Eastern University Department of Intercollegiate Athletics
Responsibilities of the Student-Athlete Participant

To be eligible, the student-athlete participant must fulfill the following requirements:

1) Complete a pre-participation medical examination administered by a licensed health care provider (MD, DO, PA, or CNP) and complete all insurance and medical history information forms.
   ***(These must be handed in prior to participation !!!!!! No exceptions !!!!!!)***
2) Prior to participating in any intercollegiate sports activity, the student-athlete must disclose full information concerning illnesses and injuries sustained prior to matriculation at Eastern University to the examining physician, team physician(s), or athletic trainer(s).
3) The student-athlete must report all injuries sustained in the course of university athletic activities as defined above, or otherwise, at the time of their occurrence to an athletic trainer or a coach.
4) The student-athlete must report to a Health Services physician, Hospital, or Sports Medicine Clinic as directed by the athletic trainer or supervisor in 2) above.
5) The student-athlete agrees to look solely to the benefits provided and described in this statement after all other insurance coverage maintained by the student-athlete is exhausted.
6) The student-athlete and policyholder must sign this document to signify that he/she has read and understood the terms and conditions under which he/she will be permitted to participate in intercollegiate athletic activities at Eastern University.

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<th>Print Student-Athlete’s Name</th>
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**PLEASE NOTE:**

Your signatures must appear where indicated on all the forms.
Send all forms to the address listed under the Parent Information Sheet (next page).

Please contact the Athletic Training Services Office at (610)341-1316 with any questions. Thank you for your cooperation. We are looking forward to a healthy and successful year!
PARENT INFORMATION FORM

Parent/Guardian to complete. Return all forms to:

Eastern University Athletic Department
1300 Eagle Road
St. David’s, PA  19087
ATTN:  John Post, MBA, LAT, ATC

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: ______________________ Sport: ______________________
   Social Security #:_________________ Date of Birth: ________________
   College Address: ___________________ Cell Phone: (___)______________
   City: ___________________ State: _________ Zip: ________________
   Home Address: ___________________ Home Phone: (___)______________
   City: ___________________ State: _________ Zip: ________________

II. Father/Guardian: _______________ Mother/Guardian: _______________
    Date of Birth: _______________ Date of Birth: _______________
    Address: ___________________ Address: ___________________ 
    City: ___________________ City: ___________________
    State: _________ Zip: __________ State: _________ Zip: __________
    Phone: (___)______________ Phone: (___)______________

III. Employer: ______________________ Employer: ______________________
     Address: ___________________ Address: ___________________
     City: ___________________ City: ___________________
     State: _________ Zip: __________ State: _________ Zip: __________
     Phone: (___)______________ Phone: (___)______________

_______ We/I have elected to **purchase** the Eastern University Student Health Plan as the primary insurance for our/my son/daughter and will not keep him/her under our family plan (please go to Section V). **(Recommended for all, especially if out-of-state.)**

_______ We/I have elected to **waive** the Eastern University Student Health Plan and will remain under our/my family plan as the primary insurance for our/my son/daughter (please fill out information on next page). Make sure you waive the Eastern University Student Health Plan

_______ We/I have elected to **remain** under our/my family plan as the primary insurance for our/my son/daughter but have also purchased the Eastern University Student Health Plan as the secondary insurance for costs not covered by our/my family plan (please fill out information on next page).
IV. Insurance Company Name: ___________________________________________
Address: ___________________________________________________________________
Policy Holder: _______________________________________________________________
Policy #: ___________________________ Group #: ___________________________
I.D. #: ___________________________ Phone #: ___________________________
Effective Date of Policy: ___________________ Expiration Date: ___________________
Policy Limit: _______________ Deductible: _______________ Co-Pay: __________

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)?
HMO: Yes _____  No _____  If yes, you must fill in physician information below:
PPO: Yes _____  No _____  If yes, you must fill in physician information below:

Primary Physician: _____________________________________________
Address: ______________________________ Phone: ________________
____________________________ Fax: ________________
City: ___________________________ State: ________ Zip: ________

Does your policy require a referral from your primary physician? Yes ____ No ____
Does your policy require pre-authorization for specialty care? Yes ____ No ____
Does your policy require a second opinion before surgery? Yes ____ No ____
Does your policy cover athletically related injuries? Yes ____ No ____

V. We/I understand my son/daughter must have personal accidental/medical insurance coverage to be eligible to participate in intercollegiate athletics at Eastern University and attest that my son/daughter has a current, in-force policy for all injuries that occur while he/she is participating in intercollegiate athletics at Eastern University. Also, we/I agree to notify Eastern University of any material change in coverage in order to update all coverage files immediately.

We/I hereby authorize Eastern University to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We/I understand and agree that Eastern University or its insurance agency, BMI Benefits, LLC., will assume no responsibility whatsoever for the payment of medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Eastern University if procedures set forth by the primary and secondary carriers are not followed as required.

______________________________________________ Date
Parent/Guardian/Father Signature

______________________________________________ Date
Parent/Guardian/Mother Signature

______________________________________________ Date
Student-Athlete Signature
TO: Eastern University Student-Athletes and Their Parents
FR: The Athletic Training Services Program and Department of Athletics
DT: May 2017
RE: Insurance Verification for 2017-2018 Academic Year as per NCAA Requirements

Please note, all Eastern University student-athletes must provide evidence of insurance that includes coverage for athletically related injuries. This is a pre-requisite for all practices and competitions. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the Eastern University Department of Athletics. The enclosed “Acknowledgement of Insurance Requirements” form and an insurance card (photocopy of both sides) must be on file before a student-athlete can participate in his or her sport.

Insurance coverage must have a limit of at least $90,000 and cover athletically related injuries. If your insurance does not meet these requirements, Eastern University will review the individual circumstances to determine if the insurance meets the coverage requirements.

Eastern University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Eastern University.

If you have questions regarding the terms of your insurance coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions to your policy regarding athletically related injuries, particularly out-of-network benefits.

The NCAA Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all terms and conditions). The policy has a $90,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Eastern University. It is supplemental coverage in the event of a catastrophic injury. More information on this program may be found on the NCAA’s web site at www.ncaa.org.

**NOTE - this form here is not the Eastern University Health Insurance Waiver**
(All students must either waive or enroll in the general Eastern University medical insurance plan prior to Sept. 15th annually. Go to www.FirstStudent.com to waive. Failure to waive this insurance will result in automatic enrollment with no refund.)

If you have any questions regarding this requirement, please contact us at your convenience at (610) 341-1736 or (610) 341-1316.
ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

I, __________________________, as parent, guardian or legal representative, attest that __________________________ has insurance coverage under a current, in-force insurance policy for all injuries that occur while he/she is participating in intercollegiate athletics at Eastern University.

If there is a material change in coverage or expiration of coverage, I agree to notify Eastern University of this development and update the insurance information I have on file with Eastern University immediately.

I understand and agree that Eastern University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Eastern University.

_______________________________________________
(signature)                                             (date)

THIS FORM MUST BE SIGNED AND RETURNED TO THE EASTERN UNIVERSITY DEPARTMENT OF ATHLETICS PRIOR TO THE START OF YOUR SON’S/DAUGHTER’S SPORT SEASON.

Return to:

Eastern University
Department of Athletics
1300 Eagle Road
St. Davids, PA  19087-3696
ATTN:  John Post, MBA, LAT, ATC

Or send via FAX:  610-341-1317
EASTERN UNIVERSITY
INSURANCE INFORMATION VERIFICATION FORM

Name: ____________________________________________________________________________

Date of Birth: ___________________________  Sport: ___________________________

SSN: ___________________________  Year: ___________________________

The Acknowledgement of Insurance Requirements must be read and understood and this form completed PRIOR to the student-athlete participating in practice and/or competition.

Parent/Guardian Name(s): __________________________________________________________________

Home Address: ____________________________________________________________________________

Home Phone: ___________________________  Work Phone: ___________________________

Cell Phone: ___________________________  Work Phone: ___________________________

Policy Holder Name: ___________________________  DOB: ___________________________

Relationship to Student-Athlete: __________________________________________________________________

Address: ____________________________________________________________________________

Home Phone: ___________________________  Work Phone: ___________________________

Insurance Company Name: __________________________________________________________________

Address: ____________________________________________________________________________

Group#: ___________________________  I.D.#: ___________________________

Phone: ___________________________

Effective Date of Policy: ___________________________  Expiration Date: ___________________________

Policy Limit: ___________________________  Policy Co-Pay: ___________________________

Policy Deductible: ___________________________

Primary Physician: ____________________________________________________________________________

Address: ____________________________________________________________________________

Office Phone: ___________________________  Office Fax: ___________________________

Does your policy cover athletically related injuries? __________________________________________________________________

Does your policy require a second opinion before surgery? __________________________________________________________________

Does your policy require a referral from your primary physician? __________________________________________________________________

DID YOU WAIVE THE EASTERN UNIVERSITY STUDENT HEALTH POLICY?
MAKE SURE YOU DID IF YOU DO NOT WANT IT!
(See Page 4!)
MEDICAL HISTORY FORM

Medical History & Injury Questionnaire – to be filled out by student-athlete

Personal Injury History
Please take your time and complete each area carefully and accurately. Your description of each injury should be in as much detail as possible. Include dates, if possible, and the exact diagnosis by the physician. If you are unsure, please consult the treating physician. List any surgical procedure performed.

1. History of Concussions? ___ Yes ___ No
   Dates: _____________________________
      If Yes, were you hospitalized? ___ Yes ___ No
      Have you ever loss consciousness? ___ Yes ___ No
      Have you experienced any amnesia? ___ Yes ___ No
      Time loss before returning to play? ___ Yes ___ No
         If Yes, how long? ______________________________

   Details:

   Details:

4. Pinched Nerves? ___ Yes ___ No Dates: _____________________________
   Details:

5. Shoulder Injury? ___ Yes ___ No Dates: _____________________________
   Details:

   Details:

7. Wrist/Forearm Injury? ___ Yes ___ No Dates: _____________________________
   Details:

8. Hand/Finger Injury? ___ Yes ___ No Dates: _____________________________
   Details:

9. Hip/Thigh Injury? ___ Yes ___ No Dates: _____________________________
   Details:
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<th>Yes</th>
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<td>10. Knee Injury?</td>
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<td>11. Lower Leg/Shin?</td>
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<td>12. Ankle Injury?</td>
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<td>13. Foot/Toe Injury?</td>
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<td>14. Fractures?</td>
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<td>15. Non-Orthopedic Problems or Surgeries?</td>
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<td>16. Have you ever had a Cortisone Injection?</td>
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<td>17. Have you ever been advised or told that</td>
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<td>you should not compete in a sport because of</td>
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<td>a medical condition?</td>
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1) It is my responsibility to consult with a licensed/certified athletic trainer before taking **ANY** medication (prescription and/or over-the-counter) or nutritional supplement to be certain it is not banned by the NCAA.  
2) Failure to do so risks loss of NCAA-and/or Eastern University eligibility.  
3) It is my responsibility to update this form as it becomes necessary.  
4) I certify that the medical history/injury history information I have provided above is complete and accurate to the best of my knowledge. I understand the information given may be relied on to determine my fitness and ability to participate in an athletic environment.

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**Signature of Student-Athlete**

**Date**
I, an Eastern University Student-Athlete:

A) Understand that injuries are an inherent part of athletics and that participation in sport requires an acceptance of risk of injury.

B) Understand that I must refrain from practice or play while ill or injured until cleared by appropriate medical practitioners (physicians) and/or their designated representatives (certified athletic trainers) whether receiving medical treatments or not.

C) Understand that having passed the physical examination does not necessarily mean that I am physically qualified to participate in athletics, but only that the evaluator did not find a medical reason for disqualification from participation.

D) Certify that the answers to the questions above are correct and true.

_____________________________________________________________________________________
Signature of Student-Athlete                                         Date
_____________________________________________________________________________________

All forms reviewed by: _____________________________________________
Certified/Licensed Athletic Trainer Signature    Date

Team Physician’s Signature    Date

This entire packet must be completed and returned to the Department of Athletics by:
August 1 (Fall Sports) or August 15 (Winter/Spring Sports)