Insurance Information Disclosure Form

To alleviate any confusion regarding athletic insurance for athletes at The Master's College, the following information has been provided to explain the coverage and the duties of those involved should an athlete be injured and require medical attention.

1. The Master's College carries athletic injury insurance for all athletes. However, our policy is a **secondary coverage policy** which means the student athlete's personal insurance company must be billed first. **Our insurance company will pay only the excess over and above expenses not covered by the athlete's primary insurance**.

2. Our policy will only cover injuries sustained during supervised team-sponsored participation, i.e., practices, athletic contests, and direct travel to and from these events. Illnesses and injuries sustained during non-team sponsored activities are not covered and are the responsibility of the athlete. **INJURIES MUST BE REPORTED TO BOTH THE COACH AND THE ATHLETIC TRAINING STAFF FOR PROPER CARE, REFERAL, AND UTILIZATION OF OUR ATHLETIC INJURY POLICY.**

3. Our policy will not cover any previous injury or condition present prior to participation in a sport at The Master's College, except in the case of re-injury or aggravation, and only if the athlete has received a "full" clearance from our team physician. Any previous injury damage not attributed to an athlete's present participation in a sport, and happens to result in a medical bill during the season, is not covered by The Master's College, and it is the athlete's responsibility to pay the medical bill.

4. If the athlete has primary insurance coverage other than The Master's College policy, then the athlete must submit an explanation of benefits along with the medical bills to the head athletic trainer no later than 30 days after the initial physician visit.
   Failure to submit an explanation of benefits or a letter of denial along with the medical bills within the required time period could result in non-payment of all expenses by The Master's College and will be the sole responsibility of the athlete.
5. The Athletic Training staff has the responsibility for care and referral of injuries sustained during team sponsored, supervised activities. Athletes who seek medical care without consultation of the athletic training staff will be financially responsible for any medical expenses incurred from self-referral.

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I have read and understand the above information. I am covered by a health insurance plan.

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

_____

Printed name of Student-Athlete

Rev. 05/15/2015

Proof of Insurance Form

Student Name: _____ Sport: _____

	Primary	Secondary
*Subscriber:	_____	_____
Subscriber Date of Birth:	_____	_____
Home Address:	_____	_____
	_____	_____
Phone Number:	(____)_____	(____)_____

***SUBSCRIBER IS PARENT/GUARDIAN/SELF WHO PURCHASED YOUR INSURANCE**

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You MUST show Proof of Insurance Coverage. Attach a photo copy of BOTH the FRONT and BACK of your Insurance Card in the space below. Failure to provide this information may cancel your eligibility to participate in intercollegiate athletics at The Master's College.

You must notify the Athletic Department of any changes to your insurance coverage

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INSURANCE CARD-FRONT	INSURANCE CARD-BACK

I ATTEST THAT THE ABOVE INFORMATION IS TRUE.

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

Rev. 05/15/2015

Voluntary Activity Participation Form

ACKNOWLEDGEMENT AND ASSUMPTION OF POTENTIAL RISK

I,_____, wish to voluntarily participate in The Master's College sponsored activity of: _____.

I understand and acknowledge that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses, which may result from participating in these activities, may include but are but are not limited to the following:

1. **Sprains/strains**
2. **Fractured bones**
3. **Unconsciousness**
4. **Head and/or neck injuries**
5. **Paralysis**
6. **Loss of eyesight**
7. **Communicable diseases**
8. **Death**

I understand and acknowledge that participating in these activities is completely voluntary and as such is not required by The Master's College.

I understand and acknowledge that in order to participate in these activities, I agree to assume liability and responsibility for any and all potential risk, which may be associated with participation in such activities.

I understand, acknowledge, and agree that The Master's College, its employees, officers, agents, or volunteers shall not be liable for any injury/illness suffered by me which is incident to and/or associated with preparing for and/or participating in this activity.

I acknowledge that I have carefully read this voluntary activities participation form and that I understand and agree to its terms.

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

_____

Printed name of Student-Athlete

Consent for Care

I hereby grant permission to the Athletic Medical Staff of The Master's College Athletic Department to employ such established treatments and therapy as may be deemed professionally necessary. This authorization shall remain in full force and effect unless the consent is canceled by written notice filed with The Master's College Department of Athletics.

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

_____

Printed name of Student-Athlete

Rev. 05/15/2015

Client Authorization to Release Information Form

I, _____, hereby authorize The Master's College Athletic Training Staff to release the pertinent information designated below from my clinical records and personal information.

I authorize release of information to: The Master's College Athletics (Athletic Training Staff, coaches, and athletic director) 21726 Placerita Canyon Road, Santa Clarita, CA 91321

Southern California Orthopedic Institute
24051 Newhall Ranch Road, Valencia, CA 91355

Other Medical Providers (such as medical specialties other than orthopedics)

Certified Athletic Trainers that host intercollegiate events at other sites (i.e. Colleges and Universities)

For the purpose of: Treating injuries or other medical conditions and maintaining healthy athletes

And (initial all that you will allow release of information to):

___Sports Information Office at The Master's College
___Accounting Office at The Master's College
___Outside Media
___Insurance Companies
___Parents of the student-athlete
___Professional Teams

For the purpose of: Media reports, and press releases, insurance claims, and parental participation in medical decisions.

Authorization valid from: August 1, 20__ to July 31, 20__ (list dates)

Designated Information:
Physical information, general medical history and health information, injury reports and diagnoses, coaches' reports, and medical referral information.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation.

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

Rev. 05/15/2015

The Master's College

Training Room EMERGENCY INFORMATION Card

(Please Print)

Name_____ Sport_____ Year: FR SO JR SR
Last First
Date of Birth_____ SS# (last four digits only)_____ Cell#: _____

Dorm/Off Campus Address _____

Name of Insurance Co. _____ Policy #: _____

Person to Notify in Case of Emergency:

Name_____ Relationship _____
Home #: _____ Work #: _____ Cell #: _____

List of Allergies: _____

List ALL medications being taken and reason for taking:

_____
_____

Student-Athlete Injury and Concussion Statement

I acknowledge 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 (e.g., athletic trainer, team physician). It is also my responsibility to follow the recommended treatment guidelines and to return to play only when medically cleared to do so. Knowingly withholding medical information that affects my safe participation in sports may be grounds for College disciplinary action.

I have read and understand the ***NCAA Concussion Fact Sheet***.
http://fs.ncaa.org/Docs/health_safety/ConFactSheetsa.pdf

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

_____ A concussion is a brain injury, which I am responsible for reporting to my Athletic
Initial Trainer or team physician.

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

_____ 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.

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

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

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

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

_____ _____

Student-Athlete Date Parent/Legal Guardian (if under 18 y/o) Date

_____

Printed name of Student-Athlete

Rev. 05/15/2015

Rev. 08/27/2015

The Master's College

Health History Questionnaire for Intercollegiate Athletes (Soph/Sen only)

(less than 12 months absence)

Name _____**Sport** _____ **Date**_____
Dorm _____
Home Address _____ **Home Phone #**
(_____)_____
Date of Birth _____ **Age** _____ **Cell Phone #**
(_____)_____

Instructions: Answer all of the following questions. If you fail to fully disclose pertinent information, you may invalidate the secondary insurance coverage provided by the college and may cancel your eligibility to participate in intercollegiate athletics. All information relating to this questionnaire will be kept strictly confidential.

Since Your Last Physical for The Master's College, Have You Had Any of the Following?

	Yes	No	Explanation
Head Injury, Concussion, Headaches, Dizziness, Fainting, etc.?			
Neck Injuries, Numbness, Tingling or Weakness of any Extremity?			
Heat Related Illness, i.e. Heatstroke, Heat Exhaustion?			
Chest Pain, Heart Problems, High or Low Blood Pressure?			
Any Bone or Joint Disorders, Fractures, Dislocations, etc.?			
Hospitalizations or Physician Visit?			
Recent Illness?			
Weight Change in the past 3 months?			

Have you been outside the U.S. within the last 6 months? _____
List ALL Allergies:_____
List ALL medications you take: _____

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I HEREBY CERTIFY THAT THE ABOVE IS A TRUE STATEMENT OF MY HEALTH.

Signature Date

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FOR OFFICIAL USE ONLY:

____ Clearance is recommended Reviewed by Head Athletic Trainer: _____ _____

____ Clearance is not recommend Signature Date