Summer 2016

The Fairfield University Sports Medicine Department requires that all student athletes complete several forms before they are eligible to participate with their athletic team in the upcoming 2016-2017 school year.

Choose the Inside Athletics Tab at the top of the page, scroll down and select the Sports Medicine link, then select Sports Medicine Forms and complete the appropriate forms indicated below:

* If this is your first year of participation with an athletic team (including transfer student athletes), please fill out the forms indicated for freshmen & transfers.

* If you are a returning student athlete, please fill out forms indicated for returnees.

All forms should be completed, printed, and mailed back prior to August 1st, 2016.

Sickle Cell Testing (for freshmen & transfers)

The NCAA has passed legislation requiring mandatory blood testing of all student athletes for the sickle cell trait. Included is a form to be filled out by all freshmen and transfers students, indicating whether you would like to have the test, have already had the test, or would like to waive the test.

Student Athlete Insurance

Please provide your current primary insurance carrier information on the designated form.

Please remember that all forms should be completed, printed, and mailed back prior to August 1st, 2016**.** If we do not have these forms, along with a **copy of your current insurance card (front and back)**, your son/daughter will **NOT** be eligible to participate with their sport. Send to:

Mark Ayotte
Fairfield University Sports Medicine Department
1073 North Benson Rd
Fairfield, CT 06824
mayotte@fairfield.edu

If you have any questions regarding the above mentioned forms, or any medical concerns with your son or daughter, please feel free to contact me.

Thank you.

Mark Ayotte
Director of Sports Medicine
Fairfield University
203 254 4000 x2273

FAIRFIELD UNIVERSITY ATHLETIC DEPARTMENT
STUDENT ATHLETE INSURANCE INFORMATION

The Fairfield University Athletic Department provides secondary insurance coverage for all student athletes who are injured participating in a Fairfield University sponsored sport-specific event.

All medical bills incurred for any athletic injury must be initially submitted through the student athlete's primary insurance. Once the medical bills have been processed through the primary insurance carrier, the remaining balance, along with any explanation of benefits (EOB) for the bills, should be forwarded to the Administrative Assistant to Athletics.

We have numerous working relationships with local physicians in town. Our local physicians have agreed to accept the amount allowed by our secondary insurance policy carrier. Unfortunately, we do not have the same agreements with providers outside of our network. We do understand that there are times when you feel more comfortable with your own physician. Should you decide to use your own physician all medical bill balances above the reasonable and customary charges for that physicians work will be the sole responsibility of the student athlete/parent or guardian.

Student Athlete Responsibilities

1) Report injury to the Athletic Training Staff immediately

2) Complete Fairfield University Athletic Department Athletic Accident Claim Form with any member of
the Athletic Training Staff.

Primary Insurance Policyholder Responsibilities

1) Obtain insurance pre-authorization

It is the responsibility of the policyholder to be familiar with personal/family insurance plans and meet the requirements of the plans, including obtaining primary physician referrals if necessary.

2) Submit all medical bills to primary insurance

It is the responsibility of the policyholder to submit medical bills to their primary insurance for payment and to work cooperatively with providers of services.

3) Submit a copy of your insurance company's "Explanation of Benefits" (EOB) along with any itemized bills, showing remaining balance, as soon as you receive them, to the following address:

Mutual of Omaha
Special Risk Services
Attn: NCAA Basic Accident Medical Program
PO Box 31156
Omaha, NE 68131
Policy # SR2014N-051085-291

Failure to comply with any of the procedures in a timely manner could result in refusal of the Athletic Department to pay any remaining medical bill balances.

STUDENT ATHLETE FOLLOW UP HEALTH QUESTIONNAIRE

Name	Date

Class	Sport	DOB

INJURY

Have you missed more than seven (7) consecutive days of participation in usual activities because of an injury this past year? ☐ Yes ☐ No

If yes, please indicate

Site of Injury_____ Type of Injury_____

ILLNESS

A. Have you had any new allergies or medical issues in the past year to report? ☐ Yes ☐ No

B. Have you had a medical illness diagnosed that has not resolved this past year? ☐ Yes ☐ No

C. Are you presently under the care of a physician for any illness/injury? ☐ Yes ☐ No

If yes, please indicate _____

HOSPITALIZATION/SURGERY

Have you had surgery or been hospitalized this past year? ☐ Yes ☐ No

If yes, please indicate reason for hospitalization/surgery_____

MEDICATIONS

Please list **ALL** medications you are presently taking and what medical problem it is for

Medication:_____ Problem:_____

Medication:_____ Problem:_____

MUSCULOSKELETAL

Are you worried about any musculoskeletal problems at this time? ☐ Yes ☐ No

If yes, please explain_____

CARDIOVASCULAR

In the past year

A. Do you have high blood pressure? ☐ Yes ☐ No
B. Do you have a heart condition? ☐ Yes ☐ No
C. Have you ever fainted or nearly fainted with strenuous exercise? ☐ Yes ☐ No
D. Have you ever had heart palpitations or chest pain with exercise? ☐ Yes ☐ No
E. Has any family member had a heart attack under age 50? ☐ Yes ☐ No
F. Are there any close relatives under age 50 with cardiac conditions?

If yes, please explain_____
_____

HEAD

In the past year

A. Have you sustained a head injury? ☐ Yes ☐ No

If yes, please explain_____

B. Have you suffered any unusual headaches (i.e. migraines)? ☐ Yes ☐ No

If yes, please explain_____

OTHER CONCERNS

Do you have any other concerns that may affect your athletic participation? ☐ Yes ☐ No

If yes, please explain_____

I hereby state, to the best of my knowledge, that my responses on this questionnaire are correct.

Student Athlete Signature_____ Date_____

Sports Medicine Staff Only

Reviewed Date
ATC_____ ____

FAIRFIELD UNIVERSITY SPORTS MEDICINE
STUDENT ATHLETE INSURANCE INFORMATION

Name _____ Sport _____ Class 20_____
Last First

Last Four Digits SSN: _____ Date of Birth: _____

Student ID Number: _____ E-Mail:_____

Home Address: _____
Street City State Zip

Home# ( ) _____ Cell# ( ) _____

Emergency Contact: _____
Name Phone

Primary Physician: _____
Name Phone

Do you have medical insurance to cover the athlete? ____ Yes ____ No
Is this company considered an HMO/PPO? ____ Yes ____ No
Is a primary physician referral required for office visits? ____ Yes ____ No
(Specialists, x-rays, diagnostic tests, lab work)

Primary Insurance Information

Parent/Guardian:_____ DOB:_____

Address:_____

Employer:_____

Employer Address:_____

Health Insurance Co:_____ ID/Group #:_____

Insurance Co. Address:_____

Secondary Insurance Information (Fairfield University Athletic Department Policy)

Mutual of Omaha (Policy # SR2014-N-051085-291)
Special Risk Services
Attn: NCAA Basic Accident Medical Program
PO Box 31156
Omaha, NE 68131
Phone: 800-524-2324

PLEASE INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD

FAIRFIELD UNIVERSITY SPORTS MEDICINE ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS & SECOND OPINION POLICY AGREEMENT

I, _____, as parent, guardian or legal representative, attest that
(Parent Name, please print)

_____, has insurance coverage under a current, in-force insurance
(Student Athlete Name)

policy for all injuries or illnesses that may occur while he/she is participating in intercollegiate

athletics at Fairfield University.

If there is a material change in coverage or expiration of coverage, I agree to notify and update the insurance information I have on file with the Fairfield University Sports Medicine Department.

_____ _____
(Parent/Guardian Signature) (Date)

Primary Physician & Second Opinion Policy

Fairfield University has accident insurance coverage that is excess to all other insurance policies. Our plan will pay charges up to what is determined to be "reasonable and customary charges" for the specialty and geographic area that the provider practices medicine, for a two (2) year period from the date of injury. We have numerous working relationships with local physicians whose expertise is sports medicine. These physicians have agreed to accept the amount allowed by our secondary insurance policy, as payment in full. Unfortunately, we do not have the same agreements with other providers.

Should you decide to use your own physician for first time visits when your son/daughter is injured, all medical bill balances above the reasonable and customary charges for that physicians work will be the sole responsibility of the student athlete/parent or guardian. The same policy holds for parents seeking second opinions that are not directed by the team physicians associated with Fairfield University Sports Medicine.

I have read the Primary Physician & Second Opinion Policy and understand that I may be responsible for medical bill balances should I opt to use an outside physician not affiliated with Fairfield University.

_____ _____
(Parent Signature) (Date)

FAIRFIELD UNIVERSITY ATHLETIC DEPARTMENT
STUDENT ATHLETE DRUG TESTING CONSENT FORM

I, _____, acknowledge that I have reviewed a copy of the Fairfield University Athletic Department drug and alcohol policy located in the student athlete handbook (pages 18-23). I have read it, and fully understand its provisions.

I consent to have samples of my urine collected and tested for the presence of anabolic steroids, cocaine, marijuana, barbiturates, amphetamines and other controlled substances proscribed by Federal or State Law and the NCAA, in accordance with provisions of the drug and alcohol policy during the 2016-2017 school year.

I authorize the Director of Sports Medicine at Fairfield University to make a confidential release of my test results to the following people: Director of Athletics, Faculty Athletics Representative, my parents, and any other individuals who may be involved in the sanction process. This disclosure will be done in accordance with the provisions of the drug and alcohol policy.

I understand that any urine samples will be sent to a certified, independent laboratory for actual testing, and that all positive test samples will be re-screened for verification.

I also understand that if it is discovered, based upon the findings of the medical lab, that I have in any way tampered with my urine sample or any other sample, I will be treated as if I have a positive drug test.

Fairfield University, its Board of Trustees, its officers, employees, and agents are hereby released from legal responsibility for any action related to the implementation of the policy or the release of such information and records as authorized by this form:

_____ _____

Student Athlete Signature Date

FAIRFIELD UNIVERSITY SPORTS MEDICINE
STUDENT ATHLETE NUTRITIONAL SUPPLEMENT DISCLOSURE

I, _____, acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I take, regardless of the reason or purpose for taking such supplements.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products do not contain substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or use, or that the NCAA endorses a product or approves its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA.

I understand that I should not use these products until their usage has been approved by a member of the NCAA & Drug Free Sport.

_____ **NO**, I am not taking or intend to take nutritional supplements.

_____ **YES**, I am taking or intend to take nutritional supplements.
(Please list supplements below)

Brand Name	Listed Ingredients

_____ _____

Student Athlete Signature Date Athletic Trainer Signature Date

Fairfield University Sports Medicine

Medical Management Agreement and Assumption of Risk

Participation in sport requires an acceptance of risk of serious injury, including death. Athletes rightfully assume that those who are responsible for the conduct of sport have taken responsible precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

Periodic analyses of injury patterns lead to refinements in the rules and other safety decisions. However, to legislate safety via rule book and equipment standards, while often necessary, seldom is effective in itself; and to rely on officials to enforce compliance with the rule book is as insufficient as to rely on warning labels to produce compliance with safety guidelines. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

This annual form must be completed and returned before the student-athlete will be permitted to practice or play. The National Collegiate Athletic Association's policies recommend that all student-athletes have a qualifying medical evaluation upon initial entrance into an institution's athletic program, and an annual "health-status" review. Fairfield University supports this NCAA policy. Further medical evaluations may be required for specific matter

Assumption of Risk

I am aware that playing, practicing, training, and/or other involvement in any sport can be a dangerous activity involving MANY RISKS OF INJURY, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of participation include, but are not limited to, death, serious neck and spinal injuries that may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligament, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Because of this risk of dangers, I recognize the importance of following all instructions of the coaching staff, strength and conditioning staff, and/or Sport Medicine Staff. Furthermore, I understand that the possibility of injury, including catastrophic injury, does exist even though proper rules and techniques are followed to the fullest. I also understand that there are risks involved with traveling in connection with intercollegiate athletics. In consideration of Fairfield University permitting me to participate in intercollegiate athletics and to engage in all activities and travel related to my sport, I hereby voluntarily assume all risks allocated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release the Board of Regents of the Fairfield University and their officers, agents, and employees from any and all liability, any medical expenses not covered by Fairfield University Department of Intercollegiate Athletics' medical insurance coverage, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics. The terms hereof shall serve as release and assumption of risk for my heirs, estate, executor, administrator, assignees, and all members of my family.

Student Athlete Initials _____

Medical Treatment

I hereby authorize the Fairfield University Certified Athletic Trainers, Team Physicians , and designated medical staff to examine and treat any injuries that may occur, while participating in intercollegiate athletic for Fairfield University. I further understand that the team physician and/or his/her designee have the authority to withhold me temporarily or disqualify me permanently from participation as a student athlete due to an injury/illness, and/or due to undue liability risk to Fairfield University.

Student Athlete Initials _____

Medical Information Release

I give my permission to the Student Health Services Staff to discuss pertinent medical information with the Sport Medicine Staff regarding any illness or injury that could impede my athletic performance.
I also give my permission to the Sport Medicine Staff to discuss any pertinent medical information with my parents or guardians regarding any illness and/or injury impacting my athletic participation.

Student Athlete Initials _____

Future Complaints

I acknowledge and agree that all future injuries, medical/dental/mental problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to an Athletic Trainer, no matter how minor or insignificant I may deem them to be. I understand that my responsibility to report injuries and illnesses includes, but is not limited to, signs and symptoms of concussions. I acknowledge that I have received educational materials about concussions from the Fairfield University Sports Medicine Staff, and that I understand the signs and symptoms of concussions.

Student Athlete Initials _____

Medical Insurance

I understand that as a student athlete at Fairfield University, I must be covered by individual health insurance before participating in any athletic related activity or engage in team travel. This insurance shall be considered the PRIMARY insurance coverage for all athletic related injuries. I understand that the *Fairfield University Department of Intercollegiate Athletics and the National Collegiate Athletic Association (NCAA)* will provide a medical and catastrophic insurance program for student athletes injured in practices, games or competitions and/or related travel, that was supervised by approved University coaching staff and approved by the Director of Athletics according to NCAA regulations. THIS POLICY, HOWEVER, IS SECONDARY TO, OR IN EXCESS OF, THE STUDENT ATHLETE'S INDIVIDUAL HEALTH INSURANCE. In addition, I further understand and agree that I will be financially responsible for an aggravation or re-injury to a preexisting injury, regardless of its disclosure to the team physician(s) and/or members of the Sports Medicine Unit.

Student Athlete Initials _____

Agreement

I hereby attest that I have read and fully understand Fairfield University Sports Medicine Department's Medical Management Agreement and Assumption of Risk Waiver. Further, I agree to abide by all the requirements set forth, and I understand that failure to abide by the requirements could result in unfavorable health consequences, disqualification from participation, or loss of scholarship.

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

_____ _____
Student Athlete Print Name Date Parent/Guardian Print Name (if under age of 18) Date

_____
Certified Athletic Trainer Signature Date