Medical Policies and Procedures

The following is a summary of the ASU medical policies and procedures for student-athletes. Each student-athlete will adhere to the policies and procedures throughout their athletic tenure. We hope this summary will answer some of the questions concerning the health care provided for your son or daughter and the financial responsibility of the ASU athletic department, the student-athlete, and their parent/guardian.

A. Pre-season Physical Examinations:

All student-athletes must undergo a complete physical examination each year prior to participation or practice with any athletic team. A student-athlete will NOT be allowed to participate in any scheduled practices, scrimmages, or competition until the physical examination has been completed. The examination will be conducted by the ASU team physician at a site, date, and time determined by the Head Athletic Trainer after consultation with the head coach.

1. Any student-athlete who desires to participate in any sport (i.e. walk-on, etc.) who does not complete a physical examination scheduled by the athletic department must perform the following BEFORE permission to participate will be granted.
   a. Obtain a physical examination form from the Head Athletic Trainer or angelosports.com web site.
   b. Schedule an appointment with a physician (not a chiropractor) to complete the physical.
   c. Walk-ons joining the athletic teams after the start of the regular season will be required to pay for their own physical.
   d. Return the physical form to the Head Athletic Trainer.
   e. If the student-athlete has had surgery within the last 8 months, a written release from the surgeon is required before practice can begin.
   f. Complete all other necessary forms as assigned by the athletic department.

B. Previous Injury or Illness:

1. If during the pre-season physical examination any previous injury, defect, or illness is discovered, the student-athlete will NOT be permitted to participate in activity until cleared by the ASU team physician. The ASU team physician has the final authority in determining if the student-athlete is physically fit to participate in athletics at ASU.

2. The ASU athletic department will NOT be responsible for or pay the cost to repair any injury incurred prior to reporting for any athletic program on the date set by the head coach. All medical tests and referrals that must be completed by the student-athlete as a result of a previous injury, defect, or illness after the initial physical examination will be the financial responsibility of the student-athlete and the parent/guardian.

C. Dental Policy

1. ASU will only pay for dental injuries incurred during supervised practices, scrimmages, or scheduled athletic competitions. This includes dental injuries to sound teeth, bridges, plates, and partial plates. ASU will NOT pay for normal dental work such as dental cavities, crowns to repair decayed teeth, or orthodontic work. It is the responsibility of the student-athlete and the parent/guardian to pay for these expenses.

2. The NCAA has a mandatory rule that all football players wear a mouthpiece. Mouthpieces will be provided by the Head Athletic Trainer. Football players are advised and instructed to wear a mouthpiece when engaging in practice and competition. Any dental injuries that occur when

the football player is NOT wearing a mouthpiece will be the financial responsibility of the student-athlete and the parent/guardian.

D. Contact Lens Policy

1. All student-athletes who wear contact lenses must register them with the Head Athletic Trainer. ASU will ONLY pay for the lost or damaged contact lenses incurred during scheduled practices, scrimmages, or competition. A copy of the student-athlete's prescription must be on file before replacement is accepted. Please complete the Optometrist information on form 2 for your son or daughter.

E. Second Medical Opinion Policy

1. All student-athletes who require further medical attention will be referred to a physician by the Head Athletic Trainer. ASU will adhere to the request of a student-athlete to obtain a second opinion. However, the physician giving the second opinion must be approved by the Head Athletic Trainer. If the student-athlete chooses to obtain any further medical opinions, the ASU athletic department cannot deny the request, but it is the financial responsibility of the student-athlete and their parent/guardian to pay for ALL expenses incurred by that opinion (i.e., office visit, X-ray, MRI, CT scan, hospital, lab tests, etc.)
2. The ASU team physicians or designated physician have the final authority in determining the participation status of the student-athlete. The option to seek a second medical opinion for the student-athlete is authorized ONLY for the determination of injury severity and insurance requirement, NOT participation status. The ASU team physicians or designated physician have the right to withhold a student-athlete from competition or practice based upon the best interest of the student athlete and status of the injury. A second medical opinion WILL NOT clear a student-athlete for participation.

F. Payment of Medical Expenses

1. ASU will pay for the cost of treatment for all athletic injuries incurred in official practices, scrimmages, or scheduled competition for a period of twelve (12) months following the date of injury.
2. ASU will NOT assume any financial responsibility for treatment of injuries incurred while participating in activities not associated with the student-athlete's sport. This includes, but is NOT limited to recreational activities, intramural activities, summer activities or during the summer, injuries incurred between semesters or semester breaks, or any injury occurring on personal time.
3. ASU will pay ONLY for medical expenses for injuries that have been reported to, and channeled through the Head Athletic Trainer. If a student-athlete does NOT inform the athletic training staff of an injury and goes to a physician, the financial responsibility is incurred by the student-athlete and parent/guardian.
4. ASU will pay ONLY for physical or occupational therapy services that have been channeled through the Head Athletic Trainer and upon written prescription by the ASU team physicians or designated physician. Rehabilitation is to be performed in the ASU athletic training room for ALL athletic injuries incurred during scheduled practices, scrimmages, or competition. If a student-athlete chooses to seek therapy services through a private rehabilitation facility, the financial responsibility is incurred by the student-athlete and the parent/guardian.
5. ASU will NOT assume any financial responsibility for illnesses unless related to scheduled practices, scrimmages, or competition. The NCAA regulates financial situations for illnesses and restricts payment of such expenses.

Athletic Insurance Information

Form 1

Athlete's Name_____ Date of Birth_____

Home Address_____City_____ State_____ Zip_____

ASU Address_____

Home Phone_____ASU Phone (Cell):_____

Social Security Number_____ Sport_____

Father'sName_____Home(Cell)Phone_____

Address_____City_____ State_____ Zip_____

Social Security Number_____Father's DOB:_____

Name of Employer_____Employer's Phone_____

Employer's Address_____City_____ State_____Zip_____

Mother's Name_____Home(Cell)Phone_____

Address_____City_____ State_____ Zip_____

Social Security Number_____Mother's DOB:_____

Name of Employer_____Employer's Phone_____

Employer's Address_____City_____ State_____Zip_____

Name of Insurance Company_____Phone_____

Name of Policy Holder_____Policy Number_____

Deductible Amount_____Group Number_____

Claims Mailing Address_____

City_____State_____Zip_____

Is athlete Married?	Yes	No
Is a second surgical opinion required?	Yes	No
Pre-Authorization for services?	Yes	No
Is your Primary insurance an HMO/PPO?	Yes	No

Affidavit of Insurance

Form 2

This form must be completed, signed and returned to the athletic department before ANY student-athlete will be allowed to participate in any practice or activity at ASU. Please check the response appropriate for your son or daughter.

_____ I do hereby authorize the athletic department to utilize my/our insurance policy on Form 2 and assign the university or designated entity (physician, hospital, etc.) the payment of benefit under this plan.

_____ My/our son or daughter is NOT covered by my personal medical insurance. Please send me more information on the Student Health Insurance Policy.

_____ I/We have no medical insurance or any type of accident and health plan under which my/our son or daughter is covered.

_____ _____

Date Signature of Parent/Guardian

***Do you have a policy to cover dental work for your son or daughter?**

Yes_____ No_____

If yes, please provide the policy number and company if different from your health insurance.

Name of Insurance Company_____

Policy Holder_____

Policy Number_____

Address_____

City/State/Zip_____

Phone_____

Deductible/Co-pay_____

***Do you have a policy to cover glasses or contact lenses for your son or daughter?**

Yes_____ No_____

If yes, please provide the policy number and company if different from your health insurance.

Name of Insurance Company_____

Policy Holder_____

Policy Number_____

Address_____

City/State/Zip_____

Phone_____

Deductible/Co-pay_____

Primary Care Physician/Optometrist Information

Form 3

Please complete the following if your health insurance company requires a referral from your primary care physician.

Name of Primary Care Physician_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Please complete the following as ASU requires a copy of the student-athlete's prescription to be on file to replace contact lenses of glasses that are lost or damaged during practice, scrimmages, or competition. If your optometrist will not provide you with a prescription, ASU will contact your physician to obtain a copy.

Name of Optometrist_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Assumption of Risk Statement

This is a warning to the student—athlete and parent/guardian of the risk your son/daughter takes while participating in athletics at ASU. By participating in any athletics at ASU a student-athlete can sustain any one of the following injuries. This forewarning and a nonexclusive list of injuries are given to make you aware of the inherent dangers and risks involved while participating in athletics.

1. Head injuries - can result in coma, brain damage, and/or death.
2. Spine injuries - can result in quadriplegia, paraplegia, and/or death.
3. Strains – completely torn, partially torn, and/or stretched muscles or tendons.
4. Sprains – completely torn, partially torn, and/or stretched ligaments.
5. Contusion.
6. Laceration, abrasion, and other flesh wounds which can result in infection.
7. Internal organ damage - such as a ruptured spleen or kidney, etc.
8. Loss of limb or vital organ of the body.
9. Cartilage damage in the joints of the body.

There are other injuries/illnesses that are not included in this list. The undersigned acknowledge this forewarning and its purpose of making the student-athlete and parent/guardian aware of the seriousness of possible injuries that occur to you the undersigned and son or daughter of the undersigned while participating in athletics at ASU.

_____ _____

Date Signature of Student-Athlete

_____ _____

Date Signature of Both Parents/Guardian

Permission for Treatment Consent

Form 4

I understand that a pre-season physical is given for no other purpose than to clear me for athletic participation at ASU. I understand it is not a physical for illnesses which may be developing or might develop in the future. I further agree that such illnesses will be taken to the student health service, personal physician, or athletic trainer for referral and care. I give authorization to the athletic trainer or team physician to evaluate and treat any injuries that occur during my athletic tenure at ASU. This includes immediate first aid and treatment, X-ray, orthopedic or physical exam, follow-up care, and rehabilitation. I understand the team physician has the authority to eliminate me from further participation because of any injury and/or an undue risk to other athletes and ASU.

_____ _____

Date Signature of Student-Athlete

Authorization to Release Medical Information

This form must be signed and returned to the athletic department before ANY student-athlete will be allowed to participate in any practice or activity at ASU.

1. We/I hereby authorize any insurance, hospital, physician, or other persons who have attended or examined the undersigned student-athlete to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescriptions, treatment and copies of all hospital and medical records.

2. We/I hereby authorize the ASU athletic training staff to release information concerning previous injuries and medical conditions to the news media representatives, professional scouts, and insurance company representatives for claim processing.

3. We/I hereby authorize the ASU athletic training staff, team physician, or designated physician to secure medical services that are in the best interest of our son or daughter.

By our/my signature, we/I agree with all statements outlined in the medical, dental, contact lens, second opinion policies, and payment of expenses and certify that all information is true and correct to the best of our/my knowledge. We/I do hereby affirm that we/I have received a copy of the ASU medical policies and procedures and acknowledge that we/I are/am familiar with them as set forth within. A photocopy of all documents in the policy will be considered as effective and valid as the original.

_____ _____

Date Signature of Student-Athlete

_____ _____

Date Signature of Both Parents/Guardian

Copy of Parent/Student Athletic Insurance Card

Form 5

Please include a CURRENT copy of your insurance card for purposes of verification. The hospital now requires all individuals to show proof of insurance. All athletes who have a copy available to them at the time of injury, would benefit by receiving services without a delay in treatment.

Please attach a legible copy of BOTH the FRONT and BACK of the insurance card to the packet of insurance papers.

ADD/ADHD Documentation Required by the NCAA

Form 6

Must Circle One

Is your son/daughter currently being treated and taking medication for ADD/ADHD? **YES NO**

If you son or daughter has been diagnosed with ADD/ADHD and is currently taking medication, the NCAA is requiring certain documents to be kept on record in their confidential medical file. These documents must be included with the insurance packet when returned to ASU:

1. Record of student-athlete's evaluation by diagnosing physician.
2. Statement of the Diagnosis, including when it was confirmed.
3. Copy of most recent prescription (as documented by the prescribing physician).
4. History of ADD/ADHD treatment (previous/ongoing).
5.

Division II Sickle Cell Testing Requirements

Form 7

Sickle Cell is not a disease. Sickle Cell Trait is an inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle Cell Trait will not turn into a disease. Beginning August 2012, Division II is requiring certain information be obtained from the student athlete prior to any practice sessions being performed. As an ASU student athlete, one of the following items must be provided to the ASU sports medicine staff prior to any practice and/or competition involvement.

1. Demonstrate proof of a prior sickle cell test.
2. Have a sickle cell test performed prior to the first practice.

Acknowledgement

I/We have read and understand the insurance procedures at Angelo State University listed within the preceding packet, including pre-season physical examination procedures, previous injury or illness procedures, dental policy, contact lens policy, second medical opinion policy, and payment of medical expenses. Also, I/We have completed all sections of the insurance packet, including FORMS 1-7. I/We understand that missing or incomplete information may cause a delay in treatment of myself and/or our son/daughter. Non-compliance with the procedures listed within and set forth by the athletic training staff may cause myself and/or parent/guardian to be responsible for the full financial amount of injury related expenses.

Name of Student Athlete (Printed)_____

Signature of Student Athlete_____

Name of Parent/Guardian (Printed)_____

Signature of Parent/Guardian_____

Date_____

Student Activity Release Form

I, _____ , understand and agree that university-related activities of Angelo State University involve certain known risks, including but not limited to, transportation accidents, personal injuries, and loss or destruction of my property. I understand and agree that Angelo State University cannot be expected to control all of said risks. In consideration of the benefits I will receive through my participation in the activities of Angelo State University, I hereby expressly and knowingly **RELEASE ANGELO STATE UNIVERSITY, ITS OFFICERS, AGENTS, VOLUNTEERS, AND EMPLOYEES FROM ANY AND ALL CLAIMS AND CAUSES OF ACTION I MAY HAVE FOR PROPERTY DAMAGE, PERSONAL INJURY OR DEATH SUSTAINED BY ME ARISING OUT OF ANY TRAVEL OR ACTIVITY CONDUCTED BY, OR UNDER THE AUSPICES OF ANGELO STATE UNIVERSITY, WHETHER CAUSED BY** MY OWN NEGLIGENCE OR THE NEGLIGENCE OF ANGELO STATE UNIVERSITY, ITS OFFICERS, AGENTS, VOLUNTEERS, OR EMPLOYEES.

I hereby give my consent for any medical treatment that may be required during my participation with the understanding that the cost of any such treatment will be my responsibility.

Further, I voluntarily and knowingly agree to HOLD HARMLESS, PROTECT, AND INDEMNIFY Angelo State University, its officers, agents, volunteers, and employees, against and from any and all claims, demands, or causes of action for property damage, personal injury or death, including defense costs and attorney's fees, arising out of my participation in the activities of Angelo State University, REGARDLESS OF WHETHER SUCH DAMAGES, INJURY OR DEATH ARE CAUSED BY MY OWN NEGLIGENCE, OR BY THE NEGLIGENCE OF ANGELO STATE UNIVERSITY, ITS OFFICERS, AGENTS, VOLUNTEERS, OR EMPLOYEES.

Angelo State University shall notify me promptly in writing of any claim or action brought against it in connection with my participation in these activities. Upon such notification, I, or my representative, shall promptly take over and defend any such claim or action.

I HAVE READ AND UNDERSTOOD THIS DOCUMENT, AND MY SIGNATURE EVIDENCES MY INTENT TO BE BOUND BY ITS TERMS.

SIGNATURE: _____ DATE: _____
(PARTICIPANT)

If the participant is under 18, I am signing as a parent or guardian to reflect my agreement to indemnify (that is, protect by payment or reimbursement) Angelo State University from any claim which may be brought by or on behalf of the participant, or any member of the participant's family, for injury or loss resulting from those inherent risks of the course, described above, and from the negligence of the participant or Angelo State University.

SIGNATURE: _____ DATE: _____
(PARENT OR GUARDIAN)

Memorandum of Understanding

This Agreement, executed on the 1st day of August, 2012, by and between ASU Cheerleader's (Cheer) and ASU Athletic Training (AT):

Now Therefore, ASU Cheer and ASU AT agree as follows:

AS it respects to ASU AT, ASU Cheer will:

A. Report any injuries to the Head Athletic Trainer within a 24 hr period, if the injury is not an emergency.
B. Any injury that is an emergency and requires immediate transportation and visitation to the emergency room, the cheer sponsor will contact the Head Athletic Trainer immediately after activating the EMS.
C. If the student athlete is suspected of having a concussion, the student athlete will be removed from competition and/or practice and will need to report the injury to the Head Athletic Trainer so the Concussion Assessment Policy will be followed appropriately.
D. Follow policies set forth in Sports Medicine Policies and Procedures manual including current Insurance Policies.
E. Follow Concussion Assessment Policy which includes initial baseline ImPact Testing and post concussion ImPact Testing.
F. Send a new roster of cheerleaders when a member is added or deleted from the squad list.

AS it respects to ASU Cheer, ASU AT will:

A. Provide athletic training services during normal athletic training operating hours.
B. Schedule physician appointments for non-life threatening emergencies after an initial evaluation.
C. Provide supplies to the cheer sponsor as needed.
D. Provide Baseline and Post Concussion ImPact Testing.

Both parties agree on understanding as of day and year stated above:

ASU Cheerleading:
By:
Name/Title:
Date:

ASU Athletic Training
By:
Name/Title:
Date: