below and sign:

☐ I hereby authorize San Diego State University Student Health Services (SDSU SHS) to provide my minor (less that 18 years of age) son or daughter 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 of any specific diagnosis or treatment that may be required.

_____ _____
Parent/Guardian Name (print) Signature or 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 title and employer [for example, Director of 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 of any specific diagnosis or treatment that may be required.

_____ _____
Parent/Guardian Name (print) Signature or Parent/Guardian

FOR STUDENT HEALTH SERVICES USE ONLY

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

_____ ( )_____
Name Area Code Phone Number

Relationship to student: Parent Legal Guardian

Date: _____ Time:_____ am/pm

_____ _____
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 box at 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 □ A heart murmur □ High cholesterol □ A heart infection	□	□
10. Has a doctor ever ordered a test for your heart (ECG, echocardiogram, etc)?	□	□
11. Has anyone in your family died for no apparent reason?	□	□
12. Does anyone in your family have a heart problem?	□	□
13. Has any family member or relative died of heart problems or sudden death before age 50?	□	□
14. Does anyone in your family have Marfan syndrome?	□	□
15. Have you ever spent the night in the hospital?	□	□
16. Have you ever had surgery? On what?	□	□

17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitits, that caused you to miss practice or game?	□	□
18. Have you ever had any broken or fractured bones or dislocated joints?	□	□
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, crutches?	□	□
If you have answered YES to any of the above questions please complete the Musculoskeletal History Section- Page 4		

20. Have you ever had a stress fracture?	□	□
21. Have you ever been told you have or have had an x-ray for atlantoaxial (neck) instability?	□	□
22. Do you regularly use a brace or an assistive device?	□	□
23. Has a doctor ever told you that you have asthma or have you ever been given an inhaler?	□	□
24. Is there anyone in your family who has asthma?	□	□
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	□	□
26. Do you currently use an inhaler or take Asthma medicine?	□	□
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	□	□
28. Have you had infectious mononucleosis (mono) within the last month?	□	□
29. Do you have any rashes, pressure sores or other skin problems?	□	□

30. Have you ever had a herpes skin infection? ☐ ☐
31. Have you ever had a head injury or concussion? ☐ ☐
    If so, when was your last one? ___ How many have you had? ___ Current problem? ___
32. Have you been hit in the head and been confused or lost your memory? ☐ ☐
33. Have you ever had a seizure? ☐ ☐
34. Do you have headaches with exercise? ☐ ☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after a hit or fall? ☐ ☐
36. Have you ever been unable to move your arms or legs after being hit or falling? ☐ ☐
37. When exercising in the heat, do you have muscle cramps or become ill? ☐ ☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ☐ ☐
39. Have you ever had any problems with eyes/vision? ☐ ☐
40. Do you wear glasses or contact lenses? ☐ ☐
41. Do you wear protective eyewear, such as goggles or a face shield? ☐ ☐
42. Are you happy with your weight? ☐ ☐
43. Are you trying to gain or lose weight? ☐ ☐
44. Has anyone recommend you change your weight or eating habits? ☐ ☐
45. Do you limit or carefully control what you eat? ☐ ☐
46. Do you have any concerns that you would like to discuss with a doctor? ☐ ☐

FEMALES ONLY:

47. Have you ever had a menstrual period? ☐ ☐
48. How old were you when you had your 1st period_____
49. How many periods have you had in the last 12 months_____

Please explain YES answers:

_____

_____

_____

_____

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)

SAN DIEGO STATE
ATHLETIC TRAINING

Please check a response for each of the following: I…

	Always	Usually	Often	Sometimes	Rarely	Never	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							

1. 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? _____
2. Have you ever made yourself sick (vomited) to control your weight or shape?
   NO_____ YES_____ How many times in the last 6 months? _____
3. 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? _____
4. Have you ever been treated for an eating disorder?
   NO_____ YES_____ How many times in the last 6 months? _____
5. Have you ever been diagnosed as having an eating disorder (anorexia, bulimia, or both?)
   NO_____ YES_____

Please list your:

Highest weight_____, Lowest weight _____, Goal weight _____

Athlete name: _____Athlete Signature: _____Date: _____

SAN DIEGO STATE
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Musculoskeletal History Section:

Please list fractures, sprains, strains, dislocations, cartilage injuries, etc.
If you need more room use lines at 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)

SAN DIEGO STATE
ATHLETIC TRAINING

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 you 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 Training 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 Physician

Current Treating Physician (print name):_____Specialty:_____

Office Address:_____

Physicians Signature:_____Date:_____

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

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

Attach written report summary of 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 clinical 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 preformed, 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.

SAN DIEGO STATE
ATHLETIC TRAINING

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.

SAN DIEGO STATE
ATHLETIC TRAINING

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 (HIPPA) or the Family Educational Rights and Privacy (FERPA) Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPPA 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 form 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 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)

SAN DIEGO STATE
ATHLETIC TRAINING

Intercollegiate Athletic Accident Policy

SDSU, like most NCAA Athletic Departments, provide 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 policy holder (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:

Nora Dawson
San Diego State University
Department of Intercollegiate Athletics
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 Nora Dawson 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 supervises 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)

Parents of student-athletes under the age of 18 – please sign below

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.

Parent Name: _____ Parent Signature: _____ Date: _____

SAN DIEGO STATE
ATHLETIC TRAINING

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_____

Attach copy of insurance card ******INSURANCE INFORMATION****** **Attach copy of insurance card**

PRIMARY Insurance Company_____

Policy Holder Name, DOB and SS#_____

Policy Holder Employee and Employer's address_____

Group # _____Policy # _____

Phone # _____Fax #_____
Billing Address (Street, City, State, Zip Code)

HMO (Y or N) PPO (Y or N) Military (Y or N)
Insurance covers prescriptions (Y or N)

DENTAL Insurance Company_____

Policy Holder Name, DOB and SS#_____

Policy Holder Employee and Employer's address____

Group #_____Policy # _____

Phone #_____Fax #_____
Billing Address (Street, City, State, Zip Code)

HMO (Y or N) PPO (Y or N) Military (Y or N)
Insurance covers prescriptions (Y or 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: _____

I hereby grant permission to the Physicians in the Athletic Medicine Department and Student Health Services at SDSU and those professional personal designated by them to treat me or my son/daughter in the event of any injury of 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: _____

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 University
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 PROVDER; 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 _____