

May 31, 2011

TO: D'Youville College Student-Athletes and Parents

FROM: D'Youville College Department of Athletics

SUBJECT: Medical and Health Information for Athletic Participation **(Now Required for Athletes)**
(This Applies for ALL Returning Athletes, Transfer Students, and Freshmen)

Please note, **ALL** D'Youville College student-athletes are **now required** to provide annual medical physicals and insurance information that includes coverage for athletically-related injuries. This is a pre-requisite for practice and competition. No student will be allowed to participate, in any way, until such evidence of current insurance coverage and medical information is on file with the D'Youville College Department of Athletics. The enclosed forms (Emergency Contact/Insurance Information, Medical History, and Physician Medical Examination) along with a **clear** photocopy of **both sides** of a current insurance card must be on file before a student can participate.

The NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). This coverage does not qualify as the basic coverage required for participation in athletics at D'Youville College. More information on this program can be found on the NCAA's web-site at www.ncaa.org.

Please submit the **completed enclosed forms** along with a **copy of both sides of your current insurance card** to the D'Youville College Department of Athletics by **Monday, August 1, 2011**. The forms are also available at www.dyc.edu/athletics.com.

Please send all forms to: D'Youville College
Athletic Department
320 Porter Ave
Buffalo, NY 14201
Attn. Rob Kennuth (Head Athletic Trainer)

If you have any questions regarding this requirement please contact Rob Kennuth, Head Athletic Trainer, at 716-829-8309.

EMERGENCY CONTACT and INSURANCE INFORMATION FORM

Name _____ Date of Birth _____

Sport(s) _____ SSN _____

Academic Year _____

Parent/Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Policy Holder Name _____

Relationship to Student-Athlete _____

Address _____

Home Phone _____ Work Phone _____

Insurance Company Name _____

Insurance Co. Address (or) Customer Service Phone # _____

Group # _____ I.D # _____

Effective Date of Policy _____ Expiration Date _____

Primary Physician _____ Office Phone # _____

Policy Limit _____ Policy Deductible _____ Policy Co-Pay _____

Does the policy cover athletically related injuries? _____

Parent/Guardian Signature and Date

Student-Athlete Signature and Date



*** Please indicate month/year for any occurrence***

DYC Athlete Medical History

1.) List any head injuries, concussions or neck injuries and when they occurred: _____

2.) List joint injuries which required physicians care: _____

3.) List previous fractures (including dates): _____

4.) Do you have asthma? _____ Yes _____ No If yes, do you use an inhaler? _____
What type of medication? _____ As needed (prn)? _____

5.) List allergies (including medications): _____

6.) List any medications taken regularly (prescription and over the counter): _____

7.) List previous infections/illnesses (mono, strep, staph, diabetes, etc.): _____

8.) Have you ever been hospitalized or had surgery? Explain: _____

9.) Have you ever experienced heat illness? Explain: _____

10.) Have you ever been treated for, or had, a heart murmur? _____ Yes _____ No
If yes, when? _____

11.) Is there any history of sickle cell disease or sickle cell trait? Explain: _____

12.) Any special problems our trainer needs to be aware of? _____

Risk of Injury Statement

I, _____, verify that I have been informed of the risk of injury while participating in intercollegiate athletics at D'Youville College. I understand that I could sustain a serious injury, which may result in permanent or temporary paralysis or even death.

I understand my responsibility to adhere to all playing and training rules and regulations as presented to me by the coaching or medical staff of my chosen sport. I will not make any modifications of protective equipment or uniforms that are issued to me.

I understand that I am to report all injuries to the sports medicine staff and that I am responsible for the follow-up care and treatment of such injuries as prescribed by the staff under their supervision.

Print name: _____

Date: _____

Signed: _____