

The University of Findlay Athletic Training Department

ATHLETIC INSURANCE INFORMATION

Date _____ Name _____ Sport _____

SS # _____ Date of Birth _____ Sex _____ Year in Sport 1 2 3 4 5

School Address _____ Phone (____) _____
Dorm / Street

City State Zip

Home Address _____ Phone (____) _____
Dorm / Street

City State Zip

PARENT/GUARDIAN INFORMATION

FATHER/GUARDIAN

Name _____

Soc Sec # _____

Address _____

City State Zip

Home Phone (____) _____

Employer _____

Address _____

City State Zip

Work Phone (____) _____

Do you have medical insurance? Yes No

Insurance Co _____

Address _____

City State Zip

Ins. Phone (____) _____

Policy # _____ Group # _____

Plan # _____

ID # _____

Authorization required for

Emergencies	Yes	No
Other	Yes	No

Explain _____

Type of Plan

HMO	_____
PPO	_____
Family/Private	_____
Work	_____
Govt.	_____
Other (describe)	_____

Do you have university student insurance? Yes No

MOTHER/GUARDIAN

Name _____

Soc Sec # _____

Address _____

City State Zip

Home Phone (____) _____

Employer _____

Address _____

City State Zip

Work Phone (____) _____

Do you have medical insurance? Yes No

Insurance Co _____

Address _____

City State Zip

Ins. Phone (____) _____

Policy # _____ Group # _____

Plan # _____

ID # _____

Authorization required for

Emergencies	Yes	No
Other	Yes	No

Explain _____

Type of Plan

HMO	_____
PPO	_____
Family/Private	_____
Work	_____
Govt.	_____
Other (describe)	_____

Directions: *The following documentation is to be read carefully. If you are under 18 years of age, your parent or guardian must also sign. If you elect not to sign any portion of these documents, please sign the “Decline” space.*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize The University of Findlay Athletic Training Department and their representatives to release my protected health information for the purpose of further treatment.

If I wish to revoke this authorization, I must do so in writing and have such authorization on file with The University of Findlay Athletic Training Department.

Print Name Signature

Date Parent/Guardian Signature (if under 18 years of age)

Signature to Decline

MEDICAL CONSENT AUTHORIZATION

I hereby grant permission to The University of Findlay Athletic Training Staff and Team Physicians/Consultants to render to myself, and/or my son/daughter, any treatment or medical care deemed reasonably necessary. This includes preventive care, first aid, rehabilitation and emergency treatment. Also, if deemed necessary, I grant permission for hospitalization.

Print Name Signature

Date Parent/Guardian Signature (if under 18 years of age)

Signature to Decline

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS AND DIRECT PAYMENT TO
MEDICAL PROVIDERS**

Student-athletes and parents must sign below for authorization to disclose medical records and authorization for personal insurance to make direct payments to health care providers:

I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, or treatment, and copies of all hospitals or medical records.

I HEREBY AUTHORIZE MY PRIVATE INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO ANY FACILITIES WHERE SERVICES WERE RENDERED.

A photocopy of this authorization shall be considered as effective and as valid as the original.

Print Name	Signature
Date	Parent/Guardian Signature (if under 18 years of age)
Signature to Decline	

**AUTHORIZATION TO NOTIFY PARENTS/GUARDIANS OF INJURY/ILLNESS SUSTAINED
VIA ATHLETIC PARTICIPATION**

I, the undersigned, do hereby give permission for The University of Findlay Athletic Training Department and their representatives to release information concerning my condition/injury to my parents/guardians listed below. All pertinent facts concerning my condition may be communicated to the party(ies) indicated below.

Name of parent/guardian (PRINTED)	Name of parent/guardian (PRINTED)
Print Name	Signature
Date	Parent/Guardian Signature (if under 18 years of age)
Signature to Decline	

STUDENT-ATHLETE ACKNOWLEDGMENT AND ASSUMPTION OF RISK

The undersigned herewith formally acknowledges and declares the following:

I understand that participation in sport requires a personal acceptance of risk of injury. Athletes generally expect that those who are responsible for the conduct of sport take reasonable precautions to minimize such risk and that their peers participating in the sport will not intentionally inflict wrongful injury upon them.

I understand that participation in Intercollegiate Athletics at The University of Findlay may result in injury/illness, permanent physical or mental impairment or even death. These injuries may be minor or may be career or life threatening. I understand that The University of Findlay cannot be held responsible for any injuries or conditions that may be caused by the actions of other athletes or teams. I also understand that injuries may be caused by my own failure to follow safety procedures or techniques which are made known to me by my coaching staff, athletic training staff, or by the strength and condition personnel or are otherwise known to me from an other source including but not limited to medical personnel of the university.

I have read the above shared responsibility statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics. I acknowledge the fact that these risks exist and I am willing to assume responsibility for **any and all** such risks while participating in Intercollegiate Athletics at The University of Findlay. I also agree to the following:

- A. I voluntarily assume all risks associated with my participation in Intercollegiate Athletics
- B. I accept that The University of Findlay and its personnel are not to be held responsible for any pre-existing medical condition(s) that I may have.
- C. I understand that having passed the physical examination **did not** necessarily mean that I am physically qualified to participate in Intercollegiate Athletics at The University of Findlay, but only that the evaluator did not find a medical reason to disqualify me at the time of the physical examination.
- D. I understand that I must refrain from practice while injured or ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission, based on independent exercise of professional judgment, by the attending Team Physician(s) or his/her designate after review of my condition and fitness for the rigors of my sport. This may occur during or at the conclusion of medical treatment(s).
- E. I understand and agree that if I experience an injury/illness or change in my health status **it is my responsibility** to inform my Head Coach and the Certified Athletic Trainer in charge of my sport and to adhere to the established injury management guidelines which includes total rehabilitation and reassessments before I am released to return to full participation.
- F. I understand that I must wear the proper equipment as dictated by the rules of the sport. I may also have to wear padding or braces as indicated by the athletic training staff or medical personnel. Failure to do so may put me at risk for further injury.

I HAVE READ, UNDERSTAND AND VOLUNTARILY AGREED TO THE ABOVE STATEMENTS.

Printed Name

Sport

Signature

Date

Parent/Guardian Signature (if under 18 years of age)

Date