

**BIOGRAPHICAL DATA QUESTIONNAIRE**  
**2009-2010**

Please answer the following questions as carefully and completely as possible. This information is needed in case of an emergency and we need to contact someone for you, and for general statistical purposes. PLEASE PRINT NEATLY! Thank you.

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

STUDENT IDENTIFICATION NUMBER \_\_\_\_\_

SPORT(S) Name of team, i.e. volleyball, etc.

FALL \_\_\_\_\_ WINTER \_\_\_\_\_ SPRING \_\_\_\_\_

STUDENT'S LOCAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ BOX NUMBER \_\_\_\_\_

CELLULAR NUMBER (     ) \_\_\_\_\_ OR ON-CAMPUS EXT. \_\_\_\_\_

STUDENT'S PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE (     ) \_\_\_\_\_

**EMERGENCY CONTACTS** – PARENTS, GUARDIANS OR SPOUSE NAME(S)

NAME \_\_\_\_\_ PHONE NUMBER (     ) \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_ BUSINESS PHONE (     ) \_\_\_\_\_

NAME \_\_\_\_\_ PHONE NUMBER (     ) \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_ BUSINESS PHONE (     ) \_\_\_\_\_

If you are from out of the area, sometimes a local relative or family friend should be contacted as someone who can join you immediately in case of emergency. If this is the case, please give us the following information:

NAME \_\_\_\_\_ PHONE NUMBER (     ) \_\_\_\_\_

RELATIONSHIP TO YOU \_\_\_\_\_ BUSINESS PHONE (     ) \_\_\_\_\_

Dear Student Athlete and/or Parent of a Lynchburg College Intercollegiate Student Athlete:

We are extremely pleased to have your son/daughter as a student-athlete at Lynchburg College and hope that he/she will achieve academic, social, and athletic success.

Each student athlete is required to have a physical examination prior to any participation in any intercollegiate sport. The final decision on physical qualifications or reason for rejection is the responsibility of the team physician or the Director of Athletic Training Services. The Team Physician or Director of Athletic Training Services also makes the decision on when an athlete may return to competition after a previous injury.

Accidents do occur and we attempt to provide our athletes with the very best possible care. Medical bills are incurred when the athlete is treated, whether it be locally, during a road trip, or by a medical vendor in his/her own home area.

One Firm Statements: 1) Each Lynchburg College Intercollegiate Student Athlete is required to have primary health insurance that covers Intercollegiate (IC) injuries in order to participate in intercollegiate athletics. Student Athletes must have valid health insurance throughout the traditional and non-traditional intercollegiate practice and competition seasons.

Excessive (Secondary) Intercollegiate Athletic Insurance Coverage: Lynchburg College provides excessive intercollegiate athletic insurance described as the following:

- HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) – For the parents to have payable coverage on their son or daughter, when a member of these organizations, they must use the authorized medical vendors from the list provided to them. Your coverage through Lynchburg College Intercollegiate athletics is EXCESS coverage and does contain an exclusion for those bills incurred that were “payable” by the family health insurance plan. If parents or students choose not to use the authorized medical vendors of their plan, they should be aware that Lynchburg College Intercollegiate athletic insurance coverage will **not** be able to pay the bills incurred that would have been honored had they used the proper vendors or procedures.

Claim Procedure: All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the college has instructed the medical vendors otherwise. In some cases the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the bill incurred to be sent.

- A. Submit the bills incurred to your family, employer group coverage or plan first. They will do one of two things:
  1. Honor the claim and pay all or a portion of the bills incurred.
  2. Not honor the claim and send you a letter of denial. An example might be that your son/daughter is no longer part of your group policy after attaining the age of twenty-three.
- B. If there remains a balance after your family, employer group insurance or plan has contributed towards the claim, send the claim sheet from the insurance company and a copy of the itemized bills incurred to James May, Director of Training Services at Lynchburg College.

If you received a letter of denial from your family, employer group insurance or plan administrator, then send the letter of denial and a copy of the bills incurred to the college's athletic department. If no coverage, a letter from your employer with verification will be necessary.

- C. If the bills incurred and not paid by the family, employer group insurance or plan are large enough, the claim will be sent from the athletic department to our insurance carrier office which is in Kalamazoo, Michigan for processing. If they need any additional information, please cooperate with them and they will process the claim in the least possible amount of time. It is in your best interest to have the claim settled promptly since all the bills incurred are in your name.

Sincerely,

Dr. Jack M. Toms  
Director of Athletics

James May, MS, ATC  
Director of Athletic Training Services



**LYNCHBURG COLLEGE ATHLETIC TRAINING – 2009-2010**  
**Parent/Student Athlete Insurance Information Form**

**FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks with information or N/A if not applicable.**

I. Name of Athlete: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
College Address: \_\_\_\_\_ Cellular Phone: (      ) \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone: (      ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

II. Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_

III. Employer: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Telephone: (      ) \_\_\_\_\_ Telephone: (      ) \_\_\_\_\_

**IV. Medical Insurance**

Company of Plan: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Telephone: (      ) \_\_\_\_\_

**Medical Insurance**

Company of Plan: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Telephone: (      ) \_\_\_\_\_

Is the company or plan listed above considered a HMO \_\_\_\_ or PPO \_\_\_\_?  
Does your insurance or plan require a second opinion before surgery? Yes \_\_\_\_ No \_\_\_\_.

***Please "Check" or "Mark" each of the following boxes to signify your acknowledgement of the corresponding statement***

- I hereby authorize Lynchburg College and Student Athletic Protection, Inc. of Kalamazoo, Michigan 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.
- I have and will maintain in good standing, Primary Health Insurance which covers Intercollegiate (IC) Injuries throughout the 2009-2010 Academic and/or Athletic calendars.
- We authorize that the college or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college.
- I have read and understand Lynchburg College Athletic Intercollegiate Insurance policy which only provides excessive secondary intercollegiate insurance.

**\*Please include a copy of your insurance card.**

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student-Athlete's Signature

\_\_\_\_\_  
Date

## Medical Authorization - Lynchburg College – 2009-2010

Name \_\_\_\_\_  
Student Athletes Name (Please Print)

DATE \_\_\_\_\_

I hereby authorize Lynchburg College Athletic Training Staff and Emergency Medical Personnel to render medical or surgical care that they deem necessary to my health and well being. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made to notify my parents or the designated emergency contact in the most expeditious manner possible. If the physician is unable to communicate with me, the treatment deemed necessary for my best interest may be given.

I also hereby authorize the Athletic Trainers at Lynchburg College to render any preventative, first-aid, rehabilitative, or emergency treatment that they deem reasonably necessary to my health and well being.

SIGNATURE \_\_\_\_\_  
(Student-Athlete)

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_  
(Parent/Guardian, if under age 18)

DATE \_\_\_\_\_

### Release of Information

I understand that the Lynchburg College Athletic Training Staff and Team Physicians may share amongst themselves for the purpose of treatment, information concerning the illness/injury relative to my past, present, or future participation in athletics at Lynchburg College. Also the above may provide medical information to insurance companies pertaining to the student-athlete as needed.

SIGNATURE \_\_\_\_\_  
(Student-Athlete)

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_  
(Parent/Guardian, if under age 18)

DATE \_\_\_\_\_

### Shared Responsibility for Sport Safety

Participation in sports requires an acceptance of risk for injury. Your decision to participate in athletics indicates your acceptance of this risk. In order to minimize this risk as a participant, you must be aware of and abide by certain procedures, safety rules, and guidelines. Any improper use or abuse of your equipment could result in injury to you, a teammate, or an opponent. Improper or illegal use of your equipment or technique may result in serious head and neck injuries, paralysis, internal injury, and death. Other injuries in athletics include, but not limited to strains, sprains, fractures, and contusions. Athletes rightfully assume that those responsibilities for the conduct of sports will not intentionally inflict injury upon them, but acknowledge that unintentional injuries, including serious head and neck injuries, paralysis, internal injury, death, sprains, strains, fractures, and contusions, can happen while participating in or training for athletic events. Periodic analyses of injury patterns lead to refinement in the rules and safety decisions, but safety cannot be legislated solely through rules and equipment standards. The responsibility for sport safety must be shared by all involved, and compliance with rules means respect on everyone's part for the intent, spirit, and purpose of the rules or guidelines. The undersigned has read and understands the statements above.

SIGNATURE \_\_\_\_\_  
(Student-Athlete)

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Lynchburg College Athletic Participation Health Status Questionnaire  
(For Returning Athletes. Must Have Original Examination Attached)

Name \_\_\_\_\_ Age \_\_\_\_\_ Year in School \_\_\_\_\_ Date \_\_\_\_\_  
                     Last                      First                      MI                      Sport(s) \_\_\_\_\_

Please answer the following questions and explain any yes answers in the space provided.

- |                                                                                                                                                                                                                                              |     |    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Have there been any changes in your Family Health History in the past year (heart attack, stroke)?                                                                                                                                        | yes | no |
| 2. Has there been a significant change in <u>your</u> health history in the past year?                                                                                                                                                       | yes | no |
| 3. Have you had an <u>illness</u> during the past month (example: cold, flu, sore throat, fever)?                                                                                                                                            | yes | no |
| 4. Have you had an <u>illness</u> during the past year that restricted your normal activity for more than one week?                                                                                                                          | yes | no |
| 5. Have you had an <u>injury</u> during the past year that restricted your normal activity for more than one week?                                                                                                                           | yes | no |
| 6. Have you had any surgeries during the past year?                                                                                                                                                                                          | yes | no |
| If yes, a) list the surgery _____                                                                                                                                                                                                            |     |    |
| b) Have you completed rehab and been released by your doctor?                                                                                                                                                                                | yes | no |
| 7. Have you had a head injury or concussion in the past year (this includes injuries sustained outside of sports)?                                                                                                                           | yes | no |
| 8. Have you had a neck and/or back injury in the past year?                                                                                                                                                                                  | yes | no |
| 9. Do you have any questions concerning previous or current injuries or illnesses?                                                                                                                                                           | yes | no |
| 10. Are you currently under a physician's care? (include care by any certified health professional, i.e. chiropractor, acupuncturist, herbologist, etc)                                                                                      | yes | no |
| 11. Have you been diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD)?                                                                                                                                                       | yes | no |
| If you answered "Yes" and you are taking prescription medication for ADHD, you <b>MUST</b> also complete the <b>ADHD Medical Exemption Form located on the Pre Participation Paperwork Page.</b>                                             |     |    |
| 12. Are you currently taking any other medications?                                                                                                                                                                                          | yes | no |
| If yes, list medications _____                                                                                                                                                                                                               |     |    |
| For what condition? _____                                                                                                                                                                                                                    |     |    |
| 13. During the past year, while exercising or shortly thereafter, have you experienced any of the following: chest pain, or the feeling as if your heart is racing or skipping a beat, fainting, significant or unusual shortness of breath? | yes | no |
| 14. Have you been seen by your primary care (family) physician in the past year?                                                                                                                                                             | yes | no |
| 15. Have you had a dental examination in the past year?                                                                                                                                                                                      | yes | no |
| 16. Have you had an eye examination in the past year?                                                                                                                                                                                        | yes | no |
| If yes, was there a change in vision that now requires the use of glasses or contacts?                                                                                                                                                       | yes | no |
| 17. <b>For Women:</b> Have you had any changes in your menstrual cycle (lack of, skipping months, etc.) ?                                                                                                                                    | yes | no |
| 18. Are you aware of any medical reasons why you should not participate in athletics?                                                                                                                                                        | yes | no |

Explanations: \_\_\_\_\_

**I hereby state that, to the best of my knowledge, my answers to the above questions are accurate.**

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Status Questionnaire reviewed by: \_\_\_\_\_ BP \_\_\_\_\_ HR \_\_\_\_\_

No Restrictions \_\_\_\_\_ Follow-up required \_\_\_\_\_ Plan \_\_\_\_\_