John Jay College of Criminal Justice
Sports Medicine Department

John Jay College of Criminal Justice Student-Athletes:

Attached you will find important forms and information regarding your athletic participation at John Jay College of Criminal Justice. Please print all forms legibly. All of the information must be completed in full so that in the event you are injured, we can deliver the best treatment, make the proper referral, and provide the medical provider with necessary information. In addition, it is a sports medicine department requirement that we have a photocopy of your insurance card on file

John Jay College of Criminal Justice has a secondary athletic accident insurance policy. This policy provides secondary insurance coverage for injuries you may incur while participating in an intercollegiate sport. Please note the NCAA does not allow coverage for injuries or illnesses that are pre-existing in nature. Our policy does not cover the following situations and/or circumstances:

- Athletic injuries or illnesses that are pre-existing in nature
- Chronic or Overuse injuries
- Medical Illnesses such as Mononucleosis, Strep Throat, Influenza, etc.
- Athletic injuries that are not directly related to John Jay College intercollegiate sport participation
- Athletic injuries that are not directly reported to the Sports Medicine Staff in a timely manner

In addition, John Jay College will not be held responsible for any medical bills above and beyond the usual and customary cost as dictated by the insurance industry. Please understand that most universities operate under the same regulations.

In the event you sustain an injury which is eligible for secondary insurance coverage under the John Jay policy, the following steps will occur:

1) We file an injury report with our insurance company indicating a legitimate claim may be forthcoming.
2) You or your parents/legal guardians are responsible for submitting any bills to your primary insurance plan if the medical provider does not do so.
3) Once bills have been submitted, your insurance carrier will send you or your parents an Explanation of Benefits (EOB) showing what has been paid to the medical provider. Please forward a copy of this EOB and any bills to the attention of the Head Athletic Trainer in the sports medicine department.

The insurance agency will make requests directly to you or your parents/legal guardians for any information needed to process the claim. At no time will the school be responsible for securing the needed information.

Lastly, please note that if your primary insurance coverage is through an HMO or PPO, you must see a physician within your network or follow proper procedures required by your plan in order for your insurance and the university's insurance to satisfactorily complete its portion of the claim. Failure to follow the proper procedures may nullify benefits.

I HAVE READ AND UNDERSTAND THE INFORMATION STATED ABOVE

Student-Athlete's Signature: ________________________________ Date: ________________________

John Jay College of Criminal Justice

Sports Medicine Department
Personal Information

Name:________________________________ **Date:**________________________________
Social Security #:____________________ **Date of Birth:**__________________________
Sport:________________________________ **Year in School** (please circle one)**:** FR / SO/ JR / SR

Address: ________________________________
City: ________________________________
State, Zip: ________________________________
Phone #: ________________________________
Cell #: ________________________________
E-Mail: ________________________________

Person to notify in the event of an EMERGENCY
Name:________________________________ **Relation:**________________________________

Daytime Phone:______________________ **Evening Phone:**______________________

Insurance Information

I am covered under the following person's insurance policy:
□ Myself * □ Spouse* □ Mother □ Father □ No Coverage
*If covered by your own or your spouses insurance please place info on the lines provided for parents/guardians.

Mother/Guardian Information		Father/Guardian Information
______________	Social Security #	______________
______________	Date of birth	______________
______________	Address	______________
______________	City, State, Zip	______________
______________	**Insurance Company**	______________
______________	**Address**	______________
______________	**City, State, Zip**	______________
______________	**Group #**	______________
______________	**Policy #**	______________
______________	**Phone #**	______________

Mother/Guardian		Father/Guardian
□ Yes □ No	Is this plan an HMO or PPO?	□ Yes □ No
□ Yes □ No	Is pre-authorization required to obtain treatment?	□ Yes □ No
□ Yes □ No	Is a second opinion required before surgery?	□ Yes □ No

In signing this document, I certify that the answers to the above questions are correct. I understand that is my responsibility to notify the appropriate departments if any of the information should change over the course of the year.

Signature of Athlete: ________________________________ Date:________________

Signature of Guardian: ________________________________ Date: ________________
(Required if Athlete is a minor)

John Jay College of Criminal Justice

Sports Medicine Department

Release of Records Authorization

Send Info To: Theresa D. Acosta MS, ATC
Head Athletic Trainer / Athletic Department
John Jay College of Criminal Justice
899 10th Avenue
New York, NY 10019-1069
Office: (212) 237-8324
Fax: (212) 237-8474
E-mail: tacosta@jjay.cuny.edu

I, ____________________________________, hereby authorize the release of the following information to the John Jay College of Criminal Justice Sports Medicine Department.

(Please place your initials on the appropriate lines)

_____ Initial evaluations
_____ Progress Notes
_____ Consultation reports
_____ Treatment summary
_____ Diagnostic test results
_____ All information
_____ Psychological reports
_____ History/Physical exam
_____ Correspondence notes
_____ Entire medical record
_____ Billing records
_____ Other

I further authorize John Jay College of Criminal Justice Sports Medicine Department and its designated agents to discuss or distribute this information as needed.

I understand that I sign this form voluntarily and that I may change my mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This consent form will expire (1) one year following the date signed.

Signature of Athlete: ______________________________ Date: _____________

Signature of Guardian: ____________________________ Date: _____________
(Required if Athlete is a minor)

Signature of Athletic Trainer: ________________________ Date: _____________

John Jay College of Criminal Justice

Sports Medicine Department
Medical Information Waiver

I, ______________________________________, hereby give permission to the medical staff of John Jay College to release and discuss medical conditions that may occur through participation in athletics with John Jay College to the following people.

(Please give consent by placing your initials on the appropriate lines)

________ Director of Athletics

________ Coaching Staff

________ Opposing team trainer

________ Parent, Guardian or Spouse

________ Insurance Company

________ CUNY Conference Administrators

I understand that the information, or some portion thereof, that may be disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This authorization form will expire (1) one year following the date signed.

Signature of Athlete: ________________________________ Date: ______________

Signature of Guardian: ______________________________ Date: ______________
(Required if Athlete is a minor)

Signature of Athletic Trainer: _________________________ Date: ______________

John Jay College of Criminal Justice

Sports Medicine Department

Assumption of Risk and Medical Consent

I, ______________________________, verify that I have been informed that I may be injured while participating in any intercollegiate athletic practice or competition. I understand that it is possible that I may sustain an injury which may result in permanent disability, paralysis, or possibly death. In addition, I understand that an injury to any of my body joints (ankle, knee, hip, spine, shoulder, etc.) may result in disfigurement, loss of movement, strength, or feeling which may last my entire lifetime.

I understand that it is my responsibility to adhere to all the rules and regulations of my chosen sport. I understand that any infraction of these rules and regulations may result in injury to my opponent or me. I also understand that no modification of protective equipment or uniform should be made. In addition, I understand that it is my responsibility to report faulty or poor fitting equipment immediately to the coach, equipment manager, or athletic trainer.

I understand that all injuries and illnesses are to be reported to the athletic trainer. I understand that I am responsible for the follow-up medical care and treatment of my injuries under the supervision of the sports medicine staff.

I hereby grant permission to John Jay College of Criminal Justice Sports Medicine Staff, team physicians, and/or their consulting physicians to render any medical treatment or surgical care they deem reasonably necessary to my health and well-being. In the event that hospitalization is required, I freely give my permission for hospitalization at an accredited hospital.

Consequently, I hereby authorize John Jay College of Criminal Justice Sports Medicine Staff who are under the direct supervision of a board certified physician to render any preventative treatment, first aid, rehabilitation, or emergency treatment that they deem reasonable and necessary to my health and well-being.

I understand that the information, or some portion thereof, that may be disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I accept these risks of athletic participation in ______________________________ (Sport) and herby give my consent for medical treatment.

Signature of Athlete: ____________________________________ Date: _______________

Signature of Guardian: __________________________________ Date: _______________
(Required if Athlete is a minor)

Signature of Athletic Trainer: _____________________________ Date: _______________

John Jay College of Criminal Justice

Sports Medicine Department

Annual Health Appraisal

The information provided remains confidential within the John Jay College of Criminal Justice Athletic Department in a *secured* medical file in the Sports Medicine Office.

Name:_______________________________ **Date:**____

Sport:_______________________________ **Year in School:**______________________________

Social Security #:_____________________ **Date of Birth:**________________________________

Home Phone Number:_________________ **Cell Phone Number:**__________________________

(Please explain all YES answers on line provided)

Are you currently suffering from an illness or injury? **Yes** **No** ______________________

____

Have you had an injury in the past two (2) years? **Yes** **No** ______________________

____

Have you been hospitalized in the past year? **Yes** **No** ______________________

____

Do you have any known allergies? **Yes** **No** ______________________

____

Are you presently taking any medications or supplements? **Yes** **No** ______________________

____

Do you wear glasses or contacts while participating in sports? **Yes** **No** ______________________

____

Women Only: Are your menstrual cycles regular? **Yes** **No** ______________________

Date of last menstrual period: _____________ ______________________

JOHN JAY SPORTS MEDICINE STAFF USE ONLY- DO NOT FILL IN ANY OF THE BLANKS BELOW

Height:_________ Weight:________ B.P.:___________ HR:___________

Body Part	Impression/Findings
Head and Neck	
Chest Wall and Upper Back	
Lower Back and Pelvis	
Shoulders	
Upper Arms and Elbows	
Hands/Forearms/Wrists	
Thighs	
Knees	
Lower Legs	
Foot/Ankle	
Neurological	

Is this patient physically capable of competing in Intercollegiate Athletics? **Yes** **No**

____

**** Note to Seniors – All athletes that are in their final year of athletic participation must obtain an Exit Medical Appraisal within two weeks following their scheduled season. If an athlete fails to obtain an Exit Appraisal all injuries will be considered resolved.***

Signature of Athlete: ____ Date: _________________

Signature of Athletic Trainer: ________________________________ Date: _________________