

BEMIDJI STATE UNIVERSITY ATHLETIC PHYSICAL EXAM FORM

Name _____ Sport _____
Last First M.I.

SS# _____ Age _____ Sex _____ BP _____ Ht. _____ Wt. _____

HISTORY:

Allergies: _____ Medications: _____

Hospitalizations / Surgeries: _____

Serious Accident or Illness: _____ Seizures: _____

Recreational Drug Use: _____

Contact Lens/Glasses: _____

Orthopedic Conditions: _____

CHRONIC ILLNESS: (Self/family--positives circled with explanation)

DM Ca Heart Prob. Hypertension Asthma Arthritis

IMMUNIZATION STATUS: Last DT _____

PHYSICAL: (Check if normal; describe abnormal findings)

Skin: _____ Extremities / MS: _____

HEENT: _____ Peripheral Pulses: _____

Neck / Thyroid: _____ Neuro: _____

Cardiovascular: _____ Hernia: _____

Abdomen: _____ Genitalia: _____

LAB: Urinalysis: _____ Hgb: _____

COMMENTS:

I have examined the above client and find him/her able to participate in intercollegiate athletics.

Date

Signature

BEMIDJI STATE UNIVERSITY SECONDARY INSURANCE FORM
PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University Bemidji State University

This form is to be completed by the
Parents, Guardians or Student.

Address PE Complex #29: 1500 Birchmont Dr NE
City Bemidji State MN Zip 56601

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____

Social Security No. or Passport No. _____ Date of Birth _____

College Address _____ College Phone () _____

Home Address _____ Home Phone () _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name _____

Social Security No. _____

Address _____

Employer _____

Address _____

Telephone () _____

Medical Insurance
Company or Plan _____

Address _____

Policy Number _____

Telephone () _____

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

MOTHER/GUARDIAN INFORMATION

Mother's Name _____

Social Security No. _____

Address _____

Employer _____

Address _____

Telephone () _____

Medical Insurance
Company or Plan _____

Address _____

Policy Number _____

Telephone () _____

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

PLEASE COMPLETE AUTHORIZATION ON SECOND PAGE OF THIS FORM



First Agency, Inc.
 5071 West H Avenue
 Kalamazoo, MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

 Name of Claimant (please print)
 (please print)

 Name of Authorized Representative, or Next of Kin

 Signature of Claimant (if claimant is 18 or older) Date
 Kin Date

 Signature of Authorized Representative or Next of Kin

 Relationship of Authorized Representative or Next of Kin to Claimant

**BEMIDJI STATE UNIVERSITY EMERGENCY CONTACT & INSURANCE
INFORMATION FORM**

Completion of information on this form is required prior to participation in athletics at BSU

Name: Last _____ First _____ MI _____

SS# _____ Date of Birth: _____ Sport(s) _____

Permanent (Home) Address

Address _____

City _____ State _____ ZIP _____

Phone _____ Cell or 2nd Number _____

Local (On/Off-Campus) Address

Address _____

City _____ State _____ ZIP _____

Phone _____ Cell or 2nd Number _____

Emergency Contact Information:

Primary (Parent/Guardian)

Name(s) _____

Address _____

Home Phone # _____

Work Phone # _____

Relationship _____

Secondary (optional)

Name(s) _____

Address _____

Home Phone # _____

Work Phone # _____

Relationship _____

Medical Information

Alerts (allergies, diabetes, asthma, heart condition, etc.):

Primary Care Physician or Provider:

_____ Phone # _____

Insurance Information: A photocopy of the front and back of your insurance enrollment card is **required** prior to participation in athletics at BSU.

Insurance Company _____

Policy Number _____ Group Number _____

ID Number _____

ASSUMPTION OF RISK AND CONSENT FOR TREATMENT

I understand that while I am participating in intercollegiate athletics, there is an inherent risk of injury. I understand that the dangers and risks include, but are not limited to, death, serious head, neck, and spinal injuries, paralysis, injuries or impairment to the musculoskeletal system, general health, and well being.

Do to the possibilities of any injury and illness while participating in an official, organized intercollegiate athletic activity, I recognize and take responsibility for reporting all such injuries and illnesses, including signs and symptoms of concussions to the athletic training staff.

I hereby grant permission to the Bemidji State University Athletic Trainers and Team Physician's to render to myself (son/daughter) any preventative measures for injuries, first aid, treatment, rehabilitation, or emergency treatment that they deem reasonable and necessary to the health and well being of the student-athlete.

Date _____

Printed or typed name

Signature student-athlete

Parent/Guardian Signature (if student-athlete is under the age of 18)