








Dear prospective TNU athlete,

Welcome to Trevecca Nazarene University! Our sports medicine staff looks forward to working with you and assisting you during your athletic participation at TNU. Our goal as a sports medicine department is to provide quality healthcare using a well-balanced approach to the overall wellness of each student-athlete. This interactive journey begins with paperwork, paperwork, paperwork...

Before you are cleared to participate as a TNU athlete, **WE REQUIRE** you to complete the following:

-  Completely fill out & sign **each** of the 7 documents (10 pages) that are enclosed in this packet
-  Secure from your Primary Insurance Co an “Enrollment Letter” verifying your coverage effective dates; listing the Beginning and Ending Term dates. You can either call the customer service number on the back of your insurance card or go to your online account and print it off
-  Submit a photo-copy (front & back) of your health insurance card
-  Get a pre-participation physical by a licensed physician *prior* to arriving on campus (including bloodwork listed on physical form)
-  Obtain all previous medical history records

- (1) These documents should be completed & signed before submitting them back to us. We should receive the completed packet no later than 4 weeks before you arrive on campus.
- (2) We will review the medical information packet for satisfactory completion. You will be notified and any omitted information requested must be faxed back to TNU’s Sports Medicine Dept. at 615-425-3816 before your arrival.
- (3) Lastly, upon your arrival on campus, you will need an orthopedic screening exam performed by our team physician.

****REMINDERS****

**** YOU WILL NOT BE ALLOWED TO PARTICIPATE IN ANY TEAM SANCTIONED ACTIVITIES (i.e. CONDITIONING, PRACTICES, GAMES, etc.) UNTIL YOUR ATHLETIC TRAINER HAS RECEIVED AND APPROVED EACH COMPLETED DOCUMENT. EACH TEAM WILL BE GIVEN A DEADLINE TO HAVE THE PACKET TURNED IN. FOR EACH DAY IT IS LATE, YOU WILL BE PENALIZED 1 DAY OF MISSING PRACTICE.****

**** YOU ARE RESPONSIBLE FOR GETTING ANY AND ALL MEDICAL HISTORY RECORDS FOR ALL PREVIOUS ILLNESSES AND INJURIES SUSTAINED PRIOR TO ARRIVING ON TNU’S CAMPUS. YOU MUST GET THESE RECORDS TO US BEFORE YOU WILL BE ALLOWED TO PARTICIPATE IN ANY TEAM SANCTIONED ACTIVITY.****

If you have any questions or concerns, please do not hesitate to call us at (615) 248-7734 or e-mail me at jwhite@trevecca.edu. Again, we look forward to providing you with any and all necessary assistance during your time here at Trevecca Nazarene University. Thank you and Go Trojans!

Check List

- Athlete Info Page
- HIPAA Medical Release Signed, Witnessed, & Dated
- Athletic Health Insurance Info Signed & Dated
- Copy of Front & Back of Insurance Card
- Enrollment Letter from your Insurance Company
- Athletic Care Policy Signed & Dated
- Media Release Signed & Dated
- Personal Representative Appointment Signed & Dated
- Wavier if you are a Walk-On



2011-2012 ATHLETE INFO PAGE

(Please Print)

FULL LEGAL NAME

First

Middle

Last

FIRST NAME YOU GO BY

SPORT










Mens

Womens

COACH'S NAME

YOUR CELL NUMBER

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ATHLETE HEALTH INSURANCE INFORMATION FOR THE 2011-2012 SCHOOL YEAR

Athlete's Legal Name: _____
(first) (middle) (last) (nickname)

Athlete's Home Address: _____
(street) (city) (state) (zip)

Athlete's Cell Number: () _____ Athlete's Home Phone: () _____

Athlete's Social Security: # _____ - _____ - _____ Athlete's date of birth: _____ / _____ / _____

Athlete's Gender: Male () Female () Sport: _____

Complete Name of Insurance Company: _____

Does your insurance have Drug/Prescription Coverage? Yes ___ No ___

Does your insurance have Dental Coverage?

Does your Primary Insurance require you to use a Network Provider? Yes ___ No ___ (If, Yes.)

Who is a local In Network Provider you will use when in Nashville?

(physician's name) (phone number) (street address) (city) (zip)

Is a referral from you Primary Care Physician required to see another health care provider? Yes ___ No ___

If yes, who needs to be contacted for authorization of care and/or verify benefits?

Doctor's Name: _____ Phone Number: () _____

Policyholder's Name: _____
(first) (middle initial) (last)

Policyholder's Address: _____
(street) (city) (state) (zip)

Policyholder's Subscriber ID Number: _____

Policyholder's Group Number (or group name): _____

Athlete's relationship to Policyholder
Self () Spouse () Child () Other ()

Father's Name: _____ Father's work/cell phone: () _____

Mother's Name: _____ Mother's work/cell phone: () _____

Guardian's Name: _____ Guardian's work/cell phone: () _____

Parent/Guardian's Address: _____
(street) (city) (state) (zip)

In case of emergency, if parents cannot be contacted, notify: (Bold)

Name: _____ Relationship: _____

Address: _____
(street) (city) (state) (zip)

Contact Phone #'s: () _____ () _____

Read Carefully

- I authorize payment of medical benefits to all providers for all services and materials they provide during the care of an injury/illness.
- I agree to supply any and all information requested by my primary insurance, Trevecca Nazarene University and their excess insurance carrier in a timely manner in order to expedite the claims process.
- I hereby authorize Trevecca Nazarene University and their excess insurance carrier to secure and inspect copies of case history records, lab reports, diagnoses, x-rays, and any other data pertaining to the injury/illness I am receiving care for or previous confinements or disabilities relevant to the care of the injury/illness.
- I authorize the athletic trainer of Trevecca Nazarene University and/or my coach to hospitalize and secure treatment for me for any athletic injury/illness. If the athlete is under 18 years of age, the undersigned parent grants permission to the Team Physician of Trevecca Nazarene University and/or their coach to hospitalize and secure treatment for their son/daughter for any athletic injury/illness.
- A photostatic copy of this authorization shall be deemed as effective and valid as the original.
- I will notify the athletic trainer of Trevecca Nazarene University immediately upon any changes in the above health insurance information.

PRINT FULL LEGAL NAME: _____
(first) (middle) (last)

ATHLETE'S SIGNATURE : _____

DATE : _____

(If under 18, parents/guardian MUST sign, otherwise MUST be signed by student-athlete)

PLEASE PUT A COPY OF YOUR INSURANCE CARD (FRONT/BACK) ON A SEPARATE SHEET OF PAPER



ATHLETIC CARE POLICY

In order to insure proper health care for all student-athletes and to insure proper payments are made for such care, student-athletes, coaches, athletic trainers and parents must adhere to the following policies:

1. **All injuries and illnesses must be reported to the athletic trainer immediately. The coaches at TNU are NOT athletic trainers.**
2. The athletic trainer will make any necessary referrals to the proper physician. Parents and athletes **SHOULD NOT** set up appointments without approval from the Head Athletic Trainer. If an appointment is set by someone other than Trevecca's athletic training staff, all bills will become the responsibility of the athlete and/or their parents.
3. Decisions on treatment will be made with the best interest of the student-athlete in mind. Decisions will be made in consultation with the physician, student-athlete, and with the athletic trainer. In the case of a minor, the parents will be contacted and included in the consultation. In all other cases, the athletic trainer and/or physician will not contact the parent(s) unless requested by the student-athlete. **PARENTAL INVOLVEMENT IS ENCOURAGED IN ALL CASES OF ADMISSION TO HOSPITALS, SURGERIES, AND INVASIVE TESTING, AND IT IS HOPED THAT THE ADULT STUDENT-ATHLETE WILL ALLOW THE LINES OF COMMUNICATIONS TO REMAIN OPEN AT ALL TIMES WITH THE PARENTS AND THE ATHLETIC TRAINER AND OR PHYSICIAN.**
4. All attempts will be made to utilize Trevecca Nazarene University recommended physicians for treatment. It is understood that some primary insurance carriers (HMO's and PPO's) require certain physicians to treat the patient. In these cases, Trevecca Nazarene University will attempt to cooperate with those carriers. In many cases, it is simply a hardship of the student-athlete to travel home for care.
5. The secondary (excess) insurance coverage provided by Trevecca Nazarene University is for **ATHLETIC-RELATED INJURIES OR ILLNESSES ONLY**. The NAIA does not permit schools to provide total health insurance to student-athletes. Therefore, only those injuries sustained while participating in a supervised practice or event will be covered. This does include off-season conditioning programs, but **not** events such as summer leagues, intramurals, pick-up games, recreational activities, etc.
6. If the insurance coverage you have is out of state, a HMO, a PPO or anything else, **IT IS YOUR RESPONSIBILITY TO DETERMINE COVERAGE IN THE NASHVILLE AREA**. If the athlete loses insurance coverage for any reason or if the insurance provider changes during the school year, it is the responsibility of the athlete or parent/guardian to notify the athletic trainer or athletic director. Sports participation will cease until the athlete is covered by a primary insurance policy. The athlete or parent/guardian will be responsible for any uncovered costs.
7. **Guidelines for claim resolution are as follows:**
 - a. The student athlete must present their Primary Insurance card in the doctor's office before each visit. You should ask if:
 - The provider will file a claim with your insurance company for today's DOS charges. **(Most Providers do this as a service, for you)**
 - Or, if **you**, are responsible for filing today's DOS charges with your insurance company. If after 21 days from that DOS, you have not received any documentation of those charges from your insurance company: You should call your insurance company and check the status of your claim.
 - TNU needs specific claim forms provided by your primary insurance company for each DOS charges, within 30 days of your visit to each provider.

- b. The student athlete is responsible for giving the medical provider of service TNU's address as secondary insurance provider.
 In all cases, Trevecca Nazarene University's secondary insurance can only be applied to these bills:
 - Where services are rendered for the treatment of an athletic injury
 - Where prior approval of that referral was granted through the athletic trainer
 - Where the care has been coordinated through the athletic training department
 - When the primary insurance company has responded to and resolved all claim processes (**Usually within 3 weeks from DOS**)
- c. Once your primary insurance coverage has paid all covered expenses, you must then forward the following documents to the address below:
 - A copy of the HCFA (Health Insurance Claim Form) and a copy of the corresponding EOB (Explanation of Benefits) received from your primary insurance, for each provider's DOS charges.

Trevecca Nazarene University
 Human Resource Department
 333 Murfreesboro Road
 Nashville, TN 37210

- TNU's HR Department can not submit your DOS charges for consideration of payment by TNU's secondary insurance provider, without these documents.
- d. These Claim Forms are to be sent to TNU within 30 days from the DOS, for timely submission for secondary insurance filing. Questions regarding secondary claim status should be addressed to:

Trevecca Nazarene University
 Linda Jones
 615.248.1654

8. Student and Parent agreement to adhere to TNU Athletic Care Policy

We understand that we have the responsibility to provide primary insurance coverage and agree to follow the proper procedures set before us concerning primary medical insurance claim procedures and in secondary claim procedures; in order to access TNU's secondary (excess) insurance coverage policy for any and all athletic related injuries. We understand that all medical expenses related to the student athlete's injuries that are not paid by these insurance carriers are ultimately the sole responsibility of the student-athlete.

I _____ fully understand and agree to the above policies:
(Student's Printed Name)

X _____ X _____
Athlete's Signature **Date**

I _____ fully understand and agree to the above policies:
Parent's Printed Name (if athlete is under 18 y.o.)

X _____ X _____
Parent's Signature (if athlete is under 18 y.o.) **Date**

MEDIA RELEASE

PERMISSION TO RELEASE STATUS OF INJURY OR ILLNESS TO MEDIA

I authorize Trevecca Nazarene University Athletic Department, Athletic Trainer, Team Physician and coaches to release information regarding my medical condition, and any injury, as it relates to my participation in athletics, to the public media.

Print Name



Signature of Student Athlete (Parent/Guardian if under 18)



Date



2011-12 Pre-participation Physical Form

****THIS FORM MUST BE COMPLETED AND RETURNED TO THE TNU SPORTS MEDICINE STAFF PRIOR TO PARTICIPATION OF ANY KIND.**

Last Name	First Name	MI	Sport
Birthdate	Social Security #		Email Address
Parent(s)/Guardians Names			
Home Address			
City	State	Zip	Home Phone
Emergency Contact/Relationship	Home Phone	Work Phone	
Insurance	Policy and/or Group Number		

List Allergies (Medicine, Bees, Other Stinging Insects, Foods)

Medical History Information	Yes	No
1. Have you had any injuries since your last check-up or sports physical?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a chronic or ongoing illness?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized overnight?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you presently taking any prescribed or over the counter medication?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently using an inhaler?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever taken any supplements or vitamins to help you control weight or improve performance?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever told you that you have Sickle Cell Anemia or that you are a carrier?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever become dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever experienced chest pain, discomfort, or unexplained shortness of breath with exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever experienced racing of your heart or skipped heartbeats?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had high blood pressure or cholesterol?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been told you have a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member or relative died of heart problems or of sudden death before age 50?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any relative had significant disability from any cardiovascular disease or event under the age of 50?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have knowledge of any heart conditions or sudden cardiac events in family members or relatives?.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had a severe viral infection (example: myocarditis or mononucleosis) within the last month?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Has a physician ever denied or restricted your participation on sports for any heart problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have any skin problems (itching, rashes, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a head injury or concussion?.....	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever been knocked out, become unconscious, or lost your memory?.....	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had a seizure?.....	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you have frequent or severe headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
25. Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever had a stinger, burner, or pinched nerve?.....	<input type="checkbox"/>	<input type="checkbox"/>

- 27. Have you ever become ill from exercising in the heat?.....
 - 28. Do you have asthma?.....
 - 29. Do you cough, wheeze, or have trouble breathing during or after activity?.....
 - 30. Have you had any problems with your eyes or vision?.....
 - 31. Do you wear glasses, contact, or protective eye wear?.....
 - 32. Have you ever had a sprain, strain, or swelling after an injury?.....
 - 33. Have you ever broken or fractured any bones or dislocated any joints?.....
 - 34. Have you ever been told that you have Marfan's syndrome?.....
 - 35. Do you want to weigh more or less than you do now?.....
 - 36. Have you had a dental checkup in the last six months?.....
 - 37. Have you ever had any problems with pain or swelling in any of the following muscles, tendons, bones, or joints?
- Head Neck Back, Chest Shoulder Elbow, Forearm
 Wrist, Hand, Finger Hip, Thigh Knee Ankle Foot

For questions 1-37, please explain all YES answers in the area below.

For Medical Personnel Only:

Urine: Normal or Abnormal Reason: _____ Hgb/HCT: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: Corrected with: Contacts _____ Glasses _____ Vision Issues: _____

Please place an X in each blank indicating the item examined.

<input type="checkbox"/> Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Shoulder/Arm	<input type="checkbox"/> Knee
<input type="checkbox"/> Ears	<input type="checkbox"/> Heart	<input type="checkbox"/> Elbow/Forearm	<input type="checkbox"/> Foot
<input type="checkbox"/> Nose	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Wrist/Hand	<input type="checkbox"/> Neck
<input type="checkbox"/> Throat	<input type="checkbox"/> Pulses	<input type="checkbox"/> Hip/Thigh	<input type="checkbox"/> Back
<input type="checkbox"/> Lymph Nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Legs/Ankles	<input type="checkbox"/> Skin

_____ **CLEARED** for Participation

_____ **CLEARED** for participation **AFTER** follow up by the indicated specialist:

Family/PCP Cardiologist Ophthalmologist Allergist
 Dentist Orthopedist Athletic Trainer Internist
 Physical Therapist Other: _____

Reason: _____

_____ **NOT CLEARED: Due to** _____

Printed Name of Physician _____

PHYSICIAN SIGNATURE _____ **Date** _____

Personal Representative Appointment

I, _____ do hereby appoint Linda Jones as my personal representative to act on my behalf in the matters of health insurance with Student Insurance.

I understand this is a voluntary designation and that this designation gives the personal representative the same rights to my health insurance information as myself. This appointment will expire at the end of the current academic/policy year.

Please complete the following information:	
Insured Information	Personal Representative Information
	(Necessary for Identity Verification) Linda Jones
Insured's Name	Personal Representative's Name
	Trevecca Nazarene University Address
Insured's Policy Number or ID Number	Address
	333 Murfreesboro Road Address
Date	Address
	Nashville, TN 37210 Address
	Trevecca Nazarene University Address
Insured's Signature	Address