Longwood University Insurance Information

Name of Athlete_____Sport_____
Social Security No._____ Date of Birth_____
College Address_____ Contact No._____
Home address_____

Father/Guardian _____ Date of Birth_____
Social Security No. _____ Home Phone _____
Address _____
City _____ State_____ Zip_____
Employer_____ Work Phone _____
Employer address_____
Insurance company name_____ Policy number_____
Insurance Address_____
Insurance phone _____

Mother/Guardian _____ Date of Birth_____
Social Security No. _____ Home Phone _____
Address _____
City _____ State_____ Zip_____
Employer_____ Work Phone _____
Employer address_____
Insurance company name_____ Policy number_____
Insurance Address_____
Insurance phone _____

Is the insurance company a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)? HMO ____ PPO ____ N/A ____ Referral required? Yes ____ No _____
If Yes give name of primary care/referring physician
Physician Name _____ Phone No. _____

In the event that an injury, illness or emergency arises during my participation at Longwood University, permission is hereby granted to the attending physician, athletic training staff, or other agent (coaches, EMTs, police, etc.) to proceed with any treatment deemed medically necessary, including, but not limited to, transport, evaluation, surgery, procedures, tests and follow-up care.

I authorize any physician and/or hospital to file claims with my primary insurance company, and release such information as relates to any illness, injury or insurance claim to the Longwood University medical and atheltic staff and/or its designated inurance agents (Student Athletic Protection, Inc.).

By signing this form you acknowledge you have read and agree to follow all Longwood University insurance policies and procedures.

Signature_____Date_____

Parent Signature_____Date_____
(must sign regardless of Student-Athlete's age)

A legible copy of both sides of the athlete's primary insurance card MUST BE ATTACHED

Longwood University Health History

Sport:_____ Name:_____
Last First MI

This form is to be completed prior to the screening. The effectiveness of this procedure is dependent upon an honest and complete review of recent health status. Please answer all questions and freely communicate any concerns you may have with your physician. All information will be held in strict confidence.

Please Explain any YES answers on the back of the form.

1.	Have you been hospitalized or had a major illness or surgery in the last 12 months?	YES	NO
2.	Are you currently ill or injured in any way?	YES	NO
3.	Have you had an injury that caused limitation of activity or required medical attention?	YES	NO
4.	Are you currently taking any medication or inhaler (prescription/nonprescription)?	YES	NO
5.	Have you ever became dizzy or passed out during exercise?	YES	NO
6.	Have you ever had chest pain or unexplained shortness of breath during exercise?	YES	NO
7.	Have you ever had racing of your heart or skipped heartbeats?	YES	NO
8.	Have you ever had high blood pressure or high cholesterol?	YES	NO
9.	Have you ever been told you have a heart murmur?	YES	NO
10.	Has any relative had significant disability related to cardiovascular disease?	YES	NO
11.	Has a physician ever denied you participation in athletics based on a heart condition, illness, injury or any other for any other reason?	YES	NO
12.	Have you ever had any concussions or head injuries?	YES	NO
13.	Have you ever been knocked out, become unconscious, or lost your memory?	YES	NO
14.	Have you ever had a seizure?	YES	NO
15.	Do you have frequent headaches?	YES	NO
16.	Have you ever had numbness or tingling in your arms or legs, or had a stinger", "burner" or pinched nerve?	YES	NO
17.	Have you ever become ill when exercising in the heat?	YES	NO
18.	Do you cough, wheeze, or have trouble breathing during exercise?	YES	NO
19.	Do you have asthma?	YES	NO
20.	Do you have any specific recurrent pains when you exercise?	YES	NO
21.	Do you know of, or believe there is any health reason why you should not participate in the intercollegiate athletic program at this time?	YES	NO
22.	Do you have any worries about your health or any other question that you would like to discuss with the doctor?	YES	NO
23.	Do you have any life threatening allergies (e.g. medications, bee stings)? Please list	YES	NO

_____

I, the undersigned, hereby swear that all the information stated above is completely true and correct.

ATHLETE'S SIGNATURE_____Date_____

Parent Signature_____Date_____
(Parent signature required only if under 18)

Longwood University Assumption of Risk statement

READ the following statements carefully, if you have any questions feel free to ask, when you fully understand all statements sign and date the form.

Having passed the sports participation medical review and screening exam **does not** necessarily mean you are physically qualified to engage in strenuous physical exercise and athletics, but only that the examiner(s) did not find a medical reason to disqualify you at the time of said review and screening.

I am aware that playing, practicing or trying out in any sport can be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that these dangers and risks include, but are not limited to, **death**; serious neck/spinal injuries, which may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system; and serious injury or impairment to other aspects of my body, general health, and well being. I understand that participation in athletic activity may also impair my future abilities to earn a living, to engage in other business, social, recreational activities, and generally enjoy life.

Because of the dangers of participating in athletics, I recognize the importance of following the instructions of coaches and staff regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

I understand that my participation is VOLUNTARY. In consideration of Longwood University permitting me to voluntarily engage in all activities related to the team, including, but not limited to, trying our, practicing, and participating in athletics. I hereby assume all risks associated with my participation, and agree to hold the Commonwealth of Virginia, Longwood University, its employees, agents, representatives, coaches, volunteers harmless from any and all liability, actions, causes of action, debt, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activity related to athletics at Longwood University. **The terms hereof shall serve as a release and assumption of risk for myself, my heirs, estate, executor, administrator, and for all members of my family.**

Name:_____Sport:_____

Signature:_____Date:_____

Parent Signature:_____Date:_____
(Parent signature required only if under 18)

Longwood University Certificate of Immunization

Certificate of immunization must be submitted to Health Services and a copy must be submitted to the Athletic Training Staff.

The form is available at http://www.longwood.edu/health/services/docs/record.pdf