



Dear Athlete:

We would like to take this time to welcome you back to another exciting year at Saint Joseph's College. I am sure that all of you are anxiously awaiting another wonderful season in athletics, but before we can begin, we are in need of some information. Enclosed is an emergency insurance form and a medical questionnaire. ***The emergency insurance form and the medical questionnaire must be filled out and returned or you will not be allowed to participate in any practices, workouts, or contests.*** Please take a moment to fill out the enclosed forms and return them to us as soon as possible. A completed form filled out and returned to us will assure that you are ready for participation when you arrive in August. It can be sent to the following address:

Saint Joseph's College Athletics
ATTN: Jared Hall
P.O. Box 875
Rensselaer, IN 47978

If you have any questions, please feel free to contact the athletic training staff at (219) 866-6336 or (219) 866-6245

Sincerely,

Jared Hall MS, LAT, ATC
Head Athletic Trainer

Saint Joseph's College

Acknowledgement of Medical Policies and Insurance Coverage Information

I have received and read a copy of the Department of Intercollegiate Athletics medical policies and insurance coverage information. I understand that these policies and procedures will be followed.

I agree also to notify, the sports medicine unit of the Department of Intercollegiate Athletics if primary insurance coverage of the student athlete changes during the course of the year.

Student-Athlete's Signature

Date

Parent/ Guardian Signature

Date

This form must be signed and returned to the Saint Joseph's College, Athletic Training Room, before the student-athlete will be allowed to practice.

Please sign and return this form to:

Jared Hall, MS, LAT, ATC
Head Athletic Trainer
Saint Joseph's College
P.O. Box 875
Rensselaer, IN 47978

EMERGENCY / INSURANCE INFORMATION FORM
To Be Used For Emergency Contact and Filing Medical Claims

Saint Joseph's College Sport: _____
Athlete Name: _____ Social Security # _____ Date of Birth: _____
College Dorm: _____ College Ext: _____ Cell: _____ Home
Phone: _____ Hall Rm: # _____
Home Address: _____
Street City State Zip
Medical Alerts _____

Parents Information

Please print clearly, or type all information requested. Do not leave any lines blank. This information is very important.

Father's Full Name _____ Mother's Full Name _____
Home Phone: _____ Cell Phone: _____ Home Phone: _____ Cell Phone: _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Social Security # _____ - _____ - _____ DOB _____ Social Security # _____ - _____ - _____ DOB _____
Medical Insurance Co. _____ Medical Insurance Co. _____
Primary or Secondary (please Circle) Phone No. _____ Primary or Secondary (please Circle) Phone No. _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Policy No. _____ Policy No. _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____

Emergency Contact: (if parent(s) cannot be reached)

Name: _____ Phone: _____ Relationship: _____

1. Is the company or listed plan considered a Health Maintenance Organization (HMO) _____ or a Preferred Provider Organization PPO? _____
2. Is your daughter/son covered at this time by your present surgical & hospital insurance policy? _____
3. Does your insurance require a second medical/doctor's opinion? _____
4. Does your insurance require pre-authorization admission for hospital admission? _____ if yes, phone number (____) _____

Parent & Athlete: I hereby authorize Saint Joseph's College and its excess insurance company to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or possibilities. A photo static copy of this authorization shall be deemed as effective and valid as the original.

X _____
PARENT'S SIGNATURE

X _____
ATHLETE'S SIGNATURE

Parents & Athlete: This form **must** be completed and returned to the following address **before the student-athlete can practice or compete.**

Parents & Athlete: **Saint Joseph's College, Athletic Training Room, P.O. Box 875, Rensselaer, IN 47978**
I acknowledge receiving one copy of SJC's Athletic Injury & Medical Policy. I understand the College responsibility and limits to a student who becomes injured as a result of participation in the intercollegiate sport.

X _____ X _____
PARENT'S SIGNATURE DATE ATHLETE'S SIGNATURE DATE

IMPORTANT NOTICE: Please attach a copy of your insurance card (front & back) along with Prescription card if separate.

Saint Joseph's College
Athletic Training - Returning Medical Update

Name: _____

Sport: _____

All answers pertain to the period of time from August 1 of last year and the summer break of the same year.
IF YES; explain what/when/prescriptions/doctor's name, address, phone number. Circle answers; fill in blanks.

YES NO 1. Have you experienced a **CONCUSSION** or **INJURY** to the **HEAD** since last season?

YES NO 2. Have you experienced any **JOINT** or **LIMB** injury and/or pain since last season?

YES NO 3. Have you had any **X-RAYS, DIAGNOSTIC TESTING,** or **DENTAL WORK** since last season?

YES NO 4. Have you had any **SURGERY** or **ILLNESS** of any type since last season?

YES NO 5. Have you been **HOSPITALIZED** or **UNDER A PHYSICIAN'S CARE**?

YES NO 6. Do you have any **NEW HEALTH CONDITIONS** or **HEALTH CONCERNS** since you last participated in your sport? (e.g. high blood pressure, heart-related problems, shortness of breath, asthma, diabetes)

YES NO 7. Do you have any **ALLERGIES** or take any **MEDICATIONS** or **SUPPLEMENTS**?

YES NO 8. Have you **FELT DIZZY, PASSED OUT, HAD CHEST PAIN,** or experienced **RACING OR SKIPPED HEART BEATS** in the last year?

YES NO 9. Have you been fitted for **CONTACTS** or **GLASSES** since you last played? (circle which)

YES NO 10. Do you have any **CURRENT SKIN PROBLEMS** or **ASTHMA** (what medications if so)?

YES NO 11. Do you know of any health reasons you should not participate in athletics at SJC?

Please sign below to certify that the above information is current and accurate.

Athlete Signature: _____ Date: _____

Athletic Trainer: _____ Date: _____