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

*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
UPMC Sports Medicine – Carlow University

Athletic Health History Form

Name __________________________ Date of Birth ____________ Sport(s) ______________

1. Have you ever been hospitalized?
   Yes ☐ Yes/Reason: __________________________________________ No ☐
2. Have you ever had surgery?
   Yes ☐ Yes/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 ☐ No ☐
   When? ____________________________________________
   Diagnosis/Treatment: _______________________________________
8. Have you ever seen a dietician or nutritionist for advice? Yes ☐ No ☐
   When/Why? ____________________________________________
9. Do you have any allergies (e.g.: bees, medicine, food)? Yes ☐ No ☐
   List: ____________________________________________________
   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 ☐
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 ☐
   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 ☐

21. Have you ever injured (sprained/strained, dislocated, fractured, etc.)

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 ☐
UPMC Sports Medicine – Carlow University

Athletic Health History Form

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: ___________ 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: ____________________________
### Physical Examination Form

**Name:**

**Date of Birth:**

**Sport(s):**

**Age:**

**School:**

**Height:**

**Weight:**

**B/P:**

**Pulse:**

**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

**Reflexes**

**Achille’s**

**Brachioradialis**

**Bicep**

**Musculoskeletal**

**Marfan’s Screening:**

High palate/crowded teeth  | Breastbone deformity

Hypermobility/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:**

---

**I have reviewed the student-athlete’s health history.**

**Initials:**

**(MD/DO)**
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]
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. IF WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE
PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY 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 ATHLETE________________________________ 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.
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)
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

Name  (Please print legibly)  Relation to Student  Date

JKREG092514
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. Athletes 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
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.
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.
(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:

_____________________________________________________________________________________

Page 2 of 2 UPMC Forms