

# Jefferson College Athletics

1000 Viking Drive • Hillsboro, MO 63050 • (636)797-3000/789-3000/942-3000, ext. 386 • TDD (636)789-5722  
FAX (636)789-2419 • Athletic Director Doug Stotler, E-Mail: [dstotler@jeffco.edu](mailto:dstotler@jeffco.edu)

Dear New/Returning JC Student-Athlete,

The Jefferson College Athletic department staff would like to welcome you to our athletic program; we are glad you have chosen to be a part of Jefferson College. In preparation for the upcoming season we need your assistance to help start your sports medicine file.

Enclosed you will find:

1. **PARENT & STUDENT INFO SHEET.** This is the form that is used *while traveling with your sport* and in the event of an *emergency medical referral or a scheduled doctor's appointment related to an athletic injury*. **THIS FORM IS VERY IMPORTANT and REQUIRES ALL PORTIONS OF THE FORM TO BE COMPLETED. THE POLICYHOLDER'S SIGNATURE AND A COPY OF THE CURRENT INSURANCE CARD (front/back) IS REQUIRED.**
2. **Letter of understanding.** A letter to you and your parents explaining care and management of athletic injuries and related medical expenses. **Please make sure you and your parents carefully read this letter and it needs to be signed.**
3. **Disclosure Statement, FERPA-Athlete form and athlete insurance claim procedure list.** These forms assist us with insurance claims related to athletic injuries.
4. **Athlete Emergency Contact form.**
5. **JC Drug Policy & Testing Program Consent Form** (Please read policy in the student handbook at [www.jeffco.edu](http://www.jeffco.edu))

We cannot emphasize enough our need for these forms to be as complete as possible. The completion of these forms will allow the process to be smoother and get you participating with your team on time. **Mail a printed and signed copy of all forms along with a copy of the front and back of your current insurance card to the JC Athletic Department no later than July 29, 2011. Failure to fully complete the forms or submitting a current health insurance card will result in a delay in your ability to practice, compete, or participate in your sport.**

If you have any questions regarding the information requested please do not hesitate to contact the JC athletic department staff at: [gcrain@jeffco.edu](mailto:gcrain@jeffco.edu) or [dmaples@jeffco.edu](mailto:dmaples@jeffco.edu). If you have suffered a recent significant injury, or have a history of a medical problem/injury please let us know immediately. This provides us time to request medical records, talk with your physician(s), etc. before you arrive in August. Thank you for your cooperation and we look forward to meeting you this fall. Have a great summer!!

Sincerely,  
Gregg Crain, MSS, ATC  
Head Athletic Trainer

# REMINDER

Jefferson College - Hillsboro  
Student Orientation  
Saturday, August 20

Program - 8:30 AM - Noon

8:30 Check-in at Fine Arts Theatre  
(Campus Tours will be available following event)  
Students will receive an informational postcard in the mail, and  
are asked to pre-register for the event on the homepage of the  
Jefferson College website.

New Student Orientation Registration link:

[http://www.jeffco.edu/jeffco/index.php?option=com\\_content&task=view&id=461&Itemid=377](http://www.jeffco.edu/jeffco/index.php?option=com_content&task=view&id=461&Itemid=377)

**JEFFERSON COLLEGE ATHLETIC DEPARTMENT  
STUDENT-ATHLETE INFORMATION CHECK LIST  
2011-2012**

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(Student-Athlete Name)

(Sport)

**Emergency Contact Information**

**Insurance Claim Procedure List**

**Copy of Current Insurance Card**

**Letter of Understanding**

**Authorization to Release Information (FERPA/Athletic Dept)**

**Authorization – Permit Use and Disclosure of Health Information**

**Student/Parent/Guardian Information Form (2 pages)**

**Medical Questionnaire and Physical Form (2 pages)**

**Consent for Drug Testing Form**

**If you have a documented disability, contact the Disability Support Services Office at ext. 158 to review accommodations and services available. Send all IEP (Individual Education Plan), 504 Plans, or doctor's documentation also known as a Diagnostic Summary (typed on the physicians letterhead) to Sundaye Harrison, Disability Support Services Coordinator**

**ALL FORMS MUST BE IN OUR OFFICE BY JULY 29, 2011**

**MAIL TO THE ATTENTION OF: ATHLETIC SECRETARY  
JEFFERSON COLLEGE  
1000 VIKING DRIVE  
HILLSBORO MO 63050**

*Failure to complete and return all forms will constitute a student not being able to practice or work out with their team until such time that all forms have been completed and received in our office.*

**JEFFERSON COLLEGE STUDENT-ATHLETE  
EMERGENCY CONTACT INFORMATION**

STUDENT-ATHLETE NAME: \_\_\_\_\_

SPORT: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ HOME NO. (\_\_\_\_) \_\_\_\_\_

FATHER'S WORK NO: (\_\_\_\_) \_\_\_\_\_ FATHER'S CELL NO: (\_\_\_\_) \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ HOME NO. (\_\_\_\_) \_\_\_\_\_

MOTHER'S WORK NO: (\_\_\_\_) \_\_\_\_\_ MOTHER'S CELL NO: (\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT NO: (\_\_\_\_) \_\_\_\_\_

**JEFFERSON COLLEGE ATHLETIC INSURANCE CLAIM PROCEDURE LIST**

If the injury is of the nature that medical attention is required, the following guidelines should be followed:

1. **THE CLAIM MUST BE AN INJURY CAUSED BY AN ATHLETIC-RELATED INCIDENT.** If claims are related to an illness, the excess insurance policy will not provide any coverage.
2. Receive authorization from the athlete’s coach or from the athletic trainer before seeing a physician or therapist **unless it is an emergency.**
3. If the athlete’s primary insurance company requires prior authorization before being seen by either a physician or therapist, unless it is an emergency, it is the **ATHLETE’S** responsibility to do so. Failing to meet compliance may result in a claim denial. This will also affect possible payment from the excess policy that Jefferson College carries for the athletes.
4. The healthcare provider must submit all charges to the athlete’s primary insurance carrier (either the athlete’s personal insurance policy or a parent’s insurance policy). After the primary insurance company has processed the claim, the healthcare provider will need to submit the claim along with the primary carrier’s EOB (Explanation of Benefits) on a HCFA 1500 or UB 92 to the Athletic Department Secretary. Once the claim and EOB are received, the claim will then be sent to Jefferson College’s insurance company for consideration of payment (**this is not a guarantee of payment**).

If the athlete **DOES NOT HAVE PRIMARY INSURANCE COVERAGE**, the healthcare provider must submit all charges on a HCFA 1500 or UB 92 to the Athletic Department Secretary for proper filing to the excess insurance carrier through Jefferson College, however, **this is not a guarantee of payment**. This information needs to be given to the healthcare provider before the athlete is seen.

5. An athletic injury claim form (obtained from the Athletic Department Secretary) **MUST** be signed by the athlete within 48 hours of the injury.
6. If the athlete or parent receives a bill from a healthcare provider for an **ATHLETIC INJURY ONLY**, take the bill to the Athletic Department Secretary. **These bills need to be received within 30 days from the date on the billing statement.** If the athlete or parent does not take responsibility to get these bills to the Athletic Department Secretary, the athlete or parent may become responsible for payment of these charges. If the bills are not handled in a timely fashion, there is a strong possibility that the healthcare provider will turn these charges over to a collections agency. When this occurs, it is the **ATHLETE’S OR PARENT’S** credit that may be damaged. Therefore, it is extremely important to follow the necessary steps in filing these claims.

**I am 18 years of age or older and have read and understand the above information.**

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Student-Athlete Printed Name

\_\_\_\_\_  
Date

**(or if student-athlete is under 18 years of age)**

**I am the parent/legal guardian of the above-name student-athlete and have read and understand the above information.**

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Legal Guardian Printed Name

\_\_\_\_\_  
Date

## AUTHORIZATION – To Permit Use and Disclosure of Health Information

This Authorization was prepared for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide the insurance company or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the insurance company. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that the insurance company may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to the insurance company pursuant to this Authorization, the information will remain protected in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

\_\_\_\_\_  
Name of Claimant (Please Print)

\_\_\_\_\_  
Name of Authorized Representative or Next of Kin (Please Print)

\_\_\_\_\_  
Signature of Claimant (if claimant is 18 or older) (Date)

\_\_\_\_\_  
Signature of Authorized Representative of Next of Kin (Date)

\_\_\_\_\_  
Relationship of Authorized Representative or Next of Kin to Claimant



**ATHLETIC DEPARTMENT**

**Consent for Drug Testing**

I have read and understand the Jefferson College Drug Testing Policy.

In response to any violations of this policy, continuation of rights and privileges of participation by the individual in Jefferson College Athletic Programs will be suspended or revoked, as appropriate.

I agree to undergo standardized drug testing, which will be conducted in accordance with the Jefferson College Drug Testing Policy. I understand that the testing results can be provided to the individuals listed in the drug testing policy. I further understand that failure to participate in good faith in the drug testing program may result in disciplinary action or revocation of athletic participation privileges as set forth in the Jefferson College Athletic Department Drug Testing Policy.

\_\_\_\_\_  
Print Full Legal Name of Student-Athlete

\_\_\_\_\_  
Student ID Number

\_\_\_\_\_  
Signature of Student-Athlete or Parent/Guardian  
for persons under the age of eighteen (18 years)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## Student Athlete Authorization to Release Information

In compliance with the Family Education Rights and Privacy Act of 1974, as amended,

I, \_\_\_\_\_

Please print your full name on the line above.

hereby authorize the release of the following information:

- Cumulative grade point average, both official and unofficial academic transcripts, class attendance records, class schedules, etc., to the Director of Athletics, Student Athlete Success Coordinator, and/or any varsity team coach as deemed necessary by the Director of Athletics or the Student Athlete Success Coordinator. My academic transcripts may be released to any college/university at the request of the Director of Athletics, my team coach, or the Student Athlete Success Coordinator.
- Cumulative grade point average and other information to the National Junior College Athletic Association and other athletic regulatory groups to verify eligibility and, if appropriate, for academic recognition (i.e., NJCAA Academic All-American).
- Cumulative grade point average and other information in reports to both on- and off-campus groups/organizations in the course of reporting on the College's athletic program.
- Photographs, action shots, and both game and physical statistics for distribution to the media, inclusion in the Jefferson College website, and for use by other electronic media.

This release is in effect from August 1, 2011 to August 1, 2012.

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

\_\_\_\_\_  
Student ID Number

\_\_\_\_\_  
Date

*Copies of this release will be kept on file in the office of the Director of Athletics, office of the Student Athlete Success Coordinator, and the Registrar/Student Records Office.*

LETTER OF UNDERSTANDING

Student Name: \_\_\_\_\_  
(Please print)

College Assigned V#: \_\_\_\_\_

I understand that Jefferson College has insurance for intercollegiate athletic injury protection. This insurance is written as **EXCESS** coverage in the event the above named student is injured in practice for, or participation in, an intercollegiate athletic event. Claims will first be submitted to my primary medical insurance coverage, if any. If there is a balance due after the primary medical insurance carrier has made payments, a claim may then be submitted against the college's policy.

I understand that if there are any unpaid charges remaining after both the primary insurance (if any) and the excess insurance pays, **THESE UNPAID CHARGES ARE MY RESPONSIBILITY TO PAY.**

I also understand the coverage provided by the college's policy **CONTAINS** certain **LIMITATIONS** of coverage. I may obtain a copy of the college's policy from the Business Office to familiarize myself with the actual coverage provided.

I am 18 years of age or older and have read and understand the above information.

\_\_\_\_\_  
(student's signature)

\_\_\_\_\_  
(date)

(or if student is under 18 years of age)

I am the parent/legal guardian of the above-named student and have read and understand the above information.

\_\_\_\_\_  
(parent/legal guardian signature)

\_\_\_\_\_  
(date)



**JEFFERSON COLLEGE  
ATHLETIC DEPARTMENT  
2011-2012  
STUDENT/PARENT/GUARDIAN  
INFORMATION FORM**



NAME <i>(Last, First, MI)</i>		MALE _____ FEMALE _____
SPORT IN WHICH YOU PLAN TO COMPETE AT JEFFERSON COLLEGE	DATE OF BIRTH <i>(mo/day/yr)</i>	SOCIAL SECURITY NUMBER
CURRENT E-MAIL ADDRESS	JEFFCO E-MAIL ADDRESS <i>(Will be primary e-mail for Athletic Correspondence)</i>	
COLLEGE ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>
HOME ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>
STUDENT'S HOME TELEPHONE NO. ( )	STUDENT'S CELL PHONE NO. ( )	
FATHER'S NAME	FATHER'S DATE OF BIRTH <i>(mo/day/yr)</i>	FATHER'S SS # <i>(needed for claims)</i>
FATHER'S E-MAIL ADDRESS	FATHER'S HOME PHONE NO. ( )	FATHER'S CELL PHONE NO. ( )
FATHER'S MAILING ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>
FATHER'S EMPLOYER	EMPLOYER'S PHONE NO. ( )	
FATHER'S EMPLOYER'S ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>
MOTHER'S NAME	MOTHER'S DATE OF BIRTH <i>(mo/day/yr)</i>	MOTHER'S SS # <i>(needed for claims)</i>
MOTHER'S E-MAIL ADDRESS	MOTHER'S HOME PHONE NO. ( )	MOTHER'S CELL PHONE NO. ( )
MOTHER'S MAILING ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>
MOTHER'S EMPLOYER	EMPLOYER'S PHONE NO. ( )	
MOTHER'S EMPLOYER'S ADDRESS <i>(Street Address)</i>	<i>(City)</i>	<i>(State) (Zip Code)</i>

# MEDICAL INSURANCE INFORMATION

FATHER'S MEDICAL INSURANCE COMPANY NAME		
MEDICAL CLAIMS MAILING ADDRESS		
POLICY IDENTIFICATION NO. & GROUP NO.		INSURANCE COMPANY PHONE NO. (      )
IS STUDENT-ATHLETE COVERED UNDER PLAN? <i>(circle one)</i> <b>YES OR NO</b>	IS PLAN AN HMO? <i>(Circle One)</i> <b>YES OR NO</b>	IS PLAN A PPO? <i>(Circle One)</i> <b>YES OR NO</b>
STUDENT-ATHLETE'S PRIMARY CARE PHYSICIAN'S(PCP) NAME AND OFFICE PHONE NO.		
MOTHER'S MEDICAL INSURANCE COMPANY NAME		
MEDICAL CLAIMS MAILING ADDRESS		
POLICY IDENTIFICATION NO. & GROUP NO.		INSURANCE COMPANY PHONE NO. (      )
IS STUDENT-ATHLETE COVERED UNDER PLAN? <i>(circle one)</i> <b>YES OR NO</b>	IS PLAN AN HMO? <i>(Circle One)</i> <b>YES OR NO</b>	IS PLAN A PPO? <i>(Circle One)</i> <b>YES OR NO</b>
STUDENT-ATHLETE'S PRIMARY CARE PHYSICIAN'S(PCP) NAME AND OFFICE PHONE NO.		
IF STUDENT-ATHLETE <u>IS NOT</u> COVERED UNDER A PARENT POLICY, DOES THE STUDENT HAVE OTHER INSURANCE? <i>(Circle One)</i> <b>YES OR NO</b> <i>(If yes, please answer the following)</i>		
STUDENT-ATHLETE INSURANCE COMPANY NAME		
MEDICAL CLAIMS MAILING ADDRESS		
POLICY IDENTIFICATION NO. & GROUP NO.		INSURANCE COMPANY PHONE NO. (      )
IS PLAN AN HMO? <i>(Circle One)</i> <b>YES OR NO</b>	IS PLAN A PPO? <i>(Circle One)</i> <b>YES OR NO</b>	
STUDENT-ATHLETE'S PRIMARY CARE PHYSICIAN'S(PCP) NAME AND OFFICE PHONE NO.		

1. **A COPY OF THE INSURANCE CARD(S), FRONT AND BACK, IS REQUIRED WITH THIS INFORMATION.**

**Jefferson College Student-Athlete Medical Questionnaire  
2011-2012**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_ Year (circle one): **Fresh** **Soph**

*Explain all "Yes" answers at the bottom of this sheet*

- |     |  |     |    |
|-----|--|-----|----|
| 1.  | Have you been hospitalized?.....   | yes | no |
|     | Have you had surgery?.....   | yes | no |
| 2.  | Are you presently taking any medication(s)?.....   | yes | no |
| 3.  | Do you have any allergies (medications, insects, bees)?.....   | yes | no |
| 4.  | Have you passed out during or after exercise?.....   | yes | no |
|     | Have you been dizzy during or after exercise?.....   | yes | no |
|     | Have you had chest pain during or after exercise?.....   | yes | no |
|     | Do you tire more quickly than your friends during exercise?.....   | yes | no |
| 5.  | Have you had a high blood pressure reading this year?.....   | yes | no |
|     | Have you been told in the past 12 months that you have a heart murmur?.....  | yes | no |
|     | Have you had racing of your heart or skipped heartbeats?.....  | yes | no |
|     | Has anyone in your family died of heart problems or sudden death before age 50?.....   | yes | no |
| 6.  | Do you have any skin problems? (itching, rashes, acne, etc.).....  | yes | no |
| 7.  | Have you had a head injury?.....   | yes | no |
|     | Have you been knocked out or unconscious? .....  | yes | no |
|     | Have you had a seizure?.....   | yes | no |
|     | Have you had a stinger, burner, or pinched nerve? .....  | yes | no |
| 8.  | Have had heat illness or muscle cramps?.....   | yes | no |
|     | Have you been dizzy or passed out from the heat?.....  | yes | no |
| 9.  | Do you have trouble breathing or do you cough during or after any activity? .....  | yes | no |
| 10. | Do you use any special equipment (pads, braces, mouth guards, etc.)? .....   | yes | no |
| 11. | Have you had any problems with your eyes or vision?.....   | yes | no |
|     | Do you wear contacts, glasses, or protective eyewear?.....   | yes | no |
| 12. | Have you sprained/strained, dislocated, fractured, broken or had repeated swelling<br>or other injuries of ANY bones or joints?..... | yes | no |

**Circle all that apply:**

Head	Shoulder	Thigh	Neck	Elbow	Knee	Chest
Back	Shin/Calf	Wrist	Ankle	Hip	Hand	Foot

- |     |  |     |    |
|-----|--|-----|----|
| 13. | Have you had any medical illnesses (mono, diabetes, etc.) in the past 12 months?.....  | yes | no |
| 14. | Have you gained or lost more than 10 pounds in the last 12 months?.....                | yes | no |
| 15. | Do you have any medical concerns that you would like to speak to a Doctor about?.....  | yes | no |
| 16. | Have you had a medical problem/injury since your last evaluation by a physician? ..... | yes | no |

**Female Athletes complete the following:**

- |     |   |     |    |
|-----|---|-----|----|
| 17. | When was your first menstrual period (approx. age)? _____               |     |    |
| 18. | When was your last menstrual period (approx. date)? _____               |     |    |
| 19. | Have you skipped any period in the last 12 months? .....                | yes | no |
| 20. | If yes, what was the longest time between your periods last year? _____ |     |    |
| 21. | Are you pregnant? .....   | yes | no |

*Explain all "Yes" answers:*

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*I herby state to the best of my knowledge, my answers to the above questions is correct.*

**Student-Athlete Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OVER FOR PHYSICAL**

**JEFFERSON COLLEGE PRE-PARTICIPATION PHYSICAL EVALUATION  
2011-2012**

NAME \_\_\_\_\_ SPORT \_\_\_\_\_

*Vital Statistics Information*

Date	Height/Weight	Blood Pressure	Pulse	Vision Correction (yes/no)

	Normal	Abnormal Findings	MD Initials
<b>MEDICAL</b>			
Cardiopulmonary			
Pulses			
Heart			
Lungs			
Skin			
Abdominal			
<b>ORTHOPEDIC</b>			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Other			

Medical Clearance (Circle One): **CLEARED**                      **LIMITED CLEARANCE**                      **NOT CLEARED**

Explain: \_\_\_\_\_

Name of Physician (Print): \_\_\_\_\_

Physician Mailing Address: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Recommendations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Office use Only; Do Not Complete*

Reviewing ATC	Date	File Updated in SportsWare