June 1, 2020

RE: Important Forms **DUE AUGUST 1**

Dear Student-Athlete:

Enclosed please find your **Letter of Intent** (if applicable) which indicates the amount of athletic aid you will receive while participating in intercollegiate athletics at Carlow during the 2020-21 academic year. Please review the letter with your parents and sign in the appropriate spaces. Keep the original for your records and return the signed copy to our office.

(Note: if you have already received and/or returned your LOI, or receive no athletic aid, a copy is not included in this mailing.)

Enclosed are copies of Medical and other Forms we need you to complete and return by August 1, 2020.

Please make sure the following forms are received in the Department of Athletics:

- **Letter of Intent**
- **Health History**
- **Physical Exam***
- **Athletic Insurance Information**
- **NAIA Consent Form for Drug Testing**
- **FERPA**
- **Annual Publicity Sheet/Website Release**
- **Consent for Treatment, Payment & Health Care Operations**
- **UPMC Authorization for Release of Protected Health Information**

All forms are also available **online** on the Athletics page of the Carlow website under Athletics Forms: www.carlow.edu/Athletics_Medical_Forms.aspx

Your physician must complete the enclosed Physical Exam form because it specifically clears you to participate in intercollegiate athletics.* ***No other form will be accepted.*

In accordance with University policy, **all these must be completed and on file with Athletic Training staff before you may participate in any team related activity**. This policy will be strictly enforced. ***These forms are due no later than August 1, 2020.***

If you have questions, please call the Department of Athletics at 412-578-6310.

We are looking forward to your participation and contribution to the athletic programs at Carlow.

Sincerely,

George S. Sliman
Director of Athletics
Enclosures

Incoming FIRST YEAR Athletes
Please Note:
You will also be receiving or have already received forms from the University Nurse. You must complete and return those forms in addition to the enclosed. If you have any questions about the Nurse forms, please call:
412-578-6174
The forms can also be found online at:
www.carlow.edu/Health_History.aspx

UPMC Sports Medicine – Carlow University

Athletic Health History Form

Name _______________________________ Date of Birth _______________ Sport(s) _______________

1. Have you ever been hospitalized?
   Yes ☐ dates/reason: ____ No ☐
2. Have you ever had surgery?
   Yes ☐ dates/reason: ____ No ☐
3. Have you ever been told by a health care provider to not partake in athletic activity? Yes☐No☐
   If yes, please explain: ____
4. Are you currently taking any medications?
   Yes ☐ List: ____No ☐
5. Are you currently taking any supplements? Yes ☐ No ☐
   If yes, what supplements/why? ____
6. Are you currently trying to gain or lose weight? Yes ☐ No ☐
   If yes, please explain: ____
7. Have you been diagnosed or treated for an eating disorder?
   Yes ☐ When? ____No ☐
   Diagnosis/Treatment: ____
8. Have you ever seen a dietician or nutritionist for advice?
   Yes ☐ When/Why? ____No ☐
9. Do you have any allergies (e.g.: bees, medicine, food)?
   Yes ☐ List: ____No ☐
   What is your reaction (i.e. hives, anaphylaxis, etc.)? ______________________________
   Do you carry an epi-pen? Yes ☐ No ☐
10. Do you smoke or vape? Yes ☐ No ☐
11. Do you use any smokeless tobacco products? Yes ☐ No ☐

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12. Cardiac History
    a. Have you ever passed out during exercise? Yes ☐ No ☐
    b. Have you ever been dizzy during exercise? Yes ☐ No ☐
    c. Have you ever had chest pain during exercise? Yes ☐ No ☐
    d. Have you ever had chest pain without engaging in exercise? Yes ☐ No ☐
    e. Do you tire more quickly than your friends during exercise? Yes ☐ No ☐
    f. Have you ever been diagnosed with high blood pressure? Yes ☐ No ☐
    g. Have you ever been told you have a heart murmur? Yes ☐ No ☐
    h. Have you ever had racing of your heart or skipped beats? Yes ☐ No ☐
    i. Has anyone in your family died suddenly before age 40? Yes ☐ No ☐
    j. Do you or anyone in your family have Marfan's Syndrome? Yes ☐ No ☐
    k. Do you have a history of irregular heart beats (arrhythmia)? Yes ☐ No ☐
13. Have you ever been dizzy or passed out from the heat? Yes ☐ No ☐
14. Have you ever had heat cramps? Yes ☐ No ☐

UPMC Sports Medicine – Carlow University

Athletic Health History Form

Name ______________________________ Date of Birth ______________ Sport(s) ______________

15. Do you have any skin problems? (itching, moles, breaking out, psoriasis/eczema, etc.)
    Yes ☐ List: ____ No ☐
16. Have you ever had a concussion?
    Yes ☐ Dates: ____ No ☐
    Total number of diagnosed concussions __________________________
17. Have you ever had any other type of head injury?
    Yes ☐ Date/Injury: ____ No ☐
    a. Have you ever been hospitalized for a head injury? Yes ☐ No ☐
18. Have you ever had a seizure?
    Yes ☐ Date/Cause if known: __________________________________No ☐
19. Have you had a stinger or burner?
    Yes ☐ Date(s): ____ No ☐
20. Are you missing one of a paired organ (eyes, kidneys, ovaries, testes, etc.)?
    Yes ☐ If yes, what/explain: __________________________________ No ☐

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21. Have you ever injured (sprained/strained, dislocated, fractured, etc.)
    a. Hand/wrist Yes ☐ Date/Injury: __________________________ No ☐
    b. Forearm/elbow Yes ☐ Date/Injury: __________________________ No ☐
    c. Shoulder/arm Yes ☐ Date/Injury: __________________________ No ☐
    d. Chest Yes ☐ Date/Injury: __________________________ No ☐
    e. Neck Yes ☐ Date/Injury: __________________________ No ☐
    f. Back Yes ☐ Date/Injury: __________________________ No ☐
    g. Hip/thigh Yes ☐ Date/Injury: __________________________ No ☐
    h. Knee Yes ☐ Date/Injury: __________________________ No ☐
    i. Lower leg/ankle Yes ☐ Date/Injury: __________________________ No ☐
    j. Foot Yes ☐ Date/Injury: __________________________ No ☐
22. Do you use any special braces or pads? (e.g. ankle brace, special insoles, sleeves, etc.)
    Yes ☐ What/why? ___________________________ No ☐
23. Do you use any special appliances? (e.g. insulin pump, hearing aids, etc.)
    Yes ☐ What: ________________________________ No ☐
24. Do you now or have you ever had …
    a. Mononucleosis Yes ☐ Date(s):______________________________ No ☐
    b. Hepatitis Yes ☐ Date(s):______________________________ No ☐
    c. Tuberculosis Yes ☐ Date(s):______________________________ No ☐
    d. Anemia Yes ☐ Date(s):______________________________ No ☐
    e. Diabetes Yes ☐ Date(s):______________________________ No ☐
    f. Headaches/Migraine Yes ☐ Date(s):______________________________ No ☐
    g. Eye Injuries Yes ☐ Date(s):______________________________ No ☐
    h. Stomach ulcers Yes ☐ Date(s):______________________________ No ☐

Name ______________________________ Date of Birth ______________ Sport(s) ______________

i. Asthma Yes ☐ Date(s): ______________________________ No ☐
Do you currently use an inhaler? Yes ☐ Name _______________________ No ☐

25. Do you have any other chronic diseases (i.e. autoimmune diseases, Lyme Disease, Crohn's Disease, Lupus etc.)? Yes ☐ List: ____ No ☐

26. Have you tested positive for COVID-19? Yes ☐ Date of test: ______________ No ☐
27. Have you been exposed to an individual who has tested positive for COVID-19?
Yes ☐ Date: ____ No ☐

28. Do you wear corrective lenses for sports? Yes ☐ No ☐
    a. What type of lenses? (i.e. contacts, safety glasses, etc.) ___________________________
29. Do you have any other problems with your eyes or vision? Yes ☐ No ☐
    a. If yes, please explain: ____

30. When was your last tetanus shot? Date: ____

31. Do you currently suffer from
    a. Anxiety? Yes ☐ Explain: _____________________________________ No ☐
    b. Depression? Yes ☐ Explain: ______________________________________ No ☐
    c. Other mental health issues? Yes ☐ Explain: _______________________ No ☐
    d. If yes, do you need additional resources to deal with these issues? Yes ☐ No ☐

32. If applicable:
    a. When was your first period? Date/approximate age: _____________________________
    b. When was your most recent period? Date: _____________________________________
    c. Are your periods irregular? Yes ☐ No ☐
        i. If no, list any known reason/explanation: _______________________________
    d. Are you currently pregnant or suspect you might be pregnant? Yes ☐ No ☐
        i. If yes, how far along: ____
        ii. Do you want any additional help/resources with this? Yes ☐ No ☐

By signing my name below, I acknowledge that the questions on this form have been answered truthfully and accurately to the best of my ability and knowledge.

Signature: ____ Date: _____________________

Print Name: ____

UPMC | SPORTS MEDICINE

DATE: ______________

Physical Examination Form

Name: ____ Date of Birth: ______________

Sport(s):____ Age: ______________

School: ____

Height: ______________ Weight: ___________________ B/P: _______________ Pulse: ________

******I have reviewed the student-athlete's health history. Initials: _____________ (MD/DO)**

Visual Acuity	
CV: Pulses	Brachial: Femoral:
Lungs	☐ Normal ☐ Abnormal Explain
Heart	☐ Normal ☐ Abnormal Explain
HEENT	☐ Normal ☐ Abnormal Explain
Abdominal	☐ Normal ☐ Abnormal Explain
Skin	☐ Normal ☐ Abnormal Explain
Genitalia	Deferred? Y / N STI Sx/Dx: Y / N
Reflexes	☐ Patellar ☐ Achille's ☐ Brachioradialis ☐ Bicep
Musculoskeletal	*Marfan's Screening*: ☐ High palate/crowded teeth ☐ Breastbone deformity ☐ Hypermobile/flexible joints ☐ Long appendages
Neck	☐ Normal ☐ Abnormal Explain
Shoulder	☐ Normal ☐ Abnormal Explain
Elbow	☐ Normal ☐ Abnormal Explain
Wrist	☐ Normal ☐ Abnormal Explain
Hand	☐ Normal ☐ Abnormal Explain
Back	☐ Normal ☐ Abnormal Explain
Knee	☐ Normal ☐ Abnormal Explain
Ankle	☐ Normal ☐ Abnormal Explain
Foot	☐ Normal ☐ Abnormal Explain

Assessment:

Recommendation:

CLEARANCE (please circle appropriate clearance):

1. **No restrictions**

2. **Limitations. Please circle highest level of allowable activity:**

    A. No Activity. Please explain in #3 below

    B. No Contact

        a. Non-strenuous

        b. Moderately strenuous

        c. Strenuous

    C. Limited contact/impact

    D. Contact/collision

3. **Clearance deferred until further evaluation by a physician or Athletic Trainer**

Please explain: ____

____

____

Other comments/explanations: ____

____

____

______________________________ ______________________________, MD/DO

Exam Date Signed

____

Printed name

[Type here]

CARLOW UNIVERSITY

Athletic Insurance Information

YOU MUST HAVE MEDICAL INSURANCE IN ORDER TO PARTICIPATE IN ATHLETICS AT CARLOW UNIVERSITY.

(Please type/print using **Black Ink**) **PLEASE NOTE:** PARENT OR GUARDIAN INSURANCE COVERAGE IS PRIMARY COVERAGE. CARLOW UNIVERSITY PROVIDES SECONDARY INSURANCE COVERAGE THAT WILL BE APPLIED AFTER PRIMARY COVERAGE.

Student Name_____________________________________ Sport(s)____________________________________

Soc. Sec. #____ Date of Birth___________________

Permanent Address____ City_______________________________

State___________ Zip___________ Phone____

Insurance Policy Holder's Name_____________________________ Relationship ________________________

Address____

Phone No. ___________________________

Employer ____ Phone No. ___________________________

Emergency Contact _______________________________________ Relationship __________________________

Address____

Phone No. ___________________________

Employer____ Phone No. ___________________________

Do you have medical insurance to cover this athlete?__YES __NO **(IF you checked No, please see below)**

*****The Policy Holder must sign this form***

Name of Insurance Company ____

Policy #: ID #________________________ Group #__________________ Phone__________________________

Is this an HMO or PPO? __YES __NO If YES, which one _________________________________

IF YOUR INSURANCE CARRIER IS AN HMO OR PPO, ARE THERE ANY EMERGENCY CARE PROVISIONS THAT WE SHOULD BE AWARE OF IN THE EVENT OF THE NEED FOR "EMERGENCY, ON-SITE CARE"? PLEASE EXPLAIN ANY SUCH PROVISIONS ON THE LINES BELOW.

____

____

I hereby authorize Carlow University and associated Insurance Group to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/ or previous confinements and/ or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize Carlow University and associated Insurance Group to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by Carlow University.

I/ WE AGREE THAT ALL INFORMATION IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/ OUR KNOWLEDGE. I/ WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPOSBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST. ALL AMOUNTS DEEMED REFUNDABLE.

PARENT/ GUARDIAN/ POLICY HOLDER_________________________________ DATE________________

STUDENT ATHELETE____ DATE________________

ALL LINES ON THIS FORM MUST BE COMPLETED. PLEASE BE SURE THAT IF YOUR INSURANCE IS HMO/ PPO THAT YOU HAVE LISTED ALL NECESSARY STEPS TO BE COMPLETED IN THE EVENT OF AN EMERGENCY OR CLAIM THAT NEEDS TO BE REPORTED. FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING.

NAIA Official Student Consent Form

A. Requirement to Sign Drug-Testing Consent Form

1. Name of Institution: ____

2. Name of student-athlete: ______________________________________ Sport(s): ________________

3. You must sign this form to participate in any NAIA National Championship competition. This includes but is not limited to Opening Rounds and Final Sites. If you have any questions, you should discuss them with your director of athletics.

B. Consent to Testing

1. You agree to allow the NAIA to test you in relation to any participation by you in any NAIA national championship or invitational competition. Examples of drugs in each class can be found at www.naia.org/wellness. Note: There is no complete list of banned substances. Check the NAIA Drug Free Sport AXIS for questions about supplements, medications and banned drugs.

C. Consequences for a Positive Drug Test

1. By signing this form, you affirm that you are aware of the NAIA drug-testing program, which provides:

2. A student-athlete who tests positive for use of a banned substance as defined by the NAIA banned-drug classes list, shall be sanctioned as outlined below:
   a. A student-athlete's first offense for testing positive for the use of any banned drug shall be immediately suspended from further competition in any sport; and
   b. The period of suspension will be for a minimum of 365 days from the date of the specimen collection that lead to the positive test result; and
   c. The student-athlete shall be charged one season of competition in all sports because of the positive test result.
   d. A student-athlete testing positive a second time for the use of any banned drug shall lose all remaining NAIA regular season and post-season eligibility in all sports.
   e. Individual placings and honors earned at the national championship at which the positive test occurred shall be vacated.
   f. Team championships will be determined by the National Drug Testing and Education Committee.

D. Signatures

1. By signing below, I consent:
   a. To be tested by the NAIA in accordance with NAIA drug-testing policy, which provides among other things that I will be notified of selection to be tested;
   b. I must appear for NAIA testing or be sanctioned for a positive drug test; and my urine sample collection will be observed by a person of my same gender;
   c. To accept the consequences of a positive drug test;
   d. To allow my drug-test sample to be used by the NAIA drug-testing laboratories for research purposes to improve drug-testing detection; and
   e. To allow disclosure of my drug-testing results only for purposes related to eligibility for participation in NAIA competition.

I understand that if I sign this statement falsely or erroneously, I violate NAIA legislation on ethical conduct and will jeopardize my eligibility.

________________________ ____
Date Signature of student-athlete

________________________ ____
Date Signature of parent (if student-athlete is a minor)

____ ___________________ _________
Name (please print) Date of birth Age

____
Home address (street, city, state and zip code)

____
Sport(s)

CARLOW UNIVERSITY

AUTHORIZATION TO RELEASE STUDENT RECORDS

In compliance with the Federal Family Education Rights and Privacy Act of 1974 on Access to and Release of Student Education Records, the University requires student permission before releasing certain information from student records to a third party, such as information on grades, schedule, on-campus living arrangements, student accounts (including billing and payment records), financial aid (including scholarships, grants, work-study, or loan amounts) and other student record information. This restriction applies, but is not limited, to your parents, your spouse, or a sponsor.

You may, at your discretion, grant the University permission to release information about your student records, to a third party by completing this form. The information will be made available only if requested by the authorized third party and if deemed appropriate by the University. The University will **not** automatically send information to a third party.

Your authorization to release information has ***no expiration date***; however, you may revoke your authorization at any time by submitting a written request to the Office of the Registrar.

I hereby grant my permission to allow Carlow University to share information from my education record with the individuals named below.

____ _______________

Signature of Student *Student ID* *Date*

____

Print Name

Third Party Designees:

____ _______________

Name (Please print legibly) *Relation to Student* *Date*

____ _______________

Name (Please print legibly) *Relation to Student* *Date*

____ _______________

Name (Please print legibly) *Relation to Student* *Date*

____ _______________

Name (Please print legibly) *Relation to Student* *Date*

____ _______________

Name (Please print legibly) *Relation to Student* *Date*

STUDENT-ATHLETE'S ANNUAL INFORMATION SHEET

Please complete this **annually** so that our records are updated for mailings and event notices. Thank you!

Name____ **Date**_____________

Sport___________________________Student ID#______________Birth Date________

Home Address____

City, State, Zip____

Home Phone No._________________________Cell Phone No. ____________________

Living on Campus _____ Yes ____ No

If Not, Local Address____

Carlow email address____

Preferred email address____

Parent/Guardian Information

First and Last Name: ____

Relationship: ______________________________ Phone: ________________________

Email:____________________________________ Cell/Work Phone:_______________

TO: Carlow University Student-Athletes
FROM: Karina Graziani, Sports Communications Manager

SUBJECT: Online Player Profiles

The Department of Athletics would like to create a Student-Athlete Player profile for you on your team's homepage. Please take a moment to fill-out this questionnaire and return to the Athletic office as soon as possible.

Name ____

Pronunciation____

Jersey Number __________ Height __________ Position _________

Year (FR/SO/JR/SR) __________________ Major _____________________________

High School/Previous School ____

Hometown ____

Collegiate Athletic Awards/Honors: _______________________________________

____

____

High School Athletic Awards/Honors (First Year Students ONLY):

____

____

____

Local Newspaper(s) and Email/Phone Contact(s)______________________________________

____

I hereby grant my consent to use and license the use of my name, my likeness, and my personal information whether in still or in motion pictures, my photograph and/or other reproduction, including my voice and features, with or without my name, for any editorial, promotion, trade, webpage, business or other purpose whatsoever, or for testimonial and endorsement or product advertising. Carlow University may exercise its rights in any way it sees fit for its production, for advertising, for the web, and for other purposes.

__________________________________ __________________

Student-Athlete Signature Date

Sickle Cell Trait Testing Waiver

SICKLE CELL TRAIT TESTING

The NAIA recommends that all student-athletes have knowledge of their sickle cell trait status. Student-athletes must complete one of the following (Check One):

1. Show proof of a prior test with results ☐
2. Have a blood test to check for sickle cell trait at your family physician's office ☐
   OR
3. Sign a testing waiver declining options 1 and 2 ☐

This must be completed prior to participation in any intercollegiate athletics event, including strength and conditioning sessions, practices, competitions, etc.

Athletes who are positive for the trait will be allowed to participate in intercollegiate athletics. Athlete who are positive for sickle cell trait or sign the waiver declining testing will be required to meet with our team physician to discuss concerns regarding participation with sickle cell trait.

ONE OF THE FOLLOWING OPTIONS MUST BE CHOSEN.
INCLUDE ANY DOCUMENTATION, IF NECESSARY:

1. Copy of athlete's newborn sickle cell testing result. __________ Date ________________
   Most states require testing at birth. Check with your hospital or pediatrician.

2. Copy of recent sickle cell screening test result. ______________ Date________________
   Copy of testing is the responsibility of the athlete.

3. SICKLE CELL TESTING WAIVER:
   By signing this waiver, I understand and acknowledge that the NAIA recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I certify that I have read and fully understand the aforementioned facts and I have had the opportunity to review the NCAA website for further information about sickle cell trait and sickle cell trait testing.
   Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Carlow University Department of Athletics.
   I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify, and hold harmless Carlow University, its officers, employees, agents and their successors and assigns from any and all costs, claims, damages or expenses, including attorney's fees, arising from any loss or personal injury that might result from my refusal to be tested.
   I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

_________________________________ _________________________________
Student-Athlete's Signature Student-Athlete's Name (Print)

____
Sport and Date

_________________________________ _________________________________
Parent/Guardian's Signature (if under 18) Parent/Guardian's Name (Print) and Date

Carlow University Athletics
Consent for Treatment Form

I___________________________(print or type name) consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, emergency response and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all the results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, certified athletic trainer, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college\university student athletic trainers may also provide care.

I have been provided a Notice of Privacy Practices document by the University's Athletic Trainer Services provider. I also understand that additional copies of this Notice are available for my review upon my request. _______ **Patient Initials**

____ ____________________
Student-Athlete Signature Date

____
Carlow Sports Medicine Representative

Please also complete UPMC Consent for Treatment form!
Thank you.

UPMC | SPORTS MEDICINE

Print Athlete's Name

Print Athlete's Sport

As part of a contractual agreement with UPMC Sports Medicine, certified athletic trainers may aide in the prevention, recognition, evaluation, and treatment of athletic injuries. **Please note that the forms below have no relationship to your health insurance plan and in no way, influence your choice of medical care.** UPMC must have these forms completed to comply with privacy and standard consent to treat laws.

(1) UPMC Authorization for Release of Protected Health Information

- I authorize UPMC to provide information related to the athlete's care to family/school/team physicians, school nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether the athlete may resume participation in school or sports activities.
- I authorize UPMC to use the athlete's medical information for UPMC internal departmental reporting purposes.
- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information maintained on electronic information systems or stored in various forms about the athlete's care, health care operations, or payment for treatment and services.
- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability because of the re-disclosure and (2) such information may no longer be protected by federal or state privacy laws.
- I understand that this Authorization is in effect for a period of one year from the date signed by the athlete.
- I understand that this Authorization is in effect if the athlete is treated for an injury during off-season workouts; however, no time frame specified shall go beyond one year from the date of signature.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to UPMC at the location where the Authorization was provided.
- I understand that my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- I understand that I am entitled to a copy of this completed Authorization form.

(Continued other side)

______________________________ ______________________________
Print Athlete's Name Print Athlete's Sport

(2) UPMC Consent for Treatment and Healthcare Operations

I consent to the provision of care. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

In the event of ImPACT baseline testing, I understand the ImPACT baseline testing provided by UPMC Sports Medicine is not intended to prevent, diagnose, or treat a concussion and is not to be administered following a possible concussion. If the athlete suffers a concussion, the administration of an ImPACT post-test is generally conducted at the discretion of the concussion specialist at their facility.

(3) UPMC Privacy Practices

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon my request or viewed at http://www.upmc.com/patients-visitors/privacy-info/Pages/default.aspx. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.

By signing below, I am acknowledging the above (1) Authorization for Release of Protected Health Information, (2) Consent for Treatment and Healthcare Operations, and (3) Notice of Privacy Practices.

______________________________ ______________
Athlete signature Date

______________________________ ______________
Parent or guardian signature/relationship Date

______________________________ ______________
Parent or guardian signature/relationship Date

For Office Use Only:
Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: ____________________
Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices:

____