



Presentation College
1500 N. Main Street
Aberdeen, SD 57401

INTERCOLLEGIATE ATHLETICS NEW STUDENT-ATHLETE MEDICAL FORMS CHECKLIST

Dear PC Student-Athletes,

Welcome to Aberdeen and the Presentation College campus. We are excited to have you as a student-athlete at Presentation College and hope that you will get the most out of your pursuit of academic excellence and athletic success. As a student-athlete you will have access to the Saints Team Physicians and Certified Athletic Trainers to care for injuries and illnesses you sustain while participating in intercollegiate athletics at the Presentation College.

We request all of the following medical documentation be completed and returned to the address below by **prior to the start of your athletic participation.**

Presentation College
Attn: Athletic Training
1500 N. Main Street
Aberdeen, SD 57401

All of the documents you will need to complete are located on the Presentation College Athletics Web Site. **Delayed completion of these requirements may delay your ability to try-out or participate in any team activities.** Please complete the following checklist and return all documentation to the above address:

- _____ Complete a **Pre-Participation Physical Exam (PPE)** using **Presentation College PPE Form**, to be completed by a physician (MD/DO) within 6 months of the first date of participation in the intercollegiate sport. Physician must sign and include contact information.
- _____ Complete the **Presentation College Pre-Participation Physical Exam History Form** You, as the student-athlete, must type on-line (and print) the requested information and sign appropriate pages. This form should be completed prior to the pre-participation physical exam and brought to the physician for the physical.
- _____ Read completely and sign the **Presentation College Consent and Medical Information Release Form**.
- _____ Read completely **Presentation College Concussion Protocol and read, initial, and sign the Concussion Acknowledgement and Statement**.
- _____ Complete and sign the **Presentation College Athletic Insurance Verification Form**. Also, include a **photocopy of the front and back of the primary insurance card** for the policy under which the student- athlete is covered. If the student-athlete is covered by more than one policy, please include copies of cards for all policies.
- _____ Complete the **Presentation College Emergency Contact Information Form**.
- _____ If you have had surgery or have been under the care of a physician for an injury or illness within the past 12 months, provide:
 - A note clearing you for unrestricted participation in the intercollegiate sport you are intending to play or a note describing current activity restrictions
 - Physician notes, including post-op reports, imaging reports, and any precautions or restrictions related to the treated condition.

The Presentation College Athletic Training Staff aims to provide the student-athletes with the best possible medical care available. If you have any questions regarding any of these forms or policies please contact us at 605.229.8303. Go SAINTS!



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INTERCOLLEGIATE ATHLETICS PREPARTICIPATION PHYSICAL EXAMINATION FORM

Name:

Date of birth

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14 on Preparticipation Physical Examination History Form).

EXAMINATION		
Height:	Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP: /	Pulse:	Vision: R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance •Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	<input type="checkbox"/>	
Eyes/ears/nose/throat •Pupils equal •Hearing	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a •Murmurs (auscultation standing, supine, +/- Valsalva) •Location of point of maximal impulse (PMI)	<input type="checkbox"/>	
Pulses •Simultaneous femoral and radial pulses	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Genitourinary (males only) ^b	<input type="checkbox"/>	
Skin •HSV, lesions suggestive of MRSA, tinea corporis	<input type="checkbox"/>	
Neurologic ^c •Loss of consciousness, mTBI, concussion	<input type="checkbox"/>	



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INTERCOLLEGIATE ATHLETICS PREPARTICIPATION PHYSICAL EXAMINATION FORM

Name: _____

Date of birth _____

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder/arm	<input type="checkbox"/>	
Elbow/forearm	<input type="checkbox"/>	
Wrist/hand/fingers	<input type="checkbox"/>	
Hip/thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg/ankle	<input type="checkbox"/>	
Foot/toes	<input type="checkbox"/>	
Functional •Duck-walk, single leg hop	<input type="checkbox"/>	

a-Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

b-Consider GU exam if in private setting. Having third party present is recommended.

c-Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____

Date _____

Address _____

Phone _____

Signature of physician _____, MD or DO





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INTERCOLLEGIATE ATHLETICS PREPARTICIPATION PHYSICAL EXAMINATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam:

Name:

Date of birth:

Sex:

Age:

Grade:

Sport(s):

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? Yes No If yes, please identify specific allergy below. Medicines Pollens Food Stinging Insects

Do you require a use of an Epi-Pen? Yes No

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	If yes, explain in the space provided
1. Has a doctor ever denied or restricted your participation in sports for any reason?			
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other:			
3. Have you ever spent the night in the hospital?			
4. Have you ever had surgery?			
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	If yes, explain in the space provided
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: High blood pressure A heart murmur High cholesterol A heart infection Kawasaki disease Other:			
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			
10. Do you get lightheaded or feel more short of breath than expected during exercise?			
11. Have you ever had an unexplained seizure?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	If yes, explain in the space provided
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			
BONE AND JOINT QUESTIONS	Yes	No	If yes, explain in the space provided
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			
18. Have you ever had any broken or fractured bones or dislocated joints?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			



INTERCOLLEGIATE ATHLETICS PREPARTICIPATION PHYSICAL EXAMINATION HISTORY FORM

Name: _____

BONE AND JOINT QUESTIONS CON'T	Yes	No	If yes, explain in the space provided
20. Have you ever had a stress fracture?			
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			
22. Do you regularly use a brace, orthotics, or other assistive device?			
23. Do you have a bone, muscle, or joint injury that bothers you?			
24. Do any of your joints become painful, swollen, feel warm, or look red?			
25. Do you have any history of juvenile arthritis or connective tissue disease?			
MEDICAL QUESTIONS	Yes	No	If yes, explain in the space provided
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
27. Have you ever used an inhaler or taken asthma medicine?			
28. Is there anyone in your family who has asthma?			
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
30. Do you have groin pain or a painful bulge or hernia in the groin area?			
31. Have you had infectious mononucleosis (mono) within the last month?			
32. Do you have any rashes, pressure sores, or other skin problems?			
33. Have you had a herpes or MRSA skin infection?			
34. Have you ever had a head injury or concussion?			
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
36. Do you have a history of seizure disorder?			
37. Do you have headaches with exercise?			
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
39. Have you ever been unable to move your arms or legs after being hit or falling?			
40. Have you ever become ill while exercising in the heat?			
41. Do you get frequent muscle cramps when exercising?			
42. Do you or someone in your family have sickle cell trait or disease?			
43. Have you had any problems with your eyes or vision?			
44. Have you had any eye injuries?			
45. Do you wear glasses or contact lenses?			
46. Do you wear protective eyewear, such as goggles or a face shield?			
47. Do you worry about your weight?			
48. Are you trying to or has anyone recommended that you gain or lose weight?			
49. Are you on a special diet or do you avoid certain types of foods?			
50. Have you ever had an eating disorder?			
51. Do you have any concerns that you would like to discuss with a doctor?			
FEMALES ONLY	Yes	No	If yes, explain in the space provided
52. Have you ever had a menstrual period?			
53. How old were you when you had your first menstrual period?			
54. How many periods have you had in the last 12 months?			

Please describe all other health concerns not addressed with the above questions:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____



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 1500 N. Main Street
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INTERCOLLEGIATE ATHLETICS CONSENT AND MEDICAL INFORMATION RELEASE

A. Consent

I, _____ understand that this athletic screening process is for no other purpose than to clear me for athletic participation at Presentation College. I understand that it is not a physical for illness, which may develop in the future. I give authorization to the certified athletic trainer or team physician to examine and treat any injuries or illness that occurs during my participation at Presentation College. This includes, for example, immediate first aid treatment, x-rays, physical exams, follow-up care, and rehabilitation. I understand the certified athletic trainer or team physician have the authority to disqualify me from further participation because of injury and/or because of undue risk to Presentation College.

Parental Consent (for Athletes under the age of 18)

The law requires parental permission before medical and surgical treatment of a minor. The hospitals in our area have a similar requirement relative to admission and treatment. If such a treatment becomes necessary, every effort will be made to obtain your specific consent before treatment. On occasion you may be unavailable. In order to avoid unnecessary delay, your prior consent to treatment is important. However, no surgical procedures will be performed without your specific knowledge and consent, except in cases of emergency. I understand the considerations set forth above, consent to use of the included insurance policy and authorize any physician and any hospital involved to perform such medical or surgical treatments as may be deemed necessary for my son/daughter.

 (PRINT ATHLETE'S FULL NAME)

 (DATE)

 (ATHLETE'S SIGNATURE)

 (PARENT'S SIGNATURE, If athlete is under the age of 17)

B. Authorization of Release of Medical Information

I authorize Presentation College and any of its health or physical care providers or practitioners to release to parents, athletic trainers, coaches, or other individuals employed by or associated or assisting with Presentation College athletic programs or student-athletes, any and all records, documents, or information they may have regarding my medical, physical or psychological condition, for the purpose of informing such individual(s) regarding such condition(s), such as records, documents or information may become available or be developed over the course of the year including and following the date of this Release Authorization.

I further authorize the release of records, documents or information regarding my medical, physical, or psychological condition to other entities or individuals, including but not limited to the Presentation College Sports Information department, media outlets and personnel, and professional team personnel for the purpose of informing such entities or individuals of such conditions. The Release Authorization should not be construed, however, to require such release.

This Release Authorization is effective for the year including and following the date of execution, and I may revoke it by means of a written or verbal statement to that effect.

 (PRINT ATHLETE'S FULL NAME)

 (DATE)

 (ATHLETE'S SIGNATURE)

 (PARENT'S SIGNATURE, If athlete is under the age of 17)





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INTERCOLLEGIATE ATHLETICS EMERGENCY CONTACT INFORMATION

Athlete's Name:

In case of emergency please list two people who should be contacted:

Contact #1

Name:

Relation to Athlete:

Emergency Number:

This number is: work cell

Address:

home

City:

State:

Zip Code:

Contact #2

Name:

Relation to Athlete:

Emergency Number:

This number is: work cell

Address:

home

City:

State:

Zip Code

The following should be completed each subsequent year of participation at PC.

I attest the above information is current:

Athlete Initials

Date

- 2nd year of eligibility _____ _____
- 3rd year of eligibility _____ _____
- 4th year of eligibility _____ _____
- 5th year of eligibility _____ _____



Preseason Baseline

- All athletes will undergo preseason baseline testing including the ImPACT Concussion Evaluation (ImPACT)

Recognition of Concussion

- Any athlete with any sign of concussion should be immediately be seen by the athletic training staff
- An athlete will be determined to have a concussion and warrant further testing if any one of the following occurs:
 - The athlete reports or demonstrates any sign or symptom of a concussion as a result of a specific hit to the head or other body part,
 - There is a witnessed hit to the head in which any sign or symptom of concussion is observed, or
 - The athlete reports any two signs or symptoms of a concussion as a result of participation in an at risk sport of concussion
- All suspected concussion should be documented using the SCAT2 assessment form.

Assessment of Concussion

- Immediate Assessment
 - Immediate assessment of a possible concussion should be performed by the PC athletic training staff as soon as it is discovered.
 - The athletic training staff will utilize the SCAT2 to determine the post-concussion symptoms (and severity); cognitive, psychomotor, and neurologic deficits.
 - The athlete should be referred to a physician if they meet the any one of the qualifications of referral outlined in the Physician Referral Checklist from the NATA Position Statement
 - Day of injury referral (* Requires immediate transport to emergency room)
 - Deterioration of neurologic function*
 - Decreasing levels of consciousness*
 - Decreasing or irregular respirations*
 - Decrease or irregular pulse*
 - Unequal, dilated or unreactive pupils*
 - Seizure activity*
 - Signs or symptoms of associated fractures of skull or spine*
 - Mental status changes*
 - Amnesia lasting longer than 15 minutes
 - Loss of consciousness on the field
 - Increase in blood pressure
 - Vomiting
 - Cranial nerve deficits
 - Balance deficits subsequent to initial evaluation
 - Cranial nerve deficits subsequent to initial evaluation
 - Sensory deficits subsequent to initial evaluation
 - Motor deficits subsequent to initial evaluation
 - Post-concussive symptoms that worsen
 - Additional post-concussive symptoms compared with those on the field
 - Delayed Referral (After day of injury)
 - Any of the findings in the day of injury referral category
 - Post-concussive symptoms worsen or do not improve over time
 - Increase in the number of Post-concussive symptoms reported
 - Post-concussive symptoms begin to interfere with athlete's daily activities
 - Post-concussive symptoms last longer than 24 hours
 - Time of initial injury will be recorded
 - Immediate assessment of a possible concussion should be performed by the PC athletic training staff as soon as it is discovered
 - The athletic training staff will utilize the SCAT2 to determine the post-concussion symptoms (and severity); cognitive, psychomotor, cranial nerve, and neurologic deficits.
- Post-injury follow-up (24-72 hours after injury)
 - Athlete will follow-up with athletic trainer
 - Athlete will take ImPACT and SCAT2 to determine post-injury lows
- Athlete will follow-up a minimum of daily until completion of Return to Play Progression
- Concussions will not be graded; however, progress will be determined by cumulative score on the SCAT2
- Athletes should not be taking any pain medications during return to play progression.

INTERCOLLEGIATE ATHLETICS CONCUSSION PROTOCOL

Return to Play Progression

- Athletes should not be returned to play the same day of injury.
- When returning athletes to play, they should be **medically cleared and then follow a stepwise supervised program**, with stages of progression. The below table illustrates the return to play steps that will be taken with PC student-athletes.

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
No activity	Physical and cognitive rest	Recovery
Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity, 70 % maximum predicted heart rate. No resistance training	Increase heart rate
Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
Non-contact training drills	Progression to more complex training drills, eg passing drills in football and ice hockey. May start progressive resistance training	Exercise, coordination, and cognitive load
Full contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
Return to play	Normal game play	

- At least 24 hours (or longer) must pass for each stage and if symptoms return the athlete should rest until they resolve once again and then resume the program at the previous asymptomatic stage. Resistance training should only be added in the later stages.
- If the athlete is symptomatic for more than 10 days, then the student-athlete will be referred to the team physician.

INTERCOLLEGIATE ATHLETICS CONCUSSION ACKNOWLEDGEMENT AND STATEMENT

CONCUSSION A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body
-From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletic department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep, and classroom performance.

Take time to recover. If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you may vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.



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INTERCOLLEGIATE ATHLETICS CONCUSSION ACKNOWLEDGEMENT AND STATEMENT

I, _____ understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g. athletic training staff, team physician). I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution. I fully understand that:

_____ athletic activities involve risks and dangers of serious bodily injury, including initial permanent disability, paralysis, and death ("Risks")
INITIAL

_____ these Risks and dangers may be caused by my own actions or inactions, the initial actions or inactions of others participating in the Activity, or the condition in which the Activity takes place or;
INITIAL

_____ there may be other risks and social and economic losses either not known to me initially or not readily foreseeable at this time; and I fully accept and assume all such risks and responsibility for losses, costs, and damages I incur as a result of my participation in the Activity.
INITIAL

I have read and understand the above *Concussion Fact Sheet for Student-Athletes*.

After reading the Concussion Fact Sheet, I am aware of the following information:

_____ A concussion is a brain injury, which I am responsible for reporting to my team initial physician or athletic trainer.
INITIAL

_____ A concussion can affect my ability to perform everyday activities, and affect initial reaction time, balance, sleep, and classroom performance.
INITIAL

_____ You cannot see a concussion, but you might notice some of the symptoms right initial away. Other symptoms can show up hours or days after the injury.
INITIAL

_____ If I suspect a teammate has a concussion, I am responsible for reporting the initial injury to my team physician or athletic trainer.
INITIAL

_____ I will not return to play in a game or practice if I have received a blow to initial the head or body that results in concussion-related symptoms.
INITIAL

_____ Following concussion the brain needs time to heal. You are much more likely initial to have a repeat concussion if you return to play before your symptoms resolve.
INITIAL

_____ In rare cases, repeat concussions can cause permanent brain damage, and initial even death.
INITIAL

Signature of Student-Athlete

Date

Printed name of Student-Athlete





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INTERCOLLEGIATE ATHLETICS ATHLETIC INSURANCE VERIFICATION

On behalf of the athletic training staff, we welcome you to Presentation College. The below information relates to the policies regarding care and treatment of athletically related injuries that occur during participation at Presentation College. Most injuries sustained during participation will be examined, cared for, and/or treated in-house by the PC athletic training staff and Team Physician. If an injury requires examination, diagnostic procedures, and or surgery outside the scope of the athletic training staff, the financial responsibility will lie with the student-athlete and/or parents/legal guardians. All student-athletes participating in intercollegiate athletics at Presentation College must provide evidence that includes coverage for athletically-related injuries.

ALL STUDENT-ATHLETES ARE REQUIRED TO HAVE PERSONAL INSURANCE, EITHER THROUGH A PERSONAL POLICY OR THROUGH THEIR PARENTS/GUARDIANS.

PRESENTATION COLLEGE DOES NOT PROVIDE ANY PRIMARY OR SECONDARY ATHLETIC INSURANCE COVERAGE.

No student-athlete will be allowed to participate in any way until such evidence of current insurance coverage is on file with the PC athletic training staff. The enclosed Acknowledgement of Insurance requirement form **and a photocopy of both sides of insurance card** must be on file before a student-athlete can participate.

Insurance coverage must have a limit of at least \$75,000 and cover athletically-related injuries. If your insurance does not meet these requirements, Presentation College can recommend insurance companies which have such policies. Presentation College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at Presentation College.

If you have any questions regarding the terms of your coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions in your policy regarding athletically-related injuries.

The NAIA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a \$75,000 deductible.

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

(Parent/Guardian Version)

I, _____, as parent, guardian or legal representative, attest that _____ has insurance coverage under a current, in force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has a limit of at least \$75,000.

(Student Version)

I, _____, attest that I have insurance coverage under a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics. This coverage has limits of at least \$75,000.

Parent/Guardian Signature

Date

Student-Athlete Signature

Date

YOU MUST INCLUDE A COPY (*FRONT AND BACK*) OF YOUR CURRENT INSURANCE CARD





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INTERCOLLEGIATE ATHLETICS ATHLETIC INSURANCE VERIFICATION

The following information and authorization must be completed, signed, and returned before the athlete will be allowed to participate!

Athlete's Full Name	Sport	Date of Birth
Permanent Address	City	Phone
	Zip	

PRIMARY INSURANCE

Policy Holder		Relationship
Policy Holder's Date of Birth		
Policy Holder's Home Address	City	Zip
Home Telephone Number	Cell Number	
Policy Holder's Employer's Name		
Employer's Address	City	Zip
Name of Insurance Company		
ID Number	Group Number	
Insurance Mailing Address	City	Zip
Insurance Company Telephone Number		

Is your dependent son/daughter covered under the above policy? Yes No.

Does your insurance require: a second opinion for surgery? Yes No

Pre-authorization for service Yes No

SECONDARY INSURANCE

Policy Holder		Relationship
Policy Holder's Date of Birth		
Policy Holder's Home Address	City	Zip
Home Telephone Number	Cell Number	
Policy Holder's Employer's Name		
Employer's Address	City	Zip
Name of Insurance Company		
ID Number	Group Number	
Insurance Mailing Address	City	Zip
Insurance Company Telephone Number		

Is your dependent son/daughter covered under the above policy? Yes No.

Does your insurance require: a second opinion for surgery? Yes No

Pre-authorization for service Yes No

Please indicate which of the following medical facilities in the Aberdeen area your insurance company will allow you to use. If your insurance company allows you to receive services anywhere, Avera-St. Luke's Clinics and Hospital will be used since our Team Physicians are affiliated with Avera-St. Lukes.

PLEASE CHECK ALL THAT APPLY:

My insurance allows for services **ANYWHERE** in the Aberdeen area.

My insurance allows for **EMERGENCY** services **ONLY** in the Aberdeen area.

Avera-St. Lukes Hospital/Clinics

Sanford Hospital/Clinics

