SPORTS MEDICINE

MEDICAL PACKET

Student-Athlete and Parents/Guardians:
Please complete ALL forms in this packet and mail to:

Athletic Training Room
1022 Elam Center
Attention: Staff Athletic Trainer
Martin, TN 38238

Please make sure that **all signatures** of parent/guardian are fully completed.

Please make sure to attach a **copy of the FRONT & BACK** of health insurance including any prescription, dental, or vision insurance cards.

Incomplete packets and/or packets missing signatures will be returned. Student-athletes will not be able to participate until all forms are fully completed.

If you have any questions regarding medical paperwork please call:

Bart Belew
at
731-881-7689

INSURANCE & PERSONAL INFORMATION FORM

PERSONAL INFORMATION

Please print all information, except signatures. This form must be signed and completed in order to participate.

Name _____ Date of Birth ____/_____/____Sport _____
960 # _____ Marital Status_____ SSN: _____
Local Address _____ City_____ State____ Zip ___
Local Phone _____ Cellular _____ Email _____
Permanent Address _____ City_____ State____ Zip _____

PARENT/GUARDIAN INFORMATION

Father/Guardian_____
Address_____
_____
Home Phone_____
Cell # _____D.O.B._____
Employer _____
Employer Address _____
_____
Work Phone _____

Mother/Guardian_____
Address_____
_____
Home Phone_____
Cell # _____ D.O.B._____
Employer _____
Employer Address _____
_____
Work Phone _____

EMERGENCY INFORMATION (In The Event Parents/Guardians Can Not Be Reached)

Name _____ Relation to Athlete _____
Address _____ City _____ State_____ Zip_____
Home Phone _____Work _____ Cellular _____

INSURANCE INFORMATION

Primary Insurance (Circle One): HMO PPO NEITHER Policy Holder's Name _____
Insurance Company Name _____ Phone _____
Address _____City _____State____ Zip_____
Policy # _____ Group # _____
Deductible Amount _____ Date Coverage Begins _____ Termination Date _____

Secondary Insurance (Circle One): HMO PPO NEITHER Policy Holder's Name _____
Insurance Company Name _____ Phone _____
Address _____City _____State____ Zip_____
Policy # _____ Group # _____
Deductible Amount _____ Date Coverage Begins _____ Termination Date _____

ALLERGIES

Please list all allergies to medications, foods, stings, and bites_____
_____

_____ I hereby authorize the Athletic Department to file a claim in my behalf for the athletic injury sustained by (dependent) under the above group medical policy. Further, I agree to consent that any amounts payable under this policy be paid to the medical provider or to the University of Tennessee at Martin Athletic Department as shown.

_____ My son/daughter is not covered under my personal health insurance. Therefore, I hereby authorize the University of Tennessee at Martin, and its representatives to inspect or secure copies of case history, laboratory reports, diagnosis, x-rays, and any other data in relation to any medical claim. This authorization my be photo copied and any photocopies should be deemed as valid and applicable as the original.

INLCUDE A COPY OF THE <u>FRONT</u> AND <u>BACK</u> OF YOUR INSURANCE CARD AND COPIES OF RELATED CARDS

Signature of Policy Holder _____ Date _____

SPORTS MEDICINE

MEDICAL HISTORY PACKET

Sport

Last Name | First | Middle | Date

Student ID Number | Date of Birth | Age | Sex | Martial Status

ALLERGIES

	Yes	No		Yes	No
Aspirin	☐	☐	Insect Bites/Stings	☐	☐
Codeine	☐	☐	Tetanus Antitoxin/Serums	☐	☐
Sulfa	☐	☐	Nail Polish/Cosmetics	☐	☐
Anti-inflammatory	☐	☐	Foods:	☐	☐
Penicillin	☐	☐	Foods:	☐	☐
Hay Fever	☐	☐	Other:	☐	☐
	☐	☐		☐	☐

IMMUNIZATIONS

	Completed	Not Completed	Date of Injection
Tetanus/Diphtheria	☐	☐	
Measles, Mumps, Rubella (MMR)	☐	☐	1. 2.
Measles and Rubella (MR)	☐	☐	1. 2.
Influenza	☐	☐	
Hepatitis	☐	☐	

FAMILY HISTORY

(has any blood relative **EVER** had any of the following)

	Yes	No	Comments
Sudden Death (before age 55)	☐	☐	
Blood Diseases (Sickle Cell, Leukemia)	☐	☐	
Diabetes	☐	☐	
Epilepsy	☐	☐	
Cancer	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Mental Disorders (anxiety/depression)	☐	☐	
Stroke	☐	☐	
Tuberculosis	☐	☐	
Drug and/or Alcohol Dependency	☐	☐	

SPORTS MEDICINE

YEARLY HEALTH QUESTIONNARIE

The National Collegiate Athletic Association's policies recommend that all student athletes have qualifying medical evaluations upon their initial entrance into an institution's intercollegiate athletic program. The University of Tennessee at Martin supports and adheres to this NCAA policy.

Any question answered as "YES" below must be explained in detail below.

Have you been hospitalized or had any major illnesses in the last 12 months?	YES ☐	NO ☐
Are you currently ill in anyway?	YES ☐	NO ☐
Have you had any injury (including a concussion) since your last physical or in the last 12 months?	YES ☐	NO ☐
Are you currently rehabilitating any injuries?	YES ☐	NO ☐
Are you currently taking any medications including supplements, dietary aids, or vitamins?	YES ☐	NO ☐
Do you have any health problems not covered above (cardiac, respiratory, digestive, or orthopedic)?	YES ☐	NO ☐
Do you know of, or do you believe there is, any health reason that would influence your ability to participate in intercollegiate athletics for the University of Tennessee at Martin?	YES ☐	NO ☐

The undersigned, herewith:

1. Understands that he or she must refrain from practice or play while ill or injured, whether or not receiving medical treatment, and during medical treatment until he or she is discharged from treatment, and during medical treatment until he or she is discharged from treatment or given permission by the clinical practitioner to restart participation despite continuing treatment.

2. Understands that having passed the physical examination does not necessarily mean that he or she is physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify him or her at the time of said examination.

3. Certifies that the answers to the questions above are correct and true.

_____	_____	_____
Student Athlete Signature	Student Athlete Name (*please print)*	Date

Have you **EVER** had or **CURRENTLY HAVE** any of the following medical conditions?

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
High Blood Pressure			
Pericarditis			
Heart Disease			
Tumor, Growth, Cyst			
Cancer			
Hepatitis			
Pleurisy			
Pneumonia			
Respiratory Infection/Bronchitis			
Tuberculosis			
Malaria			
Mononucleosis			
Measles			
Mumps			
Rubella			
Chicken Pox			
Asthma			
Exercise Induced Asthma			
Sinus Infection			
Nasal Polyps			
Nose Fracture			
Amnesia			
Seizure Disorder			
Thyroid Disease			
Skin Disease			
Diabetes			
Sickle Cell Anemia/Trait			
Anemia			
Blood Disease			
Blood Clots			
Kidney Disease			
Kidney Stones			
Blood in urine			
Frequent Urinary Infections			
Hearing Defect/Loss			
Muscular Disease			
Birth Defects			
Appendicitis			
Stomach Ulcer (Peptic)			
Gastrointestinal Bleeding			
Hemorrhoids			
Hernia			
Arthritis			
Herpes (Oral or Genital)			
Sexually Transmitted Disease			
Car or Air Sickness			
Mental Disorder (anxiety, depression)			
Drug/Alcohol Dependency			
Attention Deficit Disorder (ADD)			

INTERNAL

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments (organ/problem)
Were you born with a complete and functional set of paired organs? (eyes, ears, kidneys, overies/testicles, lungs)	☐	☐	
Have you ever had surgery to repair any organs? (hernia, tonsils, appendix, spleen, etc.)	☐	☐	
Physican's name and address:			
Have you ever had surgery to remove any organs? (hernia, tonsils, appendix, spleen, etc.)	☐	☐	
Physican's name and adderss:			

CARDIAC

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Have you ever felt dizzy, light-headed, or passed out during or after exercise?	☐	☐	
Have you ever had chest pain/discomfort while exercising?	☐	☐	
Have you ever had irregular heart beats, heart palpatations or felt like your heart skipped a beat?	☐	☐	
Have you ever been told you have a heart murmur?	☐	☐	
Have you ever been treated by a cardiologist?	☐	☐	
Have you ever had an eco-cardiogram, stress test, or any other heart tests?	☐	☐	
Have you ever been told that you have increased blood pressure?	☐	☐	
Have you or anyone in your family ever been told that they have Marfan's Syndrome? If yes, who?	☐	☐	

ORTHOPEDIC

Have you ever sprained/strained, fractured, dislocated, x-rays, MRI, CT Scan, surgery, pinched nerves, had repeated swelling or pain, or had any other injury of any of the following areas of the body? If yes, please explain include the side of the body, specific injury, and date of injury.

	Yes	No	Comments
Head	☐	☐	
Neck	☐	☐	
Elbows	☐	☐	
Wrists	☐	☐	
Hands/Fingers	☐	☐	
Shoulders	☐	☐	
Upper Arms/Forearms	☐	☐	
Chest Wall	☐	☐	
Lower Back	☐	☐	
Pelvis/Hips	☐	☐	
Thighs	☐	☐	
Lower Legs	☐	☐	
Knees	☐	☐	
Ankles	☐	☐	
Feet/Toes	☐	☐	

HEAT

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Have you ever had trouble with dehydration?	☐	☐	
Have you ever experienced heat cramps?	☐	☐	
Have you ever been hospitalized for heat related problems?	☐	☐	
Have you ever required an IV for heat related problems?	☐	☐	
Have you ever required oral medication for heat related problems?	☐	☐	

HEAD

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Do you have a problem with frequent headaches, blurry vision	☐	☐	
or dizziness?	☐	☐	
Have you ever been told you have migraine headaches?	☐	☐	
Have you ever had a concussion?	☐	☐	
If yes,			
How many?			
When was the last one?			
Did you loose consciousness?			

VISION, DENTAL, and HEARING

If yes, please provide detailed information about the condition in the comments section.

	Yes	No	Comments
Do you wear corrective lens? Contacts or glasses?	☐	☐	
Do you have to wear corrective lens during sport participation?	☐	☐	
Have you ever had an injury to your eyes?	☐	☐	
Do you have a bridge or false teeth?	☐	☐	
Have you ever fractured a tooth?	☐	☐	
Have you ever had a tooth knocked out?	☐	☐	
Do you wear a mouth guard?	☐	☐	
Do you wear orthodontic appliances?	☐	☐	
Have you ever worn hearing aids?	☐	☐	

The undersigned, herewith,

- Understands that he/she must refrain from practice or play during medical treatment until he/she is discharged from treatment or given written permission by the attending physician to resume participation.

- Certifies that the answers to those questions are correct and true.

- Understands that his/her having passed the physician examination does not necessarily mean that he/she is physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify him/her.

- Fully realizes the University Athletic Association, Inc. cannot be held responsible for any previous medical condition(s) that he/she might have.

_____ _____

Student Athlete Signature Date

_____ _____

Parent/Guardian Signature Date

Authorization for Release of Protected Health Information

Please print all information except when signatures are required

Student Athlete Name	Student ID Number	Date of Birth

Address	City	State	Zip

I hereby authorize the physicians, athletic trainers, sports medicine staff and all other health care personnel representing the University of Tennessee at Martin and the University of Tennessee at Martin Athletic Department to receive my protected health information for diagnosis and/or treatment purposes for intercollegiate athletic participation. I understand that my authorization/consent releases the following information: *(Please check one of the following)*

□ Complete Medical Records

□ Records concerning the following injury/illness _____

□ Records for the period between _____/_____/_____ to _____/_____/_____.

□ Records confined to the following information: *(Please check all that apply)*

- □ Medical Condition
- □ Medical Status
- □ Athletic Participation Status
- □ Prognosis
- □ Consultation
- □ Operative Notes
- □ Discharge Summary
- □ Pathology Reports
- □ EKG/echocardiogram
- □ Medications
- □ History and Physical
- □ X-ray Reports
- □ MRI/CT Reports
- □ Progress Notes
- □ Lab Reports
- □ Other:_____

I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment) and may not be disclosed without either my authorization under HIPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or Buckley Amendment. I understand that I may revoke this authorization/consent at any time by notifying in writing the Head Athletic Trainer, but if I do, it will not have any effect on actions the University of Tennessee at Martin or the University of Tennessee at Martin Athletic Department took in reliance on this authorizations/ consent prior to receiving the revocation. This authorization/consent shall expire one year from the date it is signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Athlete	Date

Signature of Parent/Guardian (if athlete is under 18)	Date

Authorization for Disclosure of Protected Health Information

Please print all information except when signatures are required

Student Athlete Name _____ Student ID Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing the University of Tennessee at Martin Athletic Department to release information regarding my protected health information and any related information regarding any injury or illness during my participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to:

□ All of the following parties may receive my protected health information:

Or (*Please check all appropriate boxes in which protected health information MAY be released)*

□ Health Care Providers
□ Parents/Guardians
□ Hospials and/or Medical Clinics/Laboratories
□ Insurance Carriers
□ Academic Counselors
□ NCAA Injury Surveillance System
□ Members of the media
□ NCAA
□ Athletic Coaches
□ Strength and Conditioning Coaches
□ Medical Insurance Coordinators
□ Athletic Training Education Program
□ Athletic/University Administrators
□ Sports Information Staff
□ OVC
□ Professional Sports Teams

I understand that my protected health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment) and may not be disclosed without either my authorization under HIPPPA or my consent under the Buckley Amendment. I understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPPA and/or the Buckley Amendment. I understand that I may revoke this authorization/consent at any time by notifying, in writing, the Head Athletic Trainer, but if I do so, it will not have any effect on actions the University of Tennessee at Martin or the University of Tennessee at Martin Athletic Department took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent shall expire one year from the date it is signed.

_____ _____

Signature of Athlete Date

_____ _____

Signature of Parent/Guardian (if athlete is under 18) Date

ASSUMPTION OF RISK

(Please write your sport in each blank)

I recognize that playing and practicing in _____ can be a dangerous activity involving **MANY RISKS OF INJURY**. I also understand that the dangers and risks of playing or practicing to play and participate in _____, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to all internal organs, serious injury to all bones, joints, ligaments, muscles, tendons and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health, and well-being. I understand that the dangers and risks of playing or practicing to play and participate in _____ may not only result in serious injury, but in serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life. Due to the dangers of participating in _____, I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc. and to obey such instructions. In consideration of the University of Tennessee at Martin Athletic Association permitting me to participate for the University of Tennessee at Martin _____ team and to engage in all activities related to the team, including but not limited to, trying out, practicing or playing and/or participating in _____, I hereby assume all risks associated with participating and agree to hold The University of Tennessee at Martin its employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the University of Tennessee at Martin _____ team. The terms hereof shall serve as a release and assumption of risk of my heirs, estate, executor, administrator, assignees, and for all members of my family. I recognize that I have had the opportunity to refuse signing the assumption of risk form and fully understand all risks stated above.

_____ _____ _____

Signature of Student Athlete | Student Athlete Name (*Please Print)* | Date

_____ _____ _____

Signature of Parent/Guardian | Parent/Guardian Name *(Please Print)* | Date

FEMALE ATHLETES ONLY

HISTORY FORM FOR FEMALE ATHLETES

The questions below concerns problems that are particular to women. This form is intended to reveal a complete medical picture of our female athletes, which will enable the sports medicine department to provide the best health care. All answers to the questions will remain confidential to our medical staff.

NAME:_____ DATE:_____

YES NO (1) Have you had a pelvic exam within the past 12 months?
☐ ☐ The Date was _____

YES NO (2) Have you had a pap test within the past 12 months?
☐ ☐ The Date was _____

YES NO (3) Have lumps or knots been noticed upon breast examination?
☐ ☐
A. Did you see a physician? _____
B. What was the diagnosis? _____
C. What was the date? _____

YES NO (4) Have you ever had any gynecological surgery?
☐ ☐ If yes, please explain _____
_____

YES NO (5) Within the last twenty four months, has your menstrual cycle
☐ ☐ been regular monthly?_____
A. Did you see a physician? _____
B. Was Medication prescribed? _____
C. Date? _____
D. Type of medication? _____

YES NO (6) With the onset of menstrual bleeding, do you experience any
☐ ☐ swelling and soreness of the breast, uncomfortable abdominal cramping, headaches, low back pain, and/or other _____?
PLEASE UNDERSCORE ONE OR ALL OF THE ABOVE SYMPTOMS THAT PRESENT DISCOMFORT.

YES NO (7) Have you ever taken medication for menstrual discomfort?_____
☐ ☐ What was the date?_____The medication?_____

YES NO (8) Have you ever had any unusual bleeding or vaginal discharge?___
☐ ☐ A. Did you see a physician? _____
B. Was medication prescribed?_____Date?_____
Type of medication?_____

YES NO (9) Have you experienced discomfort during ovulation?
☐ ☐

YES NO (10) Has a physician prescribed hormonal medication? _____
☐ ☐ A. What was the hormone?_____
B. What was the reason?_____
C. What was the date?_____

THE UNIVERSITY OF TENNESSEE AT MARTIN
DEPARTMENT OF INTERCOLLEGIATE ATHLETICS

PERMISSION FOR TREATMENT

Should a medical emergency or injury occur, we will make every effort to contact you about the treatment for your son or daughter. In the event you cannot be reached we ask that you give us, (UTM Sports Medical Staff, licensed physician, hospital staff), permission to provide emergency medical treatment and any follow-up care by a licensed physician.

In the event I cannot be reached by telephone, I grant permission to the University of Tennessee at Martin Sports Medicine Staff, licensed physicians, and hospital staff to provide_____ with emergency care and follow-up care.

Phone Numbers where I can be reached:
_____

Athlete's Signature:_____ Date:_____

Parent's Signature_____ Date: _____
(if athlete is under 18)

UNIVERSITY OF TENNESSEE AT MARTIN
Department of Athletics

Concussion Policy Acknowledgement

I confirm that I have been informed by The University of Tennessee at Martin Department of Athletics that by participating in intercollegiate athletics, that I may experience any of the following symptoms by suffering from a concussion:

- Headaches
- Dizziness
- Nausea
- Blurred Vision
- Amnesia
- Possible Loss of Consciousness
- Ringing in the ears (Tinnitis)
- Confusion
- Disorientation
- Slurred or Incoherent Speech
- Delayed Verbal or Motor Response
- Light Sensitivity

I, the undersigned, do herby affirm that it is my responsibility to notify the UT Martin Sports Medicine Staff should I experience any of these symptoms at any time. I further attest that should I suffer a concussion that I agree to abide by the UT Martin Concussion Policy before being allowed to return to play in my sport.

_____ _____

Student Athlete Signature (If under 18, include parent/guardian signature) Date

Medical Insurance Policy for the University of Tennessee at Martin

Note: The procedures outlined below must be followed by the athlete. Failure to do so will result in the denial of insurance coverage. UT Martin Intercollegiate Athletics has obtained the services of the physicians at the Student Health Center, as well as team physicians to treat student-athletes for sports-related injuries. Unless otherwise authorized by the athletic trainer, athletic insurance claims will not be filed by paying any other doctor or medical facility.

(A) Each year before a student-athlete may participate in any athletic activity he/she will be required to complete a series of forms from the athletic training room. These forms include a health history questionnaire and a parent insurance information form that must be completely filled out and returned with a front and back copy of any insurance card covering the athlete. Failure to complete these forms each year will result in your not being able to participate in any running, lifting, or practice activities. When any athlete arrives on campus for the first time he/she will be required to have a complete physical examination by Tennessee-Martin team physicians. This physical is a one-time event and is provided at no cost to you, but must be completed before you will be able to participate. Physicals from other physicians will not be accepted.

(B) If a student-athlete becomes injured in an intercollegiate sports related activity such as practice, competition, conditioning, etc., he/she should report to the staff athletic trainer immediately. The student-athlete will be evaluated and referred to a physician for diagnosis if necessary. Failure to report to the athletic trainer may result in the student-athlete being responsible for any bills resulting from such injury. If a student-athlete becomes ill or injured outside of athletic participation, he/she must report to the athletic training room first thing in the morning or as soon as possible. The student-athlete will be evaluated and referred to Student Health Services or one of the team physicians.

(C) If a student-athlete becomes injured while participating in a sports related activity and that injury requires a physician's care, special tests, surgery, or rehabilitation, the student-athlete's insurance will be filed and all bills will be in his/her name and home address. Once the student-athlete's insurance has responded with payment or denial, the student-athlete will receive an explanation of benefits (EOB). The student-athlete must send a copy of any EOB and any bills received to the Tennessee-Martin insurance secretary for processing and payment. Failure to do so in a timely manner or lack of cooperation may result in the student-athlete becoming 100 percent responsible for these bills. Tennessee-Martin has excess insurance coverage that will pay any bills for athletic related injuries that the student-athlete's insurance does not pay. This includes any deductible, co-pay, or out of network expenses. The student-athlete should pay nothing out of his/her own pocket. Tennessee-Martin requires that the

student-athlete's insurance be filed first and that he/she follows any and all procedures required by his/her personal insurance company. Again, failure to do so or lack of cooperation may result in the student-athlete being 100 percent responsible for these bills.

(D) The student athlete who becomes ill at any time during the night or day must notify the athletic trainer immediately (not a coach, manager, etc.). If the head athletic trainer (upon examination) feels the athlete needs further medical attention, he will arrange an appointment with the appropriate specialists as soon as possible. The athletic trainers are the only authorized persons who can refer student athletes. A student athlete may be seen by whomever he wishes for sickness, but Intercollegiate Athletics insurance does not provide benefits for ordinary sickness. No head coach or assistant coach will take it upon himself to recommend or personally acquire an appointment for any athlete unless that coach wishes to make payment for such personally and be in violation of NCAA rules.

(E) The athletic trainer must notify the hospital or doctor for any sport-related injury visitation. If this authorization is not obtained prior to the athlete's visit to the hospital or other physician or surgeon, Tennessee-Martin's athletic insurance will not be filed until after receiving notice of payment or denial by your parent's insurance.

(F) The head athletic trainer must authorize all prescriptions prior to visiting the pharmacy. Valid prescriptions must be for the treatment of athletic injuries only. If the student-athlete parent's insurance provides Major Medical coverage then the student-athlete's parents should pay for all prescriptions and file for reimbursement with their insurance. After receiving notice of payment or denial by the student-athlete parent's insurance, Tennessee-Martin will then file with Intercollegiate Athletics insurance for the percentage not covered by Major Medical.

(G) Dental expenses may be covered by Intercollegiate Athletics insurance if resulting from injuries received while participating in a formal supervised intercollegiate practice or game. Toothaches, dental caries, abscesses, root canals, etc., are the responsibility of the student or his/her parents.

(H) Correction lenses for glasses or contact lenses may be covered by Intercollegiate Athletics insurance if the glasses were broken or the contacts lost while participating in a formal supervised intercollegiate practice or game.

(I) Any situation not covered in the above regulations must first be presented to the athletic trainer to obtain approval by the medical insurance clerk before any fees, charges, or prescription costs are incurred.

(J) It must be known that the university/the university's insurance carrier will not and cannot accept the responsibility for expenses incurred for a pre-existing medical condition of an athlete. Disqualification due to that pre-existing problem is at the discretion of the team physician. Failure to report and document pre-existing problems releases the Tennessee-Martin Office of Intercollegiate Athletic from any liability in the event of another problem caused by the initial injury. The Tennessee-Martin Office of Intercollegiate Athletics will not be financially responsible for medication of long-term pre-existing conditions such as allergies, diabetes, acne, etc. The Athletic Training Staff will be happy to assist the student-athlete in ordering and coordinating the administration of the medication but will not be financially responsible for it. Reminder: In compliance with NCAA rules and regulations, Tennessee-Martin shall be responsible for providing athletic accident insurance coverage for only those injuries that are directly related to the athlete's participation in intercollegiate competition, practice, or related travel for Tennessee-Martin. All other injuries or illnesses are the responsibility of the student-athlete and his/her family.

Don't forget to include a copy of the FRONT & BACK of your insurance cards

I, _____, have read and understand the medical policies and
(Please Print Name)
procedures outlined by the UT Martin Athletic Training Staff.

Student-Athlete Signature: _____ Date:_____

Parents/Guardian Signature: _____ Date: _____

INSTRUCTIONS:

SAVE THE COMPLETED DOCUMENT, EMAIL THE COMPLETED DOCUMENT TO BBELEW@UTM.EDU. IF YOU DO NOT HAVE COMPUTER ACCESS, PRINT OFF THE FORMS AND MAIL PACKETS TO THE FOLLOWING ADDRESS: ATHLETIC TRAINING ROOM

1022 ELAM CENTER

MARTIN, TN 38238

SEND COPIES OF THE FRONT AND BACK OF ALL INSURANCE CARDS OR COPIES CAN BE MADE ON THE DAY YOUR SON/DAUGHTER REPORTS.