Important Information on Athletic Insurance Coverage
Parents Please Review

This information has been compiled to give you a better understanding of your son/daughter's coverage while participating in intercollegiate athletics at The University of Texas-Rio Grande Valley. It also contains helpful information regarding your family's primary HMO or PPO policy while your son/daughter is away at school. In the event that your son/daughter suffers an injury as a direct result of his/her participation in an official team athletic activity (practice, game, or travel), coverage of medical expenses incurred will be processed in the following order:

1. **Student-Athlete's primary insurance policy (parents' policy)**
2. **Athletic Department's secondary/excess insurance policy**
3. **NCAA's catastrophic insurance plan (after $90,000)**

1. **Student-Athlete's Primary Insurance Policy:** *In accordance with the U.S. Affordable Care Act, all U.S. citizens are now required to carry a qualified primary health insurance policy or receive an exemption from the federal requirement. (**see links to additional information below*) For insurance coverage purposes, UTRGV Athletic Department will require all student-athletes to provide proof of their primary coverage or proof of the federal exemption prior to participation in intercollegiate athletics. Student-athletes will be asked to submit a copy of both sides of their insurance card.
   In the event that the student-athlete suffers an athletic injury during participation, medical expenses incurred will be processed **first** through the student-athlete's primary insurance policy. If your primary policy is an HMO or PPO, it is imperative that you **check with your insurance company regarding out of area/network coverage for your son/daughter while he/she is away at school**. Many companies can set your son/daughter up on a "student status", thereby extending their coverage from your home area to cover them while they are away at school. If not, there may be an additional rider available for purchase that will extend your son/daughter's coverage out of area. For HMO policies, check with your company regarding changing your son/daughter's Primary Care Physician (PCP) from a physician at home to one in the area where he/she will be attending school. If needed, the UTRGV Sports Medicine Staff can help with this selection. Both of these steps will prove invaluable when seeking care in the event of an illness or accident involving your son/daughter.
   International Students: It is a University of Texas System requirement that each international student purchase the Student Health Insurance Policy offered by the Office of International Admissions and Services (*or comparable US health care plan that meet the required criteria*). This policy must be in place prior to their athletic participation. International student-athletes will be asked to submit a copy of both sides of this policy's card as well. https://utrgv.myahpcare.com/

2. **UTRGV Athletic Department's Secondary/Excess Insurance Policy:** Once related charges have been filed with the student-athlete's primary policy, remaining expenses are filed with the athletic department's secondary policy. Should the student-athlete not have insurance coverage

by virtue federal exemption, the athletic policy then becomes the primary policy. (***proof of exemption must be on file***) An Explanation of Benefits (EOB) or denial letter from the primary policy is required before a claim can be processed through the secondary athletic policy. The Sports Medicine Staff will help coordinate the processing of claims between the two (or more) policies, the doctor's office, and the parents. It is therefore very important to bring any documentation received (EOB's, denial letters, medical bills, etc.) to the attention of the Sports Medicine Staff as soon as they are received.

The Athletic Department's Secondary Excess Policy has a maximum benefit of $90,000 per claim. The NCAA Catastrophic Insurance Plan picks up after this amount.
The Athletic Department's Athletic Injury (Excess) Policy does **not** cover: illness of any sort, injuries that occur outside of official athletic participation, eye exams, glasses, or contacts, or dental work (unless as a direct result of an athletic injury to a sound and natural tooth). *Therefore, having a primary insurance policy for major medical coverage on your son or daughter is imperative.*

3. **NCAA's Catastrophic Insurance Plan:** This plan, sponsored by the NCAA, is in place to provide benefits to those student-athletes who sustain injuries in competition, practice, or team travel that results in irrecoverable loss of physical or mental capacity. This coverage is in excess to the athletic department policy's $90,000 maximum benefit.

As much as athletic participation is a shared responsibility, so is the responsibility for providing adequate insurance coverage for your son or daughter. NCAA policies and Federal mandates require that your son/daughter be adequately covered. If you do not currently carry a primary policy to cover your son or daughter that meets the minimal federal requirements, you should consider adding them to your policy or purchasing a short term policy which provides minimal essential coverage as per the Affordable Care Act while they are attending college. One such policy is available through the University. The cost of this type of coverage is not covered under athletic scholarship. The student-athlete is still ultimately responsible for charges incurred on his/her name and due to privacy laws, it is therefore extremely important to communicate closely with the Sports Medicine Staff to coordinate coverage and documentation. Please call us if you have any questions regarding the insurance coverage for your son/daughter.

We hope this information has been helpful as your son or daughter prepares for the upcoming season. If you have any questions at all regarding insurance coverage, please feel free to contact us in the Athletic Training Room at (956) 665-2233 or by email: alfred.castillo@utrgv.edu
For more information regarding the Affordable Care Act and exemptions:
https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee/

Sincerely,

Alfred Castillo MS, ATC, LAT
Head Athletic Trainer

Confidential Report of Medical History

(Please complete this form before going to your physician for examination)

Last Name (Print) First Middle Cell Phone Number

Sport Sex Date of Birth Age Student ID #

Family History:

Please fill out the charts below as they pertain to your family.

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father:					
Mother:					
Brother(s):					
Sister(s):					

	Yes	No	Relationship
Cancer			
Tuberculosis			
Diabetes			
Heart Disease			
Epilepsy/Seizures			
Stroke/Blood Clots			
Sickle Cell Trait			
Marfan's Syndrome			

Medical Illness History:

Have you ever had or do you now have any of the conditions below?

	Yes	No		Yes	No		Yes	No		Yes	No
Car, Air, Motion, or Sea Sickness			Contact with Hepatitis B (HBV)			History of Heat Illnesses or Heat Cramps			Chest Pain During Exercise		
Ear, Nose, or Throat Trouble			Contact with AIDS or HIV			Knocked Out/Unconscious			Heart Palpitations or Murmurs		
Asthma			Venereal Disease (STDs)			Head Injury/Concussions			Convulsions/Seizures		
Tuberculosis			Herpes Virus			Hospitalizations			Dizziness/Fainting		
Whooping Cough			Rectal Bleeding			Surgeries			Pain/Pressure in Chest		
Mumps			Rectal Itching			High Blood Pressure			Shortness of Breath		
Scarlet Fever			Hemorrhoids			Paralysis			Racing/Irregular Heartbeat		
Typhoid Fever			Rheumatism			Amnesia			Intestinal Trouble		
Rheumatic Fever			Gall Bladder Trouble			Migraine Headaches			Stomach Trouble		
Chicken Pox			Gallstones			Frequent Headaches			Nausea/Vomiting		
Small Pox			Appendicitis			Difficulty Sleeping			Frequent Indigestion		
Goiter/Thyroid Disease			Liver Trouble			Anemia/Blood Disorders			Peptic Ulcer		
Diphtheria			Urinary Tract Infection			Neuritis			**FEMALES ONLY:**		
Polio			Kidney Trouble			Psychiatric Problems			Irregular Periods		
Sickle Cell Anemia/Trait			Bloody Urine			Excessive Worry			Absence of Menstruation		
3-Day Measles			Sugar/Protein in Urine			Depression			Severe Cramps		
Malaria			Painful Urination			Nervous Trouble			Lumps in Breast		
Jaundice			Frequent Urination			Lyme Disease			Vaginal Discharge		
Mononucleosis (MONO)			Cancer			Wear Contacts/Glasses			Abnormal Pap Smear		
Chronic Frequent Colds			Tumor/ Growth/ Cyst			Skin Problems			Currently Taking Birth		
Diabetes (Type I or II)			Gout			Staph Infection/Boils			Control Pills?		

If you answered "**YES**" to any of the above areas, please explain.

Do you have any **ALLERGIES** to medications, foods, plants, insects, etc? If yes, list/if not write: NONE

Are you currently taking any **Prescription Medications**? If yes, please list meds, their purpose, and dosage. If not write: NO

_____

_____

Orthopedic History:

Have you ever sprained / strained, dislocated, fractured, or had repeated swelling or other injury of any muscles, tendons, bones or joints? Explain any "Yes" answers. NOTE: **Be sure to list any surgery details**.

Body Part	YES	NO	Year	Details
Head & Neck				
Shoulder				
Elbow & Arm				
Wrist, Hand & Fingers				
Back & Spine				
Hip & Thigh				
Knee				
Shin & Calf				
Ankle, Foot, & Toes				

Supplements/Nutrition:

List any supplements that you are currently taking or have taken in the past to help improve athletic performance (e.g. Creatine, Protein, Nitrous oxide, Thermogenics, etc.)?

Signatures:

I hereby state that the health information has been completed correctly to the best of my knowledge, and that I have fully disclosed all pertinent information regarding my injury history to the University and its team physicians.

Student-Athletes Signature Date

Minor consent form: Permission is hereby granted for this Student-Athlete to be treated at The University of Texas-Rio Grande Valley by the professional medical staff of the Student Health Services or by the team physicians designated by UTRGV Sports Medicine Staff.

Signature of Parent or Guardian: Date

Physician's Signature Acknowledging Review of Medical History Date

A COPY OF YOUR IMMUNIZATION RECORDS IS REQUIRED FOR OUR FILES

University of Texas-Rio Grande Valley Training Room: (956) 665-22233
Department of Sports Medicine Fax: (956) 665-7200
1201 West University Drive
Edinburg TX, 78539-2999 E-mail: alfred.castillo@utrgv.edu

Contact Information Sheet

Last Name (Print) First Middle

Sport Sex Date of Birth Age

Citizenship UTRGV Student ID Number Marital Status

Local address while attending UTRGV:

Number, Street and Apt.

City State Zip

UTRGV E-mail address

Home/Permanent Mailing Address:

Number, Street and Apt

City State Zip

Your Cell Phone Number

Personal E-mail Address

Parental Information:

Father's Name

Number, Street and Apt.

City State Zip

Work Phone Cell Phone Home Phone

Father, employed at this time? (*Circle One*)

Yes No Retired

Occupation

Employer

Employer's Address: Number and Street

City State Zip

Mother's Name

Number, Street and Apt

City State Zip

Work Phone Cell Phone Home Phone

Mother, employed at this time? (*Circle One*)

Yes No Retired

Occupation

Employer

Employer's Address: Number and Street

City State Zip

Emergency Contact:

Name Relation Day Phone Night Phone

Student-Athlete's Insurance Status Form

Important This form **MUST** be filled out completely and returned to the Athletic Training Room before the Student-Athlete will be allowed to participate in University activities or practices. Withholding any appropriate personal insurance information may invalidate your insurance coverage through the University!

Last Name (Print) First Middle Social Security Number

Sport Sex Date of Birth Age Student ID #

Personal Insurance Status: The U.S. Affordable Care Act requires each US citizen to be covered by a primary insurance plan. Please complete the following section **OR** provide written proof of your hardship exemption from required coverage.

Insurance Company Name: _____

Insurance Mailing Address: _____

Insurance Telephone: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Relationship to Student-Athlete: _____

Policy also covers: (*Circle all that apply*): Prescriptions Dental Vision

HMO/PPO Requirements or Restrictions: _____

Primary Care Physician: _____ Phone Number: _____

Other Information: _____

_____

Are there any other medical insurance policies covering this student-athlete? (*Circle One*) **YES** **NO**

_____

_____

_____

_____

_____

Please be sure to copy and submit both sides of all pertinent insurance cards (including medical, dental, and prescription cards).

I certify that the above information is correct to the best of my knowledge.

Studen- Athlete's Signature Date

Parent or Policy Holder's Signature Date

University of Texas – Rio Grande Valley
Report of Health Evaluation

(The following form needs to be completed and signed a physician prior to sport participation)

Last Name (Print) First Middle Cell Phone Number

Sport Sex Date of Birth Age Student ID #

Vital Signs		***Sickle Cell Trait Tested (*Required for NCAA purposes)***	
Height:	Weight:	Date of test:	POS or NEG
Blood Pressure:	Pulse:		

Immunizations (Required to be up-to-date)				
Diphtheria & Tetanus:		TB Skin Test	Pos.	Neg.
Polio (Under 19)		Chest X-Ray	Pos.	Neg.
Measles (Rubeola)		Meningitis		
Rubella				
Mumps				

Are there any abnormalities of the following systems? If yes, describe fully.

System	**Yes**	**No**	**Details**
Head, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Neurological			
Skin			
Hernia			
Eyes			
Genitourinary			
Metabolic/Endocrine			
Teeth & Tongue			
Spine			
Shoulders			
Elbows & Hands			
Hips			
Knees			
Feet & Ankles			

Is there loss or seriously impaired function of any paired organ? ___**Yes** ___**No**
Is this student-athlete currently under treatment for any medical or emotional condition? ___**Yes** ___**No**
Do you have any recommendations regarding the care of this student-athlete? ___**Yes** ___**No**
I certify that I have reviewed the history and examined the above student-athlete and I recommend:
_____Clearance for athletic participation with no limitations.
_____Clearance pending further evaluation or testing. (Please explain)
_____Referral to other healthcare professional prior to clearance. (Please explain)
_____Clearance with limitations. (Please explain)
_____Disqualified from competition. (Please explain)
Comments:_____

Name of Examining Physician: _____
Address: _____ Phone Number: _____
Physician's Signature: _____ Date : _____

Acknowledgement of Risk Statement

The purpose of the following statement is to inform you, as a prospective student-athlete at the University of Texas-Rio Grande Valley, of the potential risks associated with participating in intercollegiate athletics. There exists the possibility that you, as an athlete, may incur an injury, the nature of which may be serious enough to have long-term or even permanently disabling effects (These may include ankle, knee, shoulder, or even head, neck and/or back).

The University of Texas-Rio Grande Valley is concerned about your personal safety and well-being and is accepting the responsibility of attempting to keep the risks of injury to a minimum. Adequate measures have and will be taken regarding injury prevention to include pre-participation physical exams, proper coaching techniques and instruction, supervision of the safety aspects of our facility and equipment, and providing accident insurance coverage.

I _____, willfully acknowledge the University's attempt to
Clearly Print First and Last Name

inform me of the potential risks of injury involved in my participation in intercollegiate athletics. I am willing to accept the aforementioned risks, and agree to share the responsibility with the University, by taking personal preventative measures and adhering to all recommended safety/equipment guidelines for my safety and the safety of my peers.

Student-Athlete Authorization/Consent for Disclosure of Protected Health Information (PHI)

I _____, hereby authorize the University of Texas – Rio Grande Valley and its physician affiliates, athletic and other healthcare personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the following:

Your initials below indicate your agreement to the release of your PHI in each category:

_____*My Personal Medical Insurance* For the use of electronic transmission, US post mail, or facsimile involving billing, reimbursement, benefits eligibility and plan-eligibility issues. **Authorization in this category is required to participate in athletics at UTRGV.**

_____*Parents/Guardian* Should the parents/guardian inquire as to the extent of an injury or illness, you are allowing UTRGV athletics representatives to discuss your condition.

_____*My Coaches* Should this information be pertinent to my safety and participation in athletics at UTRGV.

_____I also allow any treating physicians or other medical facilities to disclose my medical records to the Sports Medicine Department at UTRGV for purposes of continued quality of care during my athletic participation at that institution.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act (FERPA) of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment.

This authorization/consent expires 380 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 Head Athletic Trainer at UTRGV. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent. My signature below also acknowledges that I understand and accept the potential risks associated with my athletic participation mentioned above.

_____
Student Athletes Signature Printed Name Date

_____
Signature of Parent or Guardian (Minors only) Date

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_____
Student Athletes Signature Printed Name Date

_____
Signature of Parent or Guardian (Minors only) Date

American Heart Association 14-Element Heart Screening

Name: _____ Sport: _____ DOB: _____ SID#: _____

Personal History (circle YES or No accordingly)

YES NO 1. Have you ever had chest pain/discomfort with exercise?

YES NO 2. Have you ever had syncope (fainting) or near-syncope when exercising?

YES NO 3. Have you ever had excessive exertional and unexplained fatigue/fatigue associated with exercise?

YES NO 4. Do you have a prior recognition of a heart murmur?

YES NO 5. Do you have elevated systemic blood pressure?

YES NO 6. Do you have prior physician restriction from participation in sports?

YES NO 7. Have you had prior testing for your heart ordered by a physician?

Family History

YES NO 8. Has there been any premature death that was sudden and unexpected before age 50 due to heart disease in one or more relatives?

YES NO 9. Have you had disability from heart disease in a close relative that was under the age of 50?

YES NO 10. Do you have specific knowledge of certain cardiac conditions in family members: hypertrophic or dilated cardiomyopathy, long-QT syndrome or other ion channelopathies, Marfan syndrome, or clinically important arrhythmias?

Items 11 through 14 will be performed by the Examining Physician

11. Heart murmur-exam supine and standing or with Valsalva, specifically to identify murmurs of dynamic L ventricular outflow tract obstruction.
12. Femoral pulses to exclude aortic stenosis.
13. Physical Stigmata of Marfan syndrome.
14. Brachial artery blood pressure (sitting, preferably taken in both arms).

Please explain all YES answers:

_____

_____

_____

_____

_____

_____