



MEDICAL SCREENING, INJURY REPORTING PROCEDURE, MEDICAL INSURANCE INFORMATION, AND CONSENT FOR CARE AUTHORIZATION FOR ATHLETIC PARTICIPATION IN THE LOS ANGELES COMMUNITY COLLEGE DISTRICT
East Los Angeles College

Student Name: _____
 SID#: _____ Year: _____ Season: _____ Sport: _____

MEDICAL SCREENING. By signing below, I understand that an annual medical screening is required by EAST LOS ANGELES COLLEGE (the "COLLEGE") prior to participation in the intercollegiate athletic program. This screening will be provided by the COLLEGE at no cost to me if I follow the procedures set forth by the COLLEGE's athletic medical staff. If I fail to follow said procedures, I must have the COLLEGE Screening Examination form completed by an accredited physician at my own expense before I am allowed to participate in the athletic program.

INJURY REPORTING PROCEDURE. By signing below, I understand that I must follow the following procedure upon incurring any injury (no matter how slight) during practice or games.

1. I will report the injury immediately to the COLLEGE athletic training staff.
2. If the COLLEGE athletic training staff refers me to a hospital, physician, or emergency clinic, I will need to assist the COLLEGE athletic training staff in filing any necessary insurance claim forms.
3. Only the COLLEGE athletic training staff can make referrals. If I go to a medical facility or physician without prior authorization from the COLLEGE athletic training staff, I will be responsible for all bills incurred.
4. If I require emergency treatment away from the COLLEGE, COLLEGE staff will contact the host school's athletic trainer or team physician to provide necessary treatment. If I receive a bill, I will submit a copy to the COLLEGE athletic training staff.

MEDICAL INSURANCE INFORMATION. By signing below, I understand that the DISTRICT's intercollegiate accident insurance plan will go into effect only after all other insurance coverage has been exhausted, as follows:

1. I must submit my medical bills to my primary insurance company first. (Most insurance companies will cover a dependent full-time student (e.g., taking at least 12 units) until age 24.) If I have moved here from out of state, it is my responsibility to ensure that my insurance coverage applies in California.
2. After my primary insurer has paid its share, the remaining balance of outstanding bills will be submitted to the DISTRICT's insurer. The DISTRICT's insurance plan covers eligible expenses that exceed my primary insurance.
3. If I do not have primary insurance coverage, the DISTRICT's insurance plan will pay 100% of eligible medical bills when network providers provide treatment, and 60% of eligible reasonable and customary charges when non-network providers provide treatment. It is my responsibility to ensure that only network providers provide medical treatment, so that eligible medical bills may be paid at 100%.
4. I understand that doctors and hospitals will hold me responsible for all payments until my primary insurer, the DISTRICT's insurer, or both, pay on my behalf. My prompt cooperation with the COLLEGE athletic training staff will enable the proper forms to be processed quickly.

I understand that the DISTRICT's plan does not cover any pre-existing injuries, nor does it cover medical expenses due to illness. Copies of the DISTRICT's plan brochure can be obtained from the COLLEGE athletic training staff. By signing below, I have read the foregoing information, agree to abide by the DISTRICT's insurance plan, and certify that all information submitted to the COLLEGE regarding my primary insurance plan is correct and currently in effect.

CONSENT FOR CARE AUTHORIZATION. By signing below, I hereby grant permission to the athletic training and medical staff of the COLLEGE to employ such established treatments and therapy as may be deemed professionally necessary for all sports related injuries that occur during my athletic participation at the COLLEGE.

I understand that sports related injuries may require evaluation, treatment, rehabilitation, and/or possible referral to specialized medical professionals. I further understand that health status decisions will be made in the best interests of my health and well-being.

This authorization shall remain in force and active for the duration of my athletic eligibility and academic matriculation at the COLLEGE. I may revoke this authorization at any time, by filing a written notice with the COLLEGE athletic training department. I understand that if I choose to revoke this authorization, I may be unable to continue my intercollegiate athletic participation at the COLLEGE.

Signature of Student

Date

Signature of Parent/Guardian, if student is under 18 years of age

Date