

**Barton College Athletic Department
Verification of Understanding**

- Policies on Drug Education and Testing, Alcohol, Tobacco, Banned Substances and Performance Enhancing Drugs
- Athletic Insurance Coverage Information
- How to File an Athletic Insurance Claim
- Policies on Determination of Play Following an Injury, Physician Referral, Second Opinions

We/I the undersigned have read and fully understand the preceding policy statements and warnings and agree to its procedures. We/I hereby release Barton College, its agents and employees, particularly the athletic training staff, from any liability caused by, or arising out of my athletic participation in the Barton College Athletic Program.

Print Name: _____ Sport: _____

Athlete Signature: _____ Date: ___/___/___

Parent Signature: _____ Date: ___/___/___

**BARTON COLLEGE ATHLETIC DEPARTMENT
MEDICAL INFORMATION UPDATE**

Name of Athlete: _____ Date: _____

Date of Birth: ____ / ____ / ____ Age: _____ Sex: M F Social Security #: _____

College/Local Address:		

Street		

City	State	Zip

Athlete Cell Phone #		

Home/Permanent Address:		

Street		

City	State	Zip

Home Phone		

MEDICAL INFORMATION UPDATE: Please answer each of the following questions by circling YES or NO. Answer all questions fully and provide explanation for each "YES" in the space provided. Failure to disclose any medical information may invalidate insurance coverage. The information provided is strictly confidential and used for health care purposes only.

Have you sustained a head injury or concussion in the last 12 months? YES NO

Have you been diagnosed with high blood pressure in the last 12 months? YES NO

Have you been diagnosed with diabetes in the last 12 months? YES NO

Have you had any dizzy spells, fainting or seizures in the last 12 months? YES NO

Have you had any infectious disease (ie. mono) or illness requiring a physician's visit in the last 12 months? YES NO

Have you sustained any musculoskeletal injury requiring a doctor's visit? If yes, describe the condition and what was done. This includes all injuries occurring during the past year's sport season. YES NO

Have you been diagnosed with asthma in the last 12 months? YES NO

Have you had any other significant medical problem in the last 12 months? YES NO

RETURN COMPLETED FORMS TO: Randy Pridgen, ATC Barton College PO Box 5000 Wilson, NC 27893

**BARTON COLLEGE ATHLETIC DEPARTMENT
HEALTH INSURANCE INFORMATION FORM**

Name of Athlete: _____ Date: _____

College/Local Address: _____
Street City State Zip

Home/Permanent Address: _____
Street City State Zip

Athlete Cell Phone # () _____ Athlete DOB: _____
 Athlete SS#: _____ - _____ - _____

Sport(s): MSOC WSOC VB CC MBK WBK BB SB TEN GOLF

Father/Guardian: _____ Address: _____ <small>Street</small> _____ <small>City State Zip</small> Father's Medical Insurance or Plan: _____ Address: _____ _____ Policy Number: _____ Group Number: _____ Is your son or daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Mother/Guardian: _____ Address: _____ <small>Street</small> _____ <small>City State Zip</small> Mother's Medical Insurance or Plan: _____ Address: _____ _____ Policy Number: _____ Group Number: _____ Is your son or daughter covered under this policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Are the companies or plans listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? YES NO

Is a referral necessary for a non-emergency physician visit? YES NO

Does your plan require a second opinion BEFORE surgery? YES NO

**A COPY OF YOUR INSURANCE CARD IS REQUIRED.
PLEASE PHOTOCOPY THE FRONT & BACK AND ATTACH.**

I hereby authorize Barton College, First Agency Insurance Company and its' representatives to secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or disabilities. A photostatic copy of this authorization shall be deemed effective and valid as the original.

Parent's Signature: _____ Date: _____
 Student's Signature: _____ Date: _____

**BARTON COLLEGE ATHLETIC DEPARTMENT
EMERGENCY CONSENT FORM**

Name of Athlete: _____ Date: _____

Sport MSOC WSOC VB CC MBK WBK BB SB TEN GOLF

Date of Birth: ____ / ____ / ____ Age: ____ Sex: M F Social Security #: _____

College/Local Address:		

Street		

City	State	Zip
()		
Athlete Cell Phone #		

Home/Permanent Address:		

Street		

City	State	Zip
()		
Home Phone		

FATHER's Information:	
Full Name: _____	
DOB: _____	
Social Security #: _____	
Employed By: _____	
Work Phone: _____	
Other Phone: _____	

MOTHER's Information:	
Full Name: _____	
DOB: _____	
Social Security #: _____	
Employed By: _____	
Work Phone: _____	
Other Phone: _____	

Insurance Company: _____ HMO or PPO? Y N

Policy Number: _____ Group Number: _____

Referral necessary for non-emergency physician visits? Y N

Primary care physician: _____ Phone: _____

Previous injuries/surgeries: _____

Allergies: _____

Medications used regularly: (includes inhalers, birth control, etc.) _____

Person to notify in case of emergency (other than parent):

Name: _____ Relationship to athlete: _____

Phone: _____ Alternate Phone: _____

I grant permission for transportation and treatment necessary for a condition arising during participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact my nearest relative prior to treatment.

Parent's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

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Barton College Athletic Department
Student-Athlete Nutritional Supplement Disclosure and Review Form

I, the undersigned, am taking or intend to take the following nutritional supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements. I acknowledge the possible health risks that may be associated with taking an over-the-counter nutritional supplement.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate because they are not regulated by the Food and Drug Administration (FDA) and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as "healthy" or "naturally occurring" do not necessarily mean safe to take or safe to use, or that the NCAA endorses a product or approves its usage. In other words, what's in the bottle is not always on the label. If I do not know what I'm taking, I'm risking both my health and my eligibility.

The NCAA does not accept ignorance as an excuse following a positive drug test for a banned substance. Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution's head athletic trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until their usage has been approved by my institution's head athletic trainer.

Brand Name	Listed Ingredients
1. _____	_____

2. _____	_____

3. _____	_____

Printed Name _____ Sport _____

Athlete Signature _____ Date ____/____/____

<p><u>Do Not Write In This Box</u></p> <p>Reviewed by Staff Athletic Trainer: _____ Date ____/____/____</p> <p>Substance Listed are: Banned _____ Acceptable _____ Do Not Take _____</p> <p>Student Athlete Notified Regarding This List On ____/____/____ ATC Init _____ Ath Init _____</p>
