2016-2017 Paperwork Checklist for New Student-Athletes

- All paperwork must be completed clearly, legibly, and in blue or black ink. Print all forms on separate sheets of paper. Please fold paperwork as little as possible. Sign and date all forms where necessary. If the student-athlete is not yet eighteen years of age at the time of completing the forms, a parent/guardian must also sign all forms.

- The following must be completed and on file with the BVU Athletic Training Department* prior to any team activities, including strength & conditioning sessions:
  - BVU Student Health Form: *This form will be turned into BVU Health Services - they will give a copy to the Athletic Training department. Physical exam must occur after the completion of any high school sports participation. Physical exam must be completed within 6 months of the beginning of your team’s competition or non-traditional season (Fall sports - middle of August, Winter sports - middle of October, Spring sports - middle of September). Physicals may only be performed by a physician (MD or DO credential), nurse practitioner (NP credential), or physician’s assistant (PA-C credential) - NO other healthcare professionals may clear a student-athlete for participation. Physical exams documented on any other form will not be accepted. Make sure to sign the bottom of the second page!
  - Student-Athlete Information Form
  - HIPAA and Consent to Treat Form: Please be sure to list the parties whom you approve the Athletic Training staff to communicate with regarding medical conditions
  - Injury and Illness Reporting & Acknowledgment Form: Initial each blank before signing the bottom of the form
  - NCAA HIPAA Form
  - Sickle Cell Trait Disclosure Form: All student-athletes must have been tested (test results from birth are acceptable). We do not allow physicians to waive testing, even if the individual is not in an at-risk group for this particular condition.
  - Copies of the front and back of all applicable medical insurance cards must also be submitted (medical, secondary, prescription, dental, etc.)

- The following form may be kept for your information: Insurance Information and Instructions

- We recommend retaining a copy of all forms and mailing originals (with the exception of the BVU Student Health Form) to:
  BVU Athletic Training, Box 2963
  610 W. 4th Street
  Storm Lake, IA 50588
  or fax to (712) 749-1460
HEALTH FORM including physical and immunizations required for ALL students entering as a freshman, transfer or re-admit. Please fill out the front page before going to your physician. This form must be received and immunization status approved by August 1 (if entering fall semester) or February 1 (if entering January Interim or spring semester). Note: the immunization record and physical exam must be filled out by a health care provider.

ATHLETES ONLY - Proof of Sickle Cell REQUIRED by National Collegiate Athletic Association (NCAA). Please complete “Sickle Cell Disclosure Form” and return with Student Health Form. Copies of all required forms including insurance card copy will be sent to the Athletic Training Department.

Name: ___________________________ SSN#: ___________________________ Gender: ___________________________

Home Address: ___________________________ Street City State Zip

Date of Birth: ___________________________ Student Cell Phone #: ___________________________

Emergency contact: ___________________________

Name: ___________________________ Relationship: ___________________________ Address: ___________________________

Home Phone #: ___________________________ Cell Phone #: ___________________________ Work Phone #: ___________________________

Family Physician: ___________________________ Phone #: ___________________________

Date of entry to BVU ______/______/______ Entering as a: □ First-year Student □ Transfer □ Re-admit □ Resident □ Commuter

HEALTH INSURANCE (Required for all students). Enclose copy of Insurance Card.

□ I will remain under a private health insurance plan. Subscriber Name: ___________________________ Date of Birth: ___________________________

□ I will remain under a public funded insurance plan. I.e. Medicaid from the State of ___________________________ (athletes must have Iowa coverage).

□ I will purchase the student health insurance plan offered through Buena Vista University. Please notify BVU Health Services if for any reason your plan changes. Please notify BVU Health Services if your insurance status changes.

FAMILY HISTORY

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PERSONAL HISTORY Have you had or are you concerned about? (Please answer all questions)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>Frequent Depression</td>
<td>Mumps</td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergic Reactions</td>
<td>Frequent Indigestion</td>
<td>Pneumonia</td>
<td>Urinary Tract Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, Hay Fever</td>
<td>Gallbladder Trouble</td>
<td>Polio</td>
<td>Sexually Transmitted Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Problem</td>
<td>Gum/Tooth Trouble</td>
<td>Recent Weight Gain/Loss</td>
<td>Suicidal Thoughts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer, Cyst</td>
<td>Head Injury</td>
<td>Recurrent Colds</td>
<td>Weakness, Paralysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Heart Murmur</td>
<td>Recurrent Diarrhea</td>
<td>Worry, Nervousness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain/Pressure</td>
<td>Heart Palpitation</td>
<td>Recurrent Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Cough</td>
<td>High/Low Blood Pressure</td>
<td>Rheumatic Fever</td>
<td>Irregular Periods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Jaundice</td>
<td>Scarlet Fever</td>
<td>Severe Cramps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness/Fainting</td>
<td>Joint Injury/Disease</td>
<td>Shortness of Breath</td>
<td>Excessive Flow</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear/Nose/Throat Trouble</td>
<td>Malaria</td>
<td>Sinusitis</td>
<td>Pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Measles</td>
<td>Stomach/Intestinal Trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizure Disorder</td>
<td>Measles (German)</td>
<td>Frequent Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Trouble</td>
<td>Malaria</td>
<td>Trouble Sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there anything not covered that you feel Health Services should be aware of? Please describe:

Please explain any “yes” responses. Provide dates if applicable.

□ Yes □ No Have you had any illness or injury which required hospitalization?

□ Yes □ No Have you consulted or been treated by clinic, physician, or other practitioners within the past five years?

□ Yes □ No Have you been rejected or discharged from military service because of physical, emotional or other reasons?

□ Yes □ No Have you had any special difficulties with school or teachers?

□ Yes □ No Have you ever experienced any personal or emotional difficulties which require professional attention?

□ Yes □ No Have you ever sustained a diagnosed concussion? If yes, how many? Please indicate date of most recent:

□ Yes □ No Have you ever been restricted by or removed from competition due to a blow to the head?
IMMUNIZATION INFORMATION (Must be completed prior to Registration and is required for all students born after 1956.)

REQUERED IMMUNIZATIONS

1. M.M.R. (Measles, Mumps, Rubella) (2 Doses Required) Dose #1 (15 mo. or after) __/__/____ Mo. Day Year Dose #2 (5 yrs. or after) __/__/____ Mo. Day Year

   If given as separate doses - please identify: Measles: __/__/____ Mumps: __/__/____ Rubella: __/__/____ Mo. Day Year Mo. Day Year Mo. Day Year

   *NOTE: If born prior to 1957 you are considered immune and require no further vaccination.

2. Tetanus/Diphtheria (Required) Primary Series Completed __/__/____ Mo. Day Year Booster (within last 10 years) __/__/____ Mo. Day Year

3. Polio (Required) Primary Series Completed __/__/____ Mo. Day Year

4. Meningococcal: Buena Vista University requires the meningitis vaccine to reduce the risk for potentially fatal bacterial meningitis.

   Menactra Vaccine __/__/____ Mo. Day Year OR Menveo Vaccine __/__/____ Mo. Day Year

5. Tuberculosis (TB) Screening Assessment (To be completed before your physician’s appointment)

   • Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No
   • Were you born or had frequent or prolonged visits to a country that has a high incidence of active TB disease? □ Yes □ No
   • Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No
   • Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? □ Yes □ No
   • Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No

   If the answer is YES to any of the above questions, Buena Vista University requires that you receive TB testing prior to the start of the subsequent semester.

   Tuberculin Skin Test: Date Given: __/__/____ Date Read: __/__/____

   Interpretation (based on mm of induration as well as risk factors): Induration _____ mm □ Positive □ Negative

   Chest x-ray (if above is positive) Results: □ Normal □ Abnormal Date of chest x-ray: __/__/____

   Mo. Day Year

RECOMMENDED IMMUNIZATIONS

6. Hepatitis B Dose #1 __/__/____ Mo. Day Year Dose #2 __/__/____ Mo. Day Year Dose #3 __/__/____ Mo. Day Year

7. Hepatitis A Dose #1 __/__/____ Mo. Day Year Dose #2 __/__/____ Mo. Day Year

8. Human Papillomavirus Vaccine (HPV) Dose #1 __/__/____ Mo. Day Year Dose #2 __/__/____ Mo. Day Year Dose #3 __/__/____ Mo. Day Year

9. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine.)

   History of disease: □ Yes □ No Varicella antibody __/__/____ Mo. Day Year

   □ Reactive □ Non-reactive Immunization: Dose #1 __/__/____ Mo. Day Year Dose #2 __/__/____ Mo. Day Year

REQUIRED PHYSICAL EXAM

Height ___________ Weight ___________ Pulse ___________ Blood Pressure ___________ Blood Hgb/Hct ___________ Urine SpGravity ___________ pH ___________

Glucose ___________ Ketones ___________ Protein ___________ Leukocytes ___________ Blood ___________ Body Fat % (opt) ___________ Other ___________

Are there any abnormalities of the following systems?

Head, Ears, Nose, or Throat □ Yes □ No Please use this area to describe any positive findings.

Respiratory
Cardiovascular
Gastrointestinal
Hernia
Eyes
Genitourinary
Musculoskeletal
Head and Neck
Shoulder/Arm
Elbow/Arm
Wrist
Hand/Fingers
Back/Spine
Pelvis/Hip
Knees
Leg/Ankles
Feet
Other

Metabolic/Endocrine
Neuropsychiatric
Skin

I have reviewed the medical history on page 1 and find no constrictions to athletic participation □ Yes □ No

Recommendations for physical activity and/or athletic participation □ Unlimited □ Limited Explain: __________________________

Is the patient now under treatment or medication for any medical or emotional condition? □ Yes □ No

Recommendations regarding the care of this student: __________________________

Physician’s Signature: __________________________________________________________________________ Date: ___________ Phone Number: __________________________

EMERGENCY TREATMENT CONSENT: In case of an accident or an emergency in which I may be unable to direct my own medical care, I authorize Buena Vista University to seek appropriate medical/surgical care for me until those identified as emergency contact persons can be notified. I hereby state that the above information is true and give permission for Health Services to release information to the Vice President for Student Affairs & Dean of Students, Campus Counselor, Athletic Training Department and to health care providers or facilities who are included in my treatment. If under 18, must be signed by both student/parent and/or guardian.

Student Signature: __________________________ Parent/Guardian Signature: __________________________ Date: ___________
**2016-2017 STUDENT-ATHLETE (S-A) INFORMATION FORM**

**COMPLETE AND RETURN TO:** Athletic Training, Box 2963  
Athletics Department  
Buena Vista University  
610 West 4th Street  
Storm Lake, IA 50588

Please return with a copy of both sides of all applicable medical insurance cards (medical, dental, prescription, secondary, vision, etc.)

PLEASE PRINT ALL INFORMATION CLEARLY IN BLUE OR BLACK INK. FAILURE TO COMPLETE ALL BLANKS CAN RESULT IN MEDICAL CARE OR CLAIMS PROCESSING DELAYS. (Complete all blanks with appropriate information or “N/A”.

<table>
<thead>
<tr>
<th>Name of athlete: ___________________________</th>
<th>Sport(s): ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #: __________________________</td>
<td>Date of Birth: ________________________</td>
</tr>
<tr>
<td>BVU ID #: ___________________________</td>
<td>School Box #: ________________________</td>
</tr>
<tr>
<td>Cell Phone: ___________________________</td>
<td>E-Mail Address: ________________________</td>
</tr>
<tr>
<td>Home Address: ___________________________</td>
<td>City/St/Zip: ________________________</td>
</tr>
</tbody>
</table>

**EMERGENCY CONTACTS (E.C.)**

<table>
<thead>
<tr>
<th>Primary E.C. Name: _________________________</th>
<th>Secondary E.C. Name: _________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to S-A: ________________________</td>
<td>Relationship to S-A: ________________________</td>
</tr>
<tr>
<td>Address: ___________________________</td>
<td>Address: ___________________________</td>
</tr>
<tr>
<td>City/St/Zip: ___________________________</td>
<td>City/St/Zip: ___________________________</td>
</tr>
<tr>
<td>Phone: ___________________________</td>
<td>Phone: ___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer: ___________________________</th>
<th>Employer: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ___________________________</td>
<td>Address: ___________________________</td>
</tr>
<tr>
<td>City/St/Zip: ___________________________</td>
<td>City/St/Zip: ___________________________</td>
</tr>
<tr>
<td>Work Phone: ___________________________</td>
<td>Work Phone: ___________________________</td>
</tr>
</tbody>
</table>

**MEDICAL INSURANCE COVERAGE**

<table>
<thead>
<tr>
<th>Primary Medical Insurance (Ins.) Company Name: ___________________________</th>
<th>Secondary Medical Insurance (Ins.) Company Name: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Policy Holder (P.H.): ___________________________</td>
<td>Name of Policy Holder (P.H.): ___________________________</td>
</tr>
<tr>
<td>P.H. Relationship to Athlete: ___________________________</td>
<td>P.H. Relationship to Athlete: ___________________________</td>
</tr>
<tr>
<td>P.H. Date of Birth: ___________________________</td>
<td>P.H. Date of Birth: ___________________________</td>
</tr>
<tr>
<td>P.H. Address: ___________________________</td>
<td>P.H. Address: ___________________________</td>
</tr>
<tr>
<td>City/St/Zip: ___________________________</td>
<td>City/St/Zip: ___________________________</td>
</tr>
<tr>
<td>Ins. Policy/ID # : ___________________________</td>
<td>Ins. Policy/ID # : ___________________________</td>
</tr>
<tr>
<td>Ins. Group # : ___________________________</td>
<td>Ins. Group # : ___________________________</td>
</tr>
<tr>
<td>Ins. Phone # : ___________________________</td>
<td>Ins. Phone # : ___________________________</td>
</tr>
</tbody>
</table>

Do you have a secondary insurance policy? Yes   No
The Buena Vista University (BVU) Athletic Training Department is committed to protecting patients’ privacy and information. All efforts will be made to protect student-athletes' information and medical records consistent with the federal Health Insurance Portability and Accountability Act (commonly referred to as HIPAA) and the federal Family Educational Rights and Privacy Act (commonly referred to as FERPA). All data is stored securely and consistent with industry standards.

I am aware that the athletic training staff at Buena Vista University may need to discuss my injury status and details of my medical condition with certain parties. By signing this document, I hereby give permission for those providing my care to speak with other certified athletic trainers, athletic training students (for educational purposes only), team physicians, BVU Health Services & Wellness, insurance representatives, coaches (for any issue that may affect sport participation), and BVU administration (may be required for more serious conditions). It is understood that all above parties will discreetly communicate any medical or personal information consistent with HIPAA and FERPA guidelines.

This protected information will be disclosed for the following reasons: coordinating with necessary parties to assure appropriate medical care, facilitating potential coverage and payment of insurance claims, determining or communicating restrictions on physical activity, and addressing concerns that may affect overall student well-being.

I also give permission for the athletic training department to release my medical information to the following parties (common examples are parents/guardians, roommates, etc.- please give full names):

________________________________________________________________________________
________________________________________________________________________________

I am aware that I may revoke permission to release my information at any time. This may be done in writing and submitted to the BVU athletic training department.

________________________________   __________________________________
Printed Name      Sport(s)

________________________________  _____________________
Signature        Date

Parent/Guardian Signature if under 18       Date

I understand that the BVU Athletic Training Department, under direction of team physicians, is charged with providing care for medical needs that may arise during my participation in intercollegiate athletics. By signing this document, I give permission for the athletic training staff to provide care consistent with current medical standards, guidelines, and ethics and BVU’s policies and procedures. It is understood that I will ask questions and communicate concerns if they arise concerning my treatments and overall well-being.

I understand that a member of the BVU Athletic Training staff may not always be present for some off-site practices or away competitions. In such scenarios, I give permission for host institutions’ certified athletic trainers to provide and direct care (if applicable) until my return to BVU. I also understand that in such situations, I should follow up with a BVU staff Certified Athletic Trainer as soon as is reasonable.

________________________________   _____________________
Signature        Date

Parent/Guardian Signature if under 18       Date
I understand that participation in any athletic activity carries significant risk for injury, disability, or even death. While all efforts will be made to provide a safe playing environment, not all injuries can be prevented. I understand that many factors go into the cause of an injury. I recognize that I will always have the ability to communicate with the Buena Vista University (BVU) Athletic Training staff regarding my safe participation in intercollegiate athletics.

I further understand that there is a possibility that participation in sport may result in a head/neck injury or concussion. I will be provided with annual education on head injuries at pre-season team meetings. I understand the importance of immediately reporting any symptoms of a potential head/neck injury or concussion to the Athletic Training staff. I understand that I will be given the opportunity to ask questions about my condition at any time.

I understand and acknowledge that I must be an active participant in my own healthcare. As such, I have the direct responsibility for immediately reporting all of my injuries and illnesses to the BVU Athletic Training staff. I recognize that an evaluation of my true physical condition is dependent upon an accurate medical history and a full disclosure of any signs, symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the BVU Athletic Training staff.

I acknowledge that it is my responsibility to follow through with treatment plans given by team physicians and the BVU Athletic Training staff. This includes attending treatment and rehabilitation sessions and complying with all given instructions. I understand that if I have concerns or questions about my treatment plan, I will always have the opportunity to ask an Athletic Training staff member and work with them to find an agreeable solution.

I understand that I may seek outside medical care for conditions sustained while participating in intercollegiate athletics. I understand that for Buena Vista University’s secondary insurance policy to cover any incurred costs, I must notify the Athletic Training staff in advance of seeking outside medical care of any kind. I also understand that the athletic training staff cannot overrule any directions given by outside medical professionals. I understand that if I utilize any outside medical professionals, that I must provide adequate documentation of the encounter before resuming treatment with the BVU Athletic Training staff.

I, ________________________________ (print name) have read the above items and agree that the statements are accurate and agree to comply with these statements.

Student-Athlete Signature

Date

Parent/Guardian Signature if under 18

Date
Student-Athlete Authorization/Consent for Disclosure of Protected Health Information for NCAA-Related Research Purposes

I, ____________________________ hereby authorize ___________________________________ Name of Student-Athlete Name of my Institution and its physicians, athletic trainers and health care personnel to disclose my protected health information including, without limitation, any information regarding any injury, illness, treatment or participation related to or affecting my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA), and its designated employees, agents and/or contractors. I further authorize the NCAA to disclose, and/or use, such information as provided herein.

I understand that my participation and protected health information may be disclosed to, and/or used by, the NCAA, and authorized third parties to receive such information for the purpose of using injury, relevant illness and participation information collected from multiple student-athletes and institutions in a manner that does not identify myself or my school. The information is provided to NCAA committees, athletics conferences and individual schools, and NCAA-approved researchers to evaluate the effectiveness of health and safety rules and policy, and to study other sports medicine questions. Selected de-identified summary (aggregate) data also are made accessible to the general public as a service to further the general understanding of athletic injury patterns and help develop education on student-athlete health topics.

I am making this authorization/consent voluntarily to release my health information otherwise protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). The NCAA and institution are not requiring this authorization/consent to be signed.

I understand that while HIPAA regulations may not apply to NCAA use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that my data will be stored securely within industry standards.

This authorization/consent for transfer of protected health information expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete ____________________________ Signature ____________________________ Date ____________________________
Sickle Cell Trait Disclosure Form

Student-Athlete Name: ___________________________ Date of Birth: _____________

Sport(s): ___________________________ Phone #: ___________________________

Home Address: ________________________________________________________________

---

About Sickle Cell Trait and Testing

- Sickle cell trait is an inherited condition affecting hemoglobin, the oxygen-carrying protein in the red blood cells.
- Sickle cell trait is usually benign, but during intense, sustained exercise, a lack of oxygen in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to crescent or 'sickle' shape). This can cause them to accumulate in the bloodstream and block blood vessels, leading to collapse from the rapid breakdown of muscle tissue starved of blood.
- Please see the below website for more information regarding sickle cell trait: [http://www.ncaa.org/health-and-safety/medical-conditions/sickle-cell-trait](http://www.ncaa.org/health-and-safety/medical-conditions/sickle-cell-trait)
- The NCAA now requires that all Division III student-athletes have knowledge and record of their sickle cell trait prior to beginning intercollegiate athletic participation.
- Most individuals were tested at birth; records of this testing are adequate as an individual’s status will not change over the course of their life.
- Sickle cell trait testing is done by a simple blood test, which performed by a physician. The BVU Athletic Training Department DOES NOT accept a waiver of testing.

---

I verify that the above named individual has been tested for Sickle Cell Trait.

Please list the date of the Sickle Cell Trait Testing:___________________

Sickle Cell Trait Testing Results: Negative:___________ Positive:___________

Restrictions to Participation: No Restrictions:___________________

______________

Physician’s signature:_________________________________ Date: _________

Physician’s Name (printed) and Address: ________________________________

_______________________________________________________________________

Please mail completed forms to:
Buena Vista University Athletic Training
Box # 2963
610 W. 4th Street
Storm Lake, IA 50588

Completed forms may also be faxed to (712) 749-1460, Attn: Athletic Training Staff
Insurance Information and Instructions

Buena Vista University (BVU) requires all students to carry primary medical insurance, including student-athletes. Students have the option to keep their previous insurance coverage or purchase a student insurance policy, which has an effective coverage of 8/1/16 through 7/31/17. The enrollment or waiver of the student insurance policy must be completed by the first day of classes annually.

If a student wishes to retain outside medical insurance coverage, they must annually opt-out of the student insurance plan. All students should be sent instructions soon with how to opt-out of this insurance in the near future: check your email, regular mail, and it will be available in Beavernet once the registration period begins.

Any changes in student-athlete insurance coverage should be immediately communicated to both the Athletic Training department and Health Services. Copies of new cards should be given to both parties immediately after they are received as well.

Student-athletes may not be covered by government assistance plans (commonly referred to as Medicaid) from any state other than Iowa. Coverage under these plans typically does not allow for payment of any medical expenses that are not life-threatening, which will also not allow the school’s secondary insurance policy to cover any incurred expenses. This potentially leaves the student, and their family, responsible for the full balance of any incurred medical costs. Students in this situation are required to purchase the insurance through BVU or another plan with the same minimum coverage levels.

BVU carries a secondary insurance policy for injuries sustained during supervised intercollegiate team activities (practices, games, strength & conditioning sessions with a BVU athletics staff member supervising). This policy covers costs remaining after the primary insurance acts on qualifying claims. Due to timely filing guidelines for injuries to be covered, injuries must be reported to the BVU Athletic Training staff before seeking outside medical care. Injuries must be reported in a timely manner. Bills and insurance documentation for any outstanding costs should be turned in as quickly as possible. Any HSA accounts should not pay anything towards these costs as the reimbursement process is time-consuming and difficult.

The secondary insurance policy does not cover injury or illness sustained outside of the guidelines listed above. Conditions that would not be covered under this policy include pre-existing issues, general medical illness, non-athletic injuries, injuries from non-supervised activities (captain’s practice, open gym, etc.), injuries during intramurals, etc.