

Dear Student-Athlete, Parent(s), or Guardian(s):

These forms need to be fully completed and returned to OC Athletic Training Services (OCATS). We ask that you return these forms to us either in person or by mail. We would like them in our offices no later than August 1 to avoid clearance delays. **It is the policy of OC that no student-athlete will be allowed to participate in any practice or competition until ALL requested information has been received by OCATS. Also, OCATS does not share medical records with ANY entity unless requested in writing (per HIPAA).**

At OC, we strive to keep student-athletes healthy, but when injuries occur it is essential for us to have all necessary information on hand to insure acute treatment can be given and medical bills can be paid in a timely fashion. OC's secondary coverage only applies to varsity scholarship student-athletes and those non-varsity student-athletes who have received prior approval from their head coach and OCATS.

OC maintains excess coverage for its student-athletes. Accordingly, all medical bills must first be filed on the student-athlete's primary insurance before OC will pay any bill. It is for this very reason that we require every student-athlete to submit his/her primary insurance information prior to participation (including a copy of both sides of his/her insurance, prescription, and dental insurance card). Once a claim has been properly filed to the student-athlete's primary insurance, the remaining balance will be paid by OC. **Should a situation arise where a student-athlete and/or their parent(s) do not uphold their obligation to insure a correct/timely filing of a claim—OC reserves the right to refuse payment on any bills not resolved with OCATS within 6-months from the date of service.**

On the Medical Information/Authorization form, please verify you check the proper box. There are separate boxes for 1) having insurance, 2) having the OC Accident and Sickness Coverage, and 3) having no medical insurance. For any student-athlete that testifies to have no insurance, should it later be determined collectible primary insurance did exist—the student-athlete, parent, and/or guardian will be required to reimburse any payment made by OC. By definition, it constitutes insurance fraud and is against the law.

OC's excess coverage extends only to injuries sustained while practicing or competing in programmed hours supervised by the coaching staff of OC. If an athlete has a pre-existing injury, OCATS will do all it can to manage the injury on campus, but future medical needs (involving pre-existing injuries or conditions) are not covered, nor will OC will be secondary.

In 2005 OC discontinued mass athletic physicals. Each of you will need to obtain a physical from your primary care physician or another approved medical provider (DO, MD or PA-C only). **We require every student-athlete to use our Preparticipation Physical Exam (PPE) form. All other physical forms will be deemed invalid.** We can email the forms to you or they can be downloaded from <http://www.oceagles.com/> just follow the Athletic Training Services link.

We know filling out these forms can be time-consuming but we do this to make certain the best medical response can be delivered without any delays and in any situation.

Best in health,

Curtis W. McAuliff, LAT, ATC  
Director of Athletic Training

Sydney G. Ringer, MS, LAT, ATC  
Head Athletic Trainer

# OKLAHOMA CHRISTIAN UNIVERSITY

## PRE-PARTICIPATION CHECKLIST

- Pre-Participation Physical Exam Form
- Medical History
- Release of Information
- Media Release
- Competitive Athletics Waiver
- Insurance Information/Authorization Form
- Securing Medical Assistance Form
- Copy of Insurance Card (both sides)
- Copy of Prescription Card (both sides)\*
- Copy of Dental Insurance Card (both sides)\*

**PLEASE NOTE: All forms must be completed and returned to OCATS before a student-athlete will be able to participate in any form of practice or competition.**

**—ALL FORMS MUST BE COMPLETED IN BLUE OR BLACK INK—**

\*If applicable.

# Oklahoma Christian University – Pre-Participation Physical Exam

Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ Year:  FR,  SO,  JR,  SR,  5<sup>th</sup> YR SR

Medical	Normal	Abnormal	Initials	Musculoskeletal	Normal	Abnormal	Initials
Appearance				Neck			
Eyes/Ears/Nose/ Throat				Back			
Lymph Nodes				Shoulder/arm			
Heart				Elbow/Forearm			
Pulses				Wrist/Hand/ Fingers			
Lungs				Hip/Thigh			
Abdomen				Knee			
Genitourinary (Males Only)				Leg/Ankle			
Skin				Foot/Toes			

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Necessary Labs/X-Rays: \_\_\_\_\_

## Clearance Status:

Not Cleared Reason(s): \_\_\_\_\_

Cleared Clearance Date: \_\_\_\_\_

Name of Physician (print): \_\_\_\_\_ Date \_\_\_\_\_

Signature of Physician: \_\_\_\_\_  DO,  MD,  PA-C

OC requires a DO, MD or PA-C to perform this pre-participate exam. Please be sure to note your credential above.

— ALL FORMS MUST BE COMPLETED IN BLUE OR BLACK INK —

# Oklahoma Christian University - Medical History Form

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sport \_\_\_\_\_  
 Sex: Male  Female  DOB \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

**Explain ALL 'Yes' answers at bottom of page**

	Yes or No		Yes or No
1. Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/> <input type="checkbox"/>	29. Is there anyone in your family who has been diagnosed with asthma?	<input type="checkbox"/> <input type="checkbox"/>
2. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/> <input type="checkbox"/>	30. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/> <input type="checkbox"/>
3. Do you have any ongoing or chronic illness like diabetes or epilepsy?	<input type="checkbox"/> <input type="checkbox"/>	31. Were you born without, or are you missing a kidney, eye, testicle, or any other organ?	<input type="checkbox"/> <input type="checkbox"/>
4. Are you currently taking any prescriptions (including female hormones/oral contraceptive) or non-prescription (over the counter) medications, pills?	<input type="checkbox"/> <input type="checkbox"/>	32. Have you had a severe viral infection (ex: myocarditis or infectious mononucleosis) within the last month?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/> <input type="checkbox"/>	33. Do you have any current skin problems (for example: itching, rashes, acne, warts, fungus, infections, or blisters)?	<input type="checkbox"/> <input type="checkbox"/>
6. Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/> <input type="checkbox"/>	34. Have you ever had a head injury or concussion?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you have allergies to <u>any</u> medications, pollens, foods or stinging insects?	<input type="checkbox"/> <input type="checkbox"/>	35. Have you ever been knocked-out, become unconscious or lost your memory?	<input type="checkbox"/> <input type="checkbox"/>
8. Have you ever developed hives with exercise?	<input type="checkbox"/> <input type="checkbox"/>	36. Have you ever had a seizure?	<input type="checkbox"/> <input type="checkbox"/>
9. Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/> <input type="checkbox"/>	37. Do you have frequent or severe headaches?	<input type="checkbox"/> <input type="checkbox"/>
10. Have you ever passed-out or nearly passed-out during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	38. Have you ever had numbness, tingling, or weakness in your arms, hands, legs, or feet?	<input type="checkbox"/> <input type="checkbox"/>
11. Have you ever been dizzy during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	39. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/> <input type="checkbox"/>
12. Have you ever had chest pain during or after exercise?	<input type="checkbox"/> <input type="checkbox"/>	40. Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/> <input type="checkbox"/>
13. Have you ever had racing of the heart or had your heart skip heartbeats?	<input type="checkbox"/> <input type="checkbox"/>	41. When exercising in the heat have you ever had severe muscle cramps, fainting, or become ill?	<input type="checkbox"/> <input type="checkbox"/>
14. Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/> <input type="checkbox"/>	42. Has a doctor ever told you or anyone in your family that you have sickle cell trait or sickle cell disease?	<input type="checkbox"/> <input type="checkbox"/>
15. Have you ever been told that you have high blood pressure, high cholesterol, a heart murmur, or heart infection?	<input type="checkbox"/> <input type="checkbox"/>	43. Have you had problems with your eyes or vision?	<input type="checkbox"/> <input type="checkbox"/>
16. Have you had any tests for your heart? (EKG or Echocardiogram?)	<input type="checkbox"/> <input type="checkbox"/>	44. Do you wear glasses, contact, or protective eyewear (ex: goggles)?	<input type="checkbox"/> <input type="checkbox"/>
17. Does anyone in your family have any heart problems?	<input type="checkbox"/> <input type="checkbox"/>	45. Have you ever had a broken, chipped, or loose tooth or dental plate?	<input type="checkbox"/> <input type="checkbox"/>
18. Has any family member or relative died of heart problems or died suddenly before the age of 50?	<input type="checkbox"/> <input type="checkbox"/>	46. Are you satisfied with your body shape and size?	<input type="checkbox"/> <input type="checkbox"/>
19. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/> <input type="checkbox"/>	47. Are you currently trying to gain or lose weight?	<input type="checkbox"/> <input type="checkbox"/>
20. Have you ever spent the night in a hospital?	<input type="checkbox"/> <input type="checkbox"/>	48. What was your highest and lowest body weight over the course of last year? _____/_____	<input type="checkbox"/> <input type="checkbox"/>
21. Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>	49. Do you have any other concerns you would like to discuss? (e.g. social, academic, or family issues)	<input type="checkbox"/> <input type="checkbox"/>
22. Have you ever had a sprain, strain, or tendonitis that caused you to miss a practice or competition?	<input type="checkbox"/> <input type="checkbox"/>	50. Do you have any other concerns you would like to discuss? (e.g. social, academic, or family issues)	<input type="checkbox"/> <input type="checkbox"/>
23. Have you broken/fractured any bones or dislocated any joints?	<input type="checkbox"/> <input type="checkbox"/>	51. Many people feel depressed at times. Please rate any recent feelings using the scale 0 = none to 10 = severe _____	
24. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/> <input type="checkbox"/>	<b>FEMALES ONLY</b>	
25. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>	52. Approximate date (or age) of your first period?	
26. Have you ever had an injury that required x-rays, MRI, CT, surgery, injections, physical therapy, a brace, a cast, or crutches?	<input type="checkbox"/> <input type="checkbox"/>	53. When was your most recent period?	
27. Do you regularly use any braces or assistive devices (ex: knee brace, special neck roll, foot orthotics, retainer on your teeth, or hearing aid)?	<input type="checkbox"/> <input type="checkbox"/>	54. Typical number of days between the start of one period to the start of the next?	
28. Has a doctor ever told you that you have asthma?	<input type="checkbox"/> <input type="checkbox"/>	55. Number of periods over the past 12-months?	
		56. Date of last pap/pelvic?	

**Explain ALL 'Yes' answers here (include question's #, date of injury [month/year], type of injury, body part injured [note right or left]):**

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*I hereby state, to the best of my knowledge, my answers to the questions above are complete and correct.*

Signature of Student-Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

# OKLAHOMA CHRISTIAN UNIVERSITY

## RELEASE OF INFORMATION AUTHORIZATION FOR PARENT(S) OR GUARDIAN(S) AND HEALTHCARE PROFESSIONALS

I, \_\_\_\_\_, DO / DO NOT (please circle one), give my consent for the team physicians, certified athletic trainers, or other medical personnel of Oklahoma Christian University, to release such information regarding my medical history, record of injury or surgery, record of serious illness, and rehabilitation results as may be requested by my parent(s) or guardian(s) seeking such information.

I, \_\_\_\_\_, DO / DO NOT (please circle one), give my consent to any healthcare professional to provide Oklahoma Christian University Athletic Training Services with information concerning benefit payments, charges for services, explanation of insurance benefits, progress notes, post-operative report(s), radiographic studies, and diagnostic test(s).

I understand that I will be verbally informed of all individuals (outside the OC Sports Medicine network) requesting such information. This information is confidential and will not be otherwise released.

**This “Release of Information Authorization” remains valid until revoked by me in writing. A photographic copy of this authorization shall be as valid as the original.**

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

# OKLAHOMA CHRISTIAN UNIVERSITY

## MEDIA RELEASE

I, the undersigned, hereby authorize the team physician(s) and/or ATC(s) to release, verbally and/or in writing, to the sports information director and/or the outside media, for purposes related to press releases and/or articles, information specific to an injury/illness that affects my sports participation.

**I Authorize**

← **CHECK ONLY ONE** →

**I Do Not Authorize**

I, \_\_\_\_\_, of lawful age and being first duly sworn on his/her oath states as follows:

That I have read the above and foregoing Media Release and understand the statement therein; that I authorize the team physician(s) and/or ATC(s) to release, verbally and/or in writing to the sports information director and/or journalists, information specific to an injury/illness that affects my sports participation.

This release will expire on upon cessation of my participation in OC's collegiate athletic program(s) unless revoked by me in writing at an earlier date.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

# OKLAHOMA CHRISTIAN UNIVERSITY

## WARNING, RELEASE, AGREEMENT TO OBEY INSTRUCTIONS, ASSUMPTION OF RISK AND AGREEMENT TO HOLD HARMLESS

I am aware that playing or practicing to play and conditioning for **competitive athletics** could be a dangerous activity involving **many risks of injury**. I understand that the dangers and risks of playing or practicing to play and conditioning for competitive athletics include, but are not limited to death, serious neck and spinal injury (spinal cord or vertebral bodies) which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of the muscular skeletal 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 conditioning for competitive athletics may result not only in serious injury but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally enjoy life.

Because of the dangers of **competitive athletics**, I recognize the importance of following coaches' instructions regarding playing techniques, training, and other team rules, etc., and to agree to obey instructions.

In consideration of Oklahoma Christian University providing medical services and in permitting me to play **competitive athletics** and to engage in all activities related to the team, including but not limited to practicing or playing competitive athletics and for other good and valuable consideration, I hereby assume all the risks associated with **competitive athletics** and agree to hold Oklahoma Christian University, and their respective employees, representatives, athletic trainers, team physicians, equipment managers and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demand of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the Oklahoma Christian University Athletics. The terms hereof serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

**This release remains valid until a written revocation, signed by the undersigned, is delivered to duly authorized representatives of Oklahoma Christian University.**

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Signature of Student-Athlete

Date

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Witness

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Signature of Parent(s) or Legal Guardian(s)\*

\*Necessary only if Student-Athlete is under the age of 18

# OKLAHOMA CHRISTIAN UNIVERSITY

## MEDICAL INSURANCE INFORMATION/AUTHORIZATION

Dear Parent(s) or Guardian(s):

The coverage OC provides for your student-athlete for injuries sustained while participating or competing in intercollegiate athletics, is EXCESS coverage. This means it pays benefits only after taking into consideration those amounts payable under any other medical insurance plan. We, as the university, do not have the option of waiving this provision. **Please provide the information requested below, i.e. medical information authorization, a front/back copy of the following (those which apply): Insurance, Dental, and/or Prescription cards. The following information will be updated annually according to the calendar, not academic, year.**

### Section 1: Student Information

Name: \_\_\_\_\_ Sport: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female

Campus Address:  Not Applicable Permanent Address: \_\_\_\_\_

\_\_\_\_\_  
P.O. Box 11000, SB # \_\_\_\_\_

\_\_\_\_\_  
Oklahoma City, OK 73136-1100 \_\_\_\_\_

Campus Phone: \_\_\_\_\_ Student Cell: \_\_\_\_\_

Student Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_

### Section 2: Health Insurance Information

Primary Policy-Holder's Name: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_ Expiration Date of Policy: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_ Work Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Is this a new policy?  Yes  No • Is pre-certification required for surgeries/services over \$500.00?  Yes  No

Is this an HMO policy?  Yes  No • If yes, please list the name/number of your Primary Care Physician below

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Mailing Address for Insurance Company's Claim Office:

\_\_\_\_\_  
Phone: \_\_\_\_\_

\_\_\_\_\_  
Fax: \_\_\_\_\_

\_\_\_\_\_  
Email: \_\_\_\_\_

**Section 3: Father/Male Guardian Information**

Same as Policy-Holder Information?  Yes  No

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_ Work Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section 4: Mother/Female Guardian Information**

Same as Policy-Holder Information?  Yes  No

Mother's Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_ Work Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

All student-athletes are required to carry medical insurance. If your son/daughter does not have insurance s/he will need to purchase a policy prior to arriving on campus. Any student-athlete who has not secured coverage will be enrolled in OC Accident and Sickness coverage. The premium for this policy will be added to his/her tuition and bills. Any individual enrolling in the OC coverage must notify Athletic Training Services.

CHECK ONLY ONE OF THE BOXES BELOW. Check the first box if you HAVE MEDICAL INSURANCE and have provided full policy information. Check the second box if you are enrolled in the OC ACCIDENT AND SICKNESS COVERAGE. Check the third box if you DO NOT have any medical insurance. The undersigned, being duly sworn under oath, depose and state that I have filled out this form completely and to the best of my knowledge, and submit to the following:

My student-athlete has medical insurance. I hereby authorize Athletic Training Services to file a claim on my behalf under the above medical insurance policy in the event of an athletic injury or illness.

My student-athlete is enrolled in the OC Accident and Sickness coverage.

My student-athlete does not have any medical insurance. As a result, my student-athlete is entitled to no benefits from any insurance policy of which I am aware. I agree, should it be determined at a later date there is collectible insurance, to reimburse any payment made by Oklahoma Christian University.

\_\_\_\_\_  
Signature of Policy-Holder

\_\_\_\_\_  
Date Signed

Should your insurance policy change, expire, or terminate; you must notify OCATS immediately. Failure to comply, negates OC's position as a provider of secondary coverage. All expenses for injuries that occur during a period of non-coverage are the sole responsibility of the student-athlete and/or policy-holder.

A photostatic or fax copy of this document shall be considered as effective and valid as the original.

— ALL FORMS MUST BE COMPLETED IN BLUE OR BLACK INK —

# OKLAHOMA CHRISTIAN UNIVERSITY

## SECURING MEDICAL ASSISTANCE FORM

1. Oklahoma Christian Athletic Training Services (OCATS) abides by the standard privacy practices set forth in the HIPAA of 1996 and does not release any medical file information without written consent. Further, OCATS does not share any information with any other campus department or outside entity.
2. All student-athletes (S-A or S-As) must have an Insurance Information/Authorization Form and Securing Medical Assistance and Expenses Form on file with OCATS prior to any participation. These forms shall be updated annually at the calendar year. OC requires a front/back copy of your medical insurance card and also requests the same for prescription, dental, or vision cards (if applicable). OC will not pay for any expenses arising due to an incomplete file (i.e. a file missing secondary cards).
3. S-A are required to report all visits to allied healthcare professionals. This is not limited to illnesses and injuries—everything must be reported to OCATS. The s-a should take an OCATS referral form (preferred method) or provide OCATS with medical documentation including, but not limited to, diagnosis, participation level, follow-up care, as well as any recommendations. S-As will not be cleared to participate until this information is received and reviewed by OCATS.
4. OC reserves the right to refer, to an outside allied health care professional, any injuries or medical conditions deemed as pre-existing. Any future medical needs relating to such pre-existing injuries/conditions are not covered by OC, nor will OC be secondary. Any incurred fees will be the sole financial responsibility of the S-A and/or their parent(s)/guardian(s).

**If the injury or illness is athletically-related, in accordance with the OC policy, the following statements apply.**

5. Should your insurance policy change, expire, or terminate; you must notify OCATS immediately. Failure to comply with this policy negates OC's position as a provider of secondary coverage. All expenses for injuries that occur during a period of non-coverage are the sole responsibility of the S-A and/or policy holder.
6. The AT refers the S-A to an OC team physician or OC-appointed specialist. It is the policy of OCATS to always, within the constraints of a S-A's primary insurance, secure care from an OC team physician or OC-appointed specialist. If the S-A chooses to have a second opinion, a one-time only office visit shall be covered only with prior approval by the OCATS staff. Should the S-A pursue further care under the second opinion physician, outside the approved OC network, all medical expenses incurred including, but not limited to, deductible(s), physician fees, rehabilitation services and fees, hospital fees, diagnostic testing, and post-op care will be the responsibility of the S-A and parent(s)/guardian(s). In addition, OC is entitled to bill (and collect co-insurance payments from) the S-A's primary insurance for any post-surgical care, rehabilitation or therapy its ATs provide.
7. The S-A must complete a Second Opinion Waiver Form prior to receiving any services rendered by a non-appointed specialist, including but not limited to, chiropractors, dieticians, physicians, physical therapists, and psychologists/psychiatrists. Appointments/procedures outside of this network are subject to the stipulations of OC's Second Opinion policy.
8. If the S-A is covered by a HMO, OC will contact the HMO by phone and receive instructions as to what coverage is afforded if care is provided other than by the HMO physician. A S-A will assume responsibility for any expenses resulting from treatment given by an out-of-network physician unless specifically directed to that physician by OCATS.
9. S-A must take a referral form from OCATS to all appointments including, but not limited to, OC team physician(s), OC-appointed specialist(s), diagnostic testing facilities, or the Eagle Community Clinic. If a referral form is not taken (and returned), the S-A and/or parent(s)/guardian(s) are responsible for the associated bill(s) and charge(s) corresponding to that date of service.

10. The OC Athletic Department shall provide excess coverage to all varsity S-As. Our policy requires all injury claims to be filed against the S-A's family or personal insurance whenever possible and, prior to, any secondary payments by OC. The excess coverage provided by OCATS is accident-only. This coverage does not extend to accidents, illnesses or conditions unrelated to an athletic injury.
11. In the case where the S-A is covered under a group insurance policy or individual policy, all itemized bills (UB 92 or HCFA 1500) for medical care received shall be forwarded to the parent(s)/guardian(s) insurance company. A copy of the insurance company's Explanation of Benefits (a worksheet that documents how the insurance policy covered the charges associated with a particular claim) must be forward to OCATS so that excess charges may be paid. The policy-holder will not have any out-of-pocket expense(s) for covered injuries.
12. Parent(s)/Guardian(s) that may have money sent to them by their insurance companies including, but not limited to, payment of medical services rendered, medications, etc. must endorse the check(s) and forward them to OCATS.
13. Dental teeth cleaning, provisional filling of teeth, or other dental work not directly related to an injury occurred during practice or competition is not covered.
14. Medical or hospital expenses incurred as the result of an injury while going to or from class, or while participating in classroom requirements (e.g., activity classes), WILL NOT be covered.
15. Medications for participation will only be paid for during the academic year (e.g. August — May) provided the prescription is written by an OC-appointed physician. The S-A will present the prescription to the pharmacy designated by OCATS. If the S-A submits the prescription to an unauthorized pharmacy, the OC will not pay for the cost of the prescription. In addition, OC will not pay for a prescription due to an athletic-related injury if a current prescription card is not on file.
16. If a coach requests flu shots, the team members shall be informed of its availability. Your coach, in coordination with OCATS, will secure an appointment time and location for the injection to be administered. Since this is preventative, the OCATS shall be responsible for the incurred expense.
17. Use of some of OC's facilities are limited to periods when authorized supervisory personnel are present. OC is not responsible for expenses incurred from injuries and/or illnesses sustained during unsupervised participation or unauthorized use of OC's facilities.
18. Any medical expenses that occur from an injury/illness sustained while participating in an unsanctioned OC activity, while out-of-season, or during the summer months WILL NOT be covered.
19. If the S-A adds risk of injury by participating in inherently dangerous activities such as but not limited to bungee jumping, skydiving, operating a two- or four-wheeled motorized vehicle, or participates in intramural sports, etc.—OC shall NOT assume any responsibility for incurred medical or other expenses related to injuries or conditions resulting from such participation and shall have the right to discontinue financial-aid if the S-A is unable to continue intercollegiate sports participation due to medical reasons whether resulting from such participation or otherwise.
20. OCATS reserves that right to seek reimbursement for services including, but not limited to, post-surgical care, rehabilitation services, or therapy from the S-A primary insurance company.
21. The S-A shall complete an Injury Disclosure Statement within two-weeks of completion of his/her athletic eligibility or before the S-A withdraws from OC or intercollegiate athletics. Failure to complete this form will result in the S-A and/or his/her parent(s)/guardian(s) being solely responsible for all medical expenses incurred. Any expenses, for which OC is the secondary payer, must be processed and paid within 6-months of this date.

# OKLAHOMA CHRISTIAN UNIVERSITY

## SECURING MEDICAL ASSISTANCE RELEASE

By signing this document I certify that I have read and accept all provisions detailed on the Securing Medical Assistance Form.

If the student-athlete (S-A) receives care from any allied health professionals including, but not limited to, physiotherapists, kinesiologists, accupuncturists, and/or chiropractors whom are unauthorized by Oklahoma Christian Athletic Training Services (OCATS) or Oklahoma (OC) team physicians, s/he assumes all responsibility (financial or otherwise). Neither OC, its agents, employees, trustees, or officers shall be held liable for this kind of treatment, its expenses, or any related expenses. Further, a S-A who seeks treatment from an unauthorized allied health professional may be required, at our discretion, to be released by an OC team physician prior to return to participation. Failure to report unauthorized medical treatment may result in further injury for which OCATS will not be responsible. Any such action may result in suspension or additional penalty.

I submit to fully understanding the statements contained herein and agree to accept any financial obligation such as, but not limited to, co-pays, doctor bills, fees for services or procedures (including those denied by the primary insurance company) should the S-A in question deviate from this policy.

Return to:  
Oklahoma Christian University  
Athletic Training Services  
P.O. Box 11000  
Oklahoma City, OK  
73136-1100  
(fax) 405.425.1962

**Unless the Student-Athlete is the policy-holder, this document must be signed by both parties.**

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Printed Name of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policy-Holder

\_\_\_\_\_  
Printed Name of Policy-Holder

\_\_\_\_\_  
Date