Roane State Department of Athletics

276 Patton Lane, Harriman, Tennessee 37748 / (865) 882-4581

Dear Parents and Student-Athletes,

Included, you will find the following forms:

1. Athletic insurance Information Questionnaire
2. Parent Information Form
3. NJCAA Medical History / Physical Examination Report
4. Authorization for Disclosure of Protected Health Information for STAR Physical Therapy, LP

Please print and fully complete each form and return to the below address no later than August 1, 2022:

Roane State Community College
Attn: Amberley Zeller, Athletic Assistant
Harriman, Tennessee 37748

All materials must be on file per the NJCAA and TCCAA before any athletic participation can occur.

Respectfully,

David Lane
Roane State Community College
Director of Athletics
276 Patton Lane
Harriman, Tennessee 37748
lanedr@roanestate.edu

Insurance Claim Procedure:

We hope your son / daughter has a successful and year free from injury, but should an injury occur, we want to be prepared. Athletic accident insurance is provided by Roane State for our student-athletes. This insurance is provided on an "excess" basis. Under this policy, the college's coverage is in excess to all other valid and collectible insurance policies. Most notable would be parental insurance coverage through your place of employment under which the student-athlete is covered as an eligible dependent. Athletic accident insurance is only applicable for athletic injuries and does not cover non-athletic illnesses.

Due to physicians / hospitals inability to provide Roane State with the information needed to file claims, the student-athlete and his / her parent / guardian is responsible for filing claims or having the attending physician / hospital file claims.

Please follow the steps below:

1. Provide the physician / hospital with any information needed on your primary insurance provider.

2. Roane State will pay any balance due after all insurance payments have been made. For Roane State to pay the balance, please have the physician / hospital statement showing the balance due after all insurance payments have been made along with an Explanation of Benefits (EOB) from your primary insurance company.

3. After providing your statement balance and EOB to the athletic department, your student-athlete must request an accident claim form from either the athletic department assistant or the athletic director.

PARENT INFORMATION

STUDENT-ATHLETE: _____

DATE OF BIRTH: _____

SPORT: _____ SCHOOL: ROANE STATE COMMUNITY COLLEGE

PLEASE NOTE:
Most employers' group insurance allows dependent coverage to be continued until age 26. Please, DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.

The following information and authorization must be fully completed and returned to the Roane State Athletic Department:

Father's Name: _____ SS#:_____

Home Address: _____ City:_____ St:_____ Zip:_____

Employer: _____

Employer Address: _____ City:_____ St:_____ Zip:_____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Insurance Company: _____ Group Policy #:_____

Does your insurance require: A second opinion for surgery? Yes:_____ No:_____
Pre-authorization for services? Yes:_____ No:_____

My son / daughter is **not** covered under my group insurance: _____

Mother's Name: _____ SS#:_____

Home Address: _____ , City:_____ St:_____ Zip:_____

Employer: _____

Employer Address: _____, City: _____ St:_____ Zip:_____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Insurance Company: _____ Group Policy #:_____

Does your insurance require: A second opinion for surgery? Yes: _____ No: _____
Pre-authorization for services? Yes: _____ No: _____

My son / daughter is **not** covered under my group insurance: _____

I hereby certify that the answers provided are true, complete, and correct to the best of my knowledge.

Father's signature: _____ Date: _____

Mother's signature: _____ Date: _____

INSURANCE QUESTIONNAIRE

STUDENT-ATHLETE: _____

SOCIAL SECURITY NO:_____

DATE OF BIRTH: _____

FATHER: _____ SSN: _____ EMPLOYED? _____ (Y / N)

MOTHER: _____ SSN: _____ EMPLOYED? _____ (Y / N)

If your son / daughter has a medical insurance coverage as an eligible dependent from a previous marriage, as mandated in a divorce decree, please provide details for filing a claim.

_____

_____

I / We agree that all the information provided in this document is accurate and complete to the best of our / my knowledge. I / we understand that any incorrect or undisclosed information can result in duplicate payments creating substantial overpayment. The responsibility of such overpayment will be the obligation of the undersigned to reimburse in full, upon request, all amounts deemed refundable.

Parent / Guardian / Father: _____Date: _____

Parent / Guardian / Mother: _____Date: _____

MEDICAL HISTORY / PHYSICAL EXAMINATION REPORT

ALL PLAYERS MUST HAVE BOTH PAGES COMPLETED AND ON FILE WITH THE ATHLETIC DEPARTMENT PRIOR TO THE BEGINNING OF FALL PRACTICE

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TO BE COMPLETED MY ATHLETE: Have you had any of the following:

_____ASTHMA	_____EYE / VISION PROBLEMS	_____KIDNEY DISEASE
_____BROKEN BONE	_____EPILEPSY / SEIZURES	_____RHEUMATIC FEVER
_____CHEST PAIN	_____HEART TROUBLE / MURMUR	_____RUPTURE / HERNIA
_____CHRONIC CAUGH	_____HEAD INJURY	_____SINUS TROUBLE
_____DIABETES	_____JAUNDICE	_____TUBURCULOSIS

ARE YOU ALERGIC TO ANY MEDICATION? _____ LIST MEDICINE ALLERGIES: _____
_____

LIST ANY PREVIOUS ILLNESSES, OPERATIONS OR INJURIES AND TREATMENT DATES:
_____
_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? _____
_____

HAVE YOU HAD ANY EMOTIONAL PROBLEMS_____ IF SO, LIST TREATMENTS:_____
_____

EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____

CITY: _____, STATE_____, ZIP _____

RELATIONSHIP: _____

PHONE: _(_____)_____

TO BELCOMPLETED BY THE PHYSICIAN:

PHYSICIAN'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: (____)_____

PHYSICAL EXAMINATION:

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____

VISION WITHOUT GLASSES: R_____ L_____ VISION WITH GLASSES R_____ L _____

GENERAL CONDITION OF TEETH _____ HEARING _____

ABDOMEN (PAIN, SCARS, MASSES) _____SKIN _____

SKELETAL SYSTEM _____ POSTURE _____

HEART _____ LUNGS _____

VERICOSITIS / HEMORROIDS _____ HERNIA _____

THE FOLLOWING TESTS ARE REQUIRED:

URINALYSIS: GLUCOSE_____ ALBUMIN _____ BLOOD _____

TB SKIN TEST OR X-RAY DATE DONE _____ RESULTS_____

IMMUNIZATION DATES:

MEASLES/MUMPS/RUBELLA_____ TETANUS_____ POLIO_____

Please make any comments regarding physical capabilities for competitive athletics, any restrictions or recommendations for this athlete, stating whether these are permanent or temporary:

_____

_____

_____

Physician's Signature_____ Date _____