Dear Student-Athlete, Parents, and/or Guardians:

We would like to welcome you to the University of Miami. As a new member of our athletic program, it is important that the enclosed forms are completed and returned to the Department of Athletic Training as soon as possible.

The package should include the following:

1. General Information
2. Insurance Authorization and Information
3. Medical and Orthopedic History
4. Procedures for Securing Medical Assistance & Payment of Expenses for Covered Injuries/Illnesses
5. Guidelines For Student Health Center Payment For Services
6. Emergency Medical Treatment Authorization
7. Student-Athlete Injury/Illness Release/Information Release
8. Waiver of Liability and Hold Harmless Agreement
9. Player Agency Statement/Treatment and Rehabilitation Adherence/Exit Interview Requirement
10. UM Hospital – Authorization for 3rd Party Disclosures
11. Request for Release of Medical Information
12. Medical Treatment Authorization for Minors
13. Concussion Education – NCAA Athlete Education
14. Concussion and Injury Reporting Acknowledgement
15. Sickle Cell Trait – NCAA Athlete Education
16. Sickle Cell Trait Education Acknowledgement
17. Football Helmet Warning

If you have any questions or concerns regarding these forms, please do not hesitate to call the Athletic Training Facility at 305-284-4131.

Thank you for your time and we welcome you to the University of Miami.

Sincerely,

Vincent A. Scavo, ATC, LAT
Associate Athletic Director for Athletic Training

UNIVERSITY OF MIAMI ATHLETIC TRAINING
5821 San Amaro Drive • Coral Gables, FL 33146-0820
Tel: 305-284-4131 • Fax: 305-284-3008

General Information Form

_____________________________ __________________ ______/______/________
Student-Athlete Name C Number Date of Birth

__________________________ _________________________ _____________________
Sport E-mail Social Security Number

____
Permanent Address

____ ____________________________
City State Zip Code

_____________________________ _________________________________
Home Phone Cell Phone

____
Campus Address

____
City State Zip Code

____
Phone

In Case of Emergency, CONTACT:

________________________________ _________________________________
Name Relationship

____
Address

____
City State Zip Code

____________________ __________________________ ___________________________
Home Phone Work Phone Cell Phone

Person to contact other than Parent/Guardian in an emergency:

______________________________________ _________________________________
Name Relationship

Home Phone: _______________ Work Phone: _______________ Cell Phone: ________________

The following information is kept confidential and will not be released to any individual without your authorization.

Insurance Authorization and Information

The University of Miami medical insurance policy, which provides insurance for the student- athlete for injury/illness sustained while participating in intercollegiate sports is EXCESS coverage. This means it pays benefits only AFTER taking into consideration those amounts payable under any other medical insurance plan. We, as the University, do not have the option of waiving this provision. Please provide the information requested below (i.e., medical insurance information/authorization, claim forms, copy of insurance card, copy of prescription card, etc.).

STUDENT-ATHLETE NAME__________________________________ SPORT________________

SS#____________________ DATE OF BIRTH____________________ SEX__________________

EMAIL ____ CELL PHONE#______________________

ADDRESS____________________ CITY_____________ STATE___________ ZIP____________

Is the student-athlete covered by medical insurance? YES / NO

If so, does the insurance require pre-certification for surgeries/services? YES / NO

FATHER/GUARDIAN

NAME____ SS#______________ DOB_____________

EMAIL____ CELL PHONE #_____________________

ADDRESS____________________ CITY_____________ STATE___________ ZIP____________

MOTHER/GUARDIAN

NAME____ SS#______________ DOB_____________

EMAIL____ CELL PHONE #_____________________

ADDRESS____________________ CITY_____________ STATE___________ ZIP____________

For Office Use Only:

Insurance Authorization and Information

FATHER/GUARDIAN
INSURANCE COMPANY________________________________ Phone________________________

Policy #________________________ Group #________________________ Deductible_____________

Effective Date of Policy ___________________

Claim Office Mailing Address____

City____________________ State____________ Zip Code________

MOTHER/GUARDIAN
INSURANCE COMPANY________________________________ Phone________________________

Policy #________________________ Group #________________________ Deductible_____________

Effective Date of Policy ___________________

Claim Office Mailing Address____

City____________________ State____________ Zip Code________

Primary Care Physician______________________________ Phone_______________________________

Address____

City_________________________________ State______________ Zip Code______________________

Please initial one option below:

______ Initial I hereby authorize the Department of Athletics to file a claim on my behalf under the above medical insurance policy in the event of an athletic injury or illness is sustained by the above student-athlete.

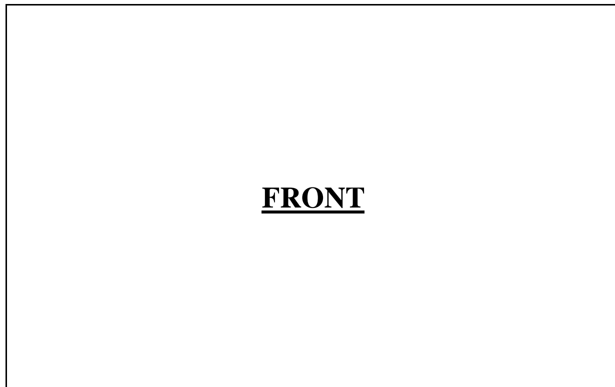
______ Initial My student-athlete plans to enroll in the University of Miami Student Sponsored Health Insurance plan (United HealthCare). Please see Pages 15-16 for more information.

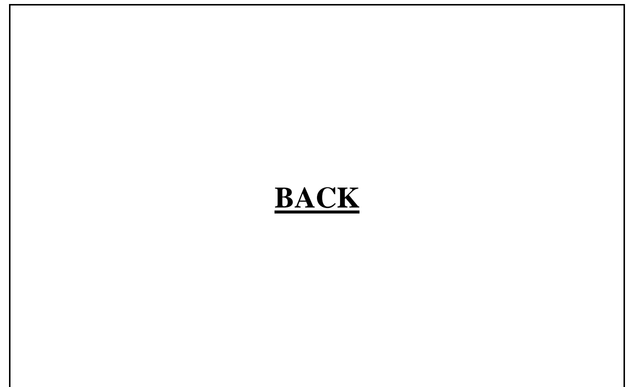
I HAVE READ THE ABOVE MEDICAL INSURANCE INFORMATION AND UNDERSTAND THE STATEMENTS CONTAINED THEREIN.

____ ___________________________
Signature of Parent or Guardian Date Signed

Please send a signed claim form, a copy of the insurance card, and a copy of the prescription card (if applicable)

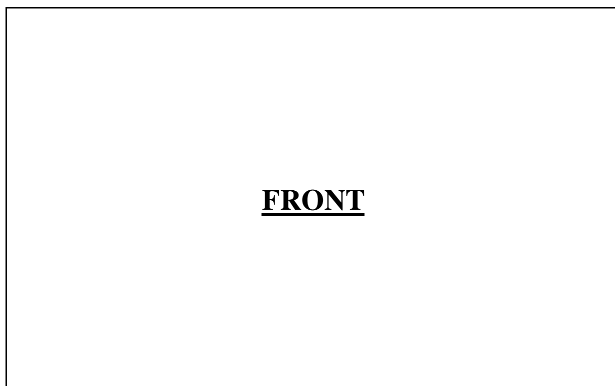
Copy of Insurance Card

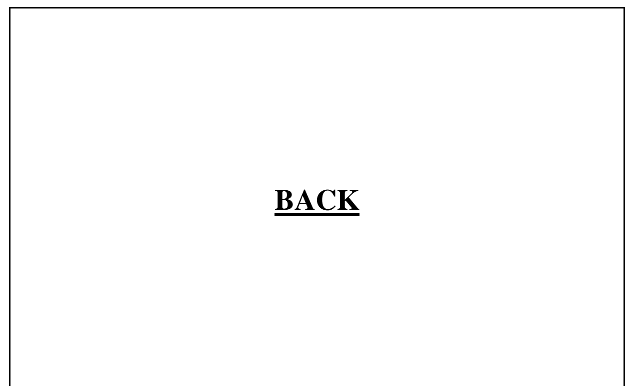




Copy of Identification

(i.e., Driver's License, Military ID, etc.)





*Copies do not have to be attached to this document.

U ATHLETIC TRAINING

Medical History

FAMILY HISTORY

	If Living: Age	Health	If Deceased: Age at death	Cause
Father				
Mother				
Brother/Sister				
2.				
3.				

Have you or any blood relative ever had any of the following:

Cancer Yes ___ No ___ If yes, who________________________
Tuberculosis Yes ___ No ___ If yes, who________________________
Diabetes Yes ___ No ___ If yes, who________________________
Heart Trouble Yes ___ No ___ If yes, who________________________
Sudden Death Yes ___ No ___ If yes, who________________________
High Blood Pressure Yes ___ No ___ If yes, who________________________
Stroke Yes ___ No ___ If yes, who________________________
Epilepsy Yes ___ No ___ If yes, who________________________
Mental Illness Yes ___ No ___ If yes, who________________________
Suicide Yes ___ No ___ If yes, who________________________

ALLERGIES

Are you allergic to:

Penicillin Yes ___ No ___
Sulfa Yes ___ No ___
Aspirin Yes ___ No ___
Mycins/other antibiotics Yes ___ No ___
Tetanus antitoxin/ serums Yes ___ No ___
Bee Stings Yes ___ No ___
Mold/Dust Yes ___ No ___
Pollen (Seasonal Allergies) Yes ___ No ___
Codeine Yes ___ No ___
Adhesive Tape Yes ___ No ___
Latex Yes ___ No ___
Cold treatments Yes ___ No ___
Any other drugs Yes ___ No ___ If so, please list____________________
Any Foods Yes ___ No ___ If so, please list____________________

MEDICATIONS

Are you currently taking any medication(s) on a regular basis? Yes ___ No ___
*If so, please list the *NAME* of each medication, and the *REASON* for taking it below:

Medication	Reason

U ATHLETIC TRAINING

Medical History

PERSONAL HISTORY

Have you ever had:

Measles/ German Measles	Yes ___ No ___
Infectious Mononucleosis	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___
Whooping Cough	Yes ___ No ___
Chicken Pox	Yes ___ No ___
Mumps	Yes ___ No ___
Cancer	Yes ___ No ___
Diabetes	Yes ___ No ___
Pneumonia	Yes ___ No ___
Asthma	Yes ___ No ___
Tuberculosis	Yes ___ No ___
Hepatitis	Yes ___ No ___
Frequent colds/ sore throat	Yes ___ No ___
Frequent/ Severe Headaches	Yes ___ No ___
Nervous Breakdown	Yes ___ No ___
Palpitations/ Irregular Heartbeat	Yes ___ No ___
Heart Murmur	Yes ___ No ___
Chest Pain	Yes ___ No ___
Heart Issues/ Heart Disease	Yes ___ No ___
Dizziness or Fainting	Yes ___ No ___
Shortness of Breath/ Wheezing	Yes ___ No ___
Problems with the nose/ Sinuses	Yes ___ No ___
High/ Low Blood Pressure	Yes ___ No ___
Polio/ Meningitis	Yes ___ No ___
Stomach Trouble/ Ulcers	Yes ___ No ___
Gallbladder Problems	Yes ___ No ___
Bladder/ Urinary Tract Problems	Yes ___ No ___
Frequent Diarrhea	Yes ___ No ___
Constipation	Yes ___ No ___
Colitis	Yes ___ No ___
Liver Problems	Yes ___ No ___
Kidney Problems	Yes ___ No ___
Rectal Bleeding/ Hemorrhoids	Yes ___ No ___
Enlarged Glands	Yes ___ No ___
Temporary/ Permanent Paralysis	Yes ___ No ___
Birth Defects	Yes ___ No ___
Gout	Yes ___ No ___
Anemia	Yes ___ No ___
Cramping Associated With Exercise	Yes ___ No ___
Arthritis/ Rheumatism	Yes ___ No ___
Night Sweats	Yes ___ No ___
Skin Problems	Yes ___ No ___
Frequent Skin infections	Yes ___ No ___
MRSA/ Staph Infection	Yes ___ No ___
Gonorrhea/ Syphilis/ Herpes	Yes ___ No ___
Depression/ Anxiety Issues	Yes ___ No ___
Eating Disorders	Yes ___ No ___

U athletic training

Medical History

MEDICAL HOSPITILIZATION

Have you ever been hospitalized for any injury or illness not related to surgery? Yes___ No___

If so, list reason and date(s): ____

SURGERIES

Have you had surgery of any type (i.e. Appendectomy, Tonsillectomy, Arthroscopy)?
Yes___ No___

If so, list surgery type(s) and date(s): ____

____

*Have you been advised to have any surgical operations, which have not been done?
Yes___ No___

SPECIAL TESTS

Have you ever had any diagnostic testing (x-ray, CT Scan, MRI, Ultrasound, Electrocardiogram) of:

	No	Yes	Right	Left	Date	Type of Test
Head/Face						
Neck						
Shoulder/Upper Arm						
Elbow/Forearm						
Chest/Abdomen						
Back/Spine						
Wrist/Hand/Fingers						
Hips/Pelvis						
Thigh						
Knee						
Lower Leg						
Ankle/Foot/Toes						

EYES

Have you ever been to an eye doctor? Yes___ No___
Date of last visit: ____/_____/_______
Name of eye doctor: ___________________________________
Do you wear glasses? Yes___ No___
Date prescribed? ____ /_____ /_______
Worn only for reading or driving? Yes___ No___
Worn all the time? Yes___ No___
Do you wear contact lenses? Yes___ No___
Date prescribed? ____ /_____ /_______
Soft lenses___ / Hard lenses___
Do you have a second pair available? Yes___ No___
Do you have any discomfort or difficulty with your eyes? Yes___ No___
When reading for a long time? Yes___ No___
In sunlight? Yes___ No___
At Night? Yes___ No___
Is your color vision normal? Yes___ No___
Have you ever had a serious eye injury? Yes___ No___
Do you believe your vision is normal? Yes___ No___

Medical History

EARS

Infections Yes___ No___
Loss of Hearing Yes___ No___
Surgery Yes___ No___
Ruptured Eardrum Yes___ No___

DENTAL

Date of last dental visit: ____/_____/________

Name of dentist: ____
Do you have any filled cavities? Yes___ No___
Do you have any capped teeth? Yes___ No___
Do you have any chipped teeth? Yes___ No___
Do you have any tooth pain? Yes___ No___
Have you ever had braces or a retainer? Yes___ No___
Have you had your wisdom teeth removed? Yes___ No___

PSYCHOLOGICAL

Have any immediate family members been treated for drug, alcohol, or emotional issues?
Yes___ No___
Have you ever been treated for any drug, alcohol, or emotional issues? Yes___ No___
Have you experienced frequent mood swings? Yes___ No___
Have you experienced periods of depression? Yes___ No___
Have you experienced increased nervousness? Yes___ No___
Have you ever missed any time from school or work for emotional reasons? Yes___ No___
What medication(s) have you taken for emotional problems?
____
Have you ever used any illegal substances (i.e. Cocaine, steroids)? Yes___ No___
Would you like to speak with someone about alcohol or substance abuse? Yes___ No___

CONCUSSION/ HEAD TRAUMA HISTORY

Have you ever hit your head or had a blow to the head? Yes___ No___
Have you ever sustained a concussion and experienced any of the follow symptoms- dizziness, headaches, visual problems, balance problems, memory problems? Yes___ No___
*If so, when (dates)____
Have you ever experienced a loss of consciousness or blacked out while playing sports?
Yes___ No___
*If so, when (dates)____
Have you ever experienced a loss of consciousness or blacked out while not playing sports?
Yes___ No___
*If so, when (dates)____

SICKLE CELL QUESTIONS

Have you ever been told you have Sickle Cell Trait? Yes___ No___
Have you ever been tested for Sickle Cell Trait? Yes___ No___
Have you had a discussion with a physician about Sickle Cell Trait? Yes___ No___

U ATHLETIC TRAINING

Medical History

ADHD QUESTIONS

Have you been diagnosed with ADHD? Yes___ No___
*If so, when_______________________________________
Are you taking ADHD medications? Yes___ No___
*If so, what medication____________________________
Name of prescribing physician____

*****THE NCAA REQUIRES PROOF OF TESTING BY A MEDICAL PROFESSIONAL LICENSED TO DIAGNOSE AND TREAT ADHD. IF YOU ARE TAKING ADHD MEDICATION YOU WILL NEED TO PROVIDE MEDICAL RECORDS FROM YOUR PRESCRIBING PHYSICIAN PROVING DIAGNOSIS OF ADHD, AS WELL AS A RATIONALE FOR MEDICATION. TESTING MUST BE COMPREHENSIVE.***

EPILEPSY/ SEIZURE QUESTIONS

Have you ever had a seizure or been diagnosed with Epilepsy? Yes___ No___

WOMEN'S HEALTH HISTORY

Is your menstrual cycle regular? Yes___ No___
Age of onset ____/_____/_______
Date of last period ____/_____/_______
Date of last gynecological exam ____/_____/_______
Have you ever had an abnormal pap smear? Yes___ No___
Is heavy bleeding an issue? Yes___ No___
Do you experience bleeding between periods? Yes___ No___
Do you experience unusual discharge? Yes___ No___
Is severe cramping an issue? Yes___ No___
Have you ever been pregnant? Yes___ No___
Are you currently on birth control medication? Yes___ No___
Do you have breast lumps or tenderness? Yes___ No___
Do you experience frequent urinary tract infections? Yes___ No___
Have you ever had a blood clot in your veins? Yes___ No___
Have you ever been treated for one of the following:
Anemia Yes___ No___
Eating Disorders Yes___ No___
Osteoporosis/ Stress fractures Yes___ No___

ALL STUDENT-ATHLETES MUST SIGN BELOW

I do hereby state that, to the best of my knowledge and belief, the medical history that I have provided is correct and accurate. I fully understand that any attempts to mislead the medical staff about my medical history may result in revocation of my privilege to be a student-athlete at the University of Miami.

____ ____________________
Student-Athlete's signature Date

____ ____________________
Parent's signature (if student-athlete is under 18 years old) Date

U ATHLETIC TRAINING

Orthopedic History

Have you ever had any of the following:

Neck	No	Yes	Right	Left	Date
Pinched nerves					
Burners/ Stingers					
Fractures					
Strains					
Sprains					
Pains					
Surgery					
Hand/Wrist/Fingers	**No**	**Yes**	**Right**	**Left**	**Date**
Dislocations					
Tendon injuries					
Fractures					
Sprains					
Pain					
Surgery					
Spine/Back	**No**	**Yes**	**Right**	**Left**	**Date**
Ruptured disc					
Muscle spasm					
Strain					
Stiffness					
Pain w/ lifting					
Numbness in legs					
Surgery					
Pelvis/ Hips	**No**	**Yes**	**Right**	**Left**	**Date**
Groin Strains					
Hip Flexor Strains					
Hip pointers					
Fractures					
Pain					
Surgery					

Orthopedic History

Have you ever had any of the following:

Shoulder/Clavicle	No	Yes	Right	Left	Date
Separations					
Sprains					
Strains					
Dislocations					
Fractures					
Slipping in joint					
Pain with throwing					
Surgery					
Arm	**No**	**Yes**	**Right**	**Left**	**Date**
Calcium deposits					
Burners/Stingers					
Fractures					
Pain					
Surgery					
Elbow	**No**	**Yes**	**Right**	**Left**	**Date**
Dislocations					
Sprains					
Tennis elbow					
Fractures					
Pain					
Surgery					
Thigh	**No**	**Yes**	**Right**	**Left**	**Date**
Quad strain					
Hamstring strain					
Fractures					
Torn muscles					
Pain					
Calcium deposits					

U ATHLETIC TRAINING

Orthopedic History

Have you ever had any of the following:

Lower Leg	No	Yes	Right	Left	Date
Shin splints					
Achilles pain					
Torn Achilles					
Fracture					
Calf pain					
Surgery					
Knee	**No**	**Yes**	**Right**	**Left**	**Date**
Torn cartilage					
Knee cap pain					
Fractures					
Ligament injury					
Swelling					
Locking					
Giving way					
Dislocations					
Wear braces					
Casted					
Arthroscopy					
Surgery					
Feet/Toes	**No**	**Yes**	**Right**	**Left**	**Date**
Dislocation					
Turf toe					
Fractures					
Sprains					
Wear orthotics					
Pain					
Surgery					

UATHLETIC TRAINING

Orthopedic History

Have you ever had any of the following:

Ankle	No	Yes	Right	Left	Date
Dislocations					
Casted					
Fractures					
Sprains					
Pain					
Wear Braces					
Surgery					

Please use this space provided below to explain in detail the questions you have answered with a ***Yes*** response.

I do hereby state that, to the best of my knowledge and belief, the orthopedic history that I have provided is correct and accurate. I fully understand that any attempts to mislead the medical staff about my medical history may result in revocation of my privilege to be a student-athlete at the University of Miami.

____ __________________

Student-athlete's signature Date

____ __________________

Parent/Guardian signature (if student-athlete is under 18 years old) Date

U ATHLETIC TRAINING

Securing Medical Assistance & Payment of Expenses for Covered Injuries/Illness

All student-athletes must complete the following forms before they can be eligible for medical clearance

1. All students attending the University of Miami must have completed the Insurance Verification forms online with the University. All students must have appropriate insurance coverage as defined by the University of Miami. Domestic students enrolled in six or more credit hours per semester (or considered full time, including graduate students enrolled in a 700/800 level class) are required to obtain adequate health insurance (see exceptions). The annual premium for the health insurance plan offered through the Student Health Service is added to each student's fees. Domestic students with adequate alternative coverage need to complete a waiver to request cancellation of the insurance fee via CaneLink. Insurance cancellation requests must be renewed each academic year via CaneLink.

2. All student-athletes must have a MEDICAL INSURANCE INFORMATION AUTHORIZATION FORM (pages 3-4) on file with the Department of Athletic Training prior to any participation. Please provide documentation (i.e., signed claim forms, copy of insurance card, and copy of prescription card).

3. The student-athlete reports all injuries and illnesses to the Athletic Trainer. If the injuries or illnesses are athletically-related in accordance with the NCAA Medical Expenses Guidelines, the following statements apply.

4. The Athletic Trainer refers the student-athlete to a UM Team Physician or UM appointed specialist. If the student-athlete chooses to have a second opinion, this will be covered only with prior approval by the Athletic Training Staff. If the student-athlete chooses to have further care given by the second opinion physician outside the UM appointed physician, all medical expenses incurred including deductible(s) and co-insurance payments will be the responsibility of the student-athlete and parent(s)/guardian.

5. The student-athlete must take a referral form from the Department of Athletic Training to all appointments with a UM Team Physician, UM appointed specialist, and UM Student Health Center. If a referral form is NOT taken, the student-athlete and parent(s)/guardian are responsible for the bill(s) incurred.

6. In the case where the student-athlete is covered under a group insurance policy or an individual policy, all bills for medical care received shall be forwarded to the Department of Athletic Training for filing with the parent(s)/guardian insurance company.

7. Parent(s)/guardian that may have money sent to them by their insurance companies for payment of medical services must endorse the check(s) and forward the check(s) to the University of Miami Department of Athletic Training. These checks are not to be cashed and kept by the parent(s)/guardian for personal use. Further, if the parent(s)/guardian falsify the insurance authorization form, insurance fraud charges would also be in order.

8. If the student-athlete is covered by a HMO, the Department of Athletic Training will contact the HMO by phone to receive instructions as to what coverage is afforded if care if provided other than by the HMO physician.

Securing Medical Assistance & Payment of Expenses for Covered Injuries/Illness

9. Surgical expenses to a student-athlete who is injured during the academic year while participating in voluntary campus physical activities such as weightlifting and playing an intramural sport(s) that will prepare the student-athlete for competition (to be determined by the athletic training staff) will be filed using the same procedures as an in-season sports injury.

10. Dental teeth cleaning, provisional filling of teeth or other dental work not directly related to an injury that occurred during practice or competition is not covered under the NCAA Guidelines.

11. Glasses, contact lenses, or protective eye wear (i.e., goggles) for student-athletes who require visual correction in order to participate in practice or games may be provided. However, this cannot be provided for classroom use only per NCAA Guidelines.

12. Medical or hospital expenses incurred as the result of an injury that occurred while outside the supervision of the coaching staff will NOT be covered expenses. Medical expenses as a result of appendicitis are not athletic-related: therefore, these expenses will NOT be covered under NCAA Guidelines.

I HAVE READ THE PROCEDURES FOR SECURING MEDICAL ASSISTANCE AND PAYMENT OF EXPENSES FOR COVERED INJURIES AND ILLNESSES. I FULLY UNDERSTAND THE STATEMENTS CONTAINED THEREIN.

______________________________________ ____________
Signature of Student-Athlete Date

____
Print Name of Student-Athlete

______________________________________ ____________
Signature of Parent/Guardian Date

____
Print Name of Parent/Guardian

Guidelines for Student Health Center Payment for Services

Many services including most routine visits are provided at no charge to eligible students. Other services including specialty clinic visits, x-ray, non-routine lab charges and immunizations will be submitted for payment from your insurance provider. Payment from your insurance company may be subject to deductibles, co-payment, co-insurance and may be processed by your health plan as “out-of-network” leading to a lower level of coverage. For any athletically-related injuries or illnesses, any amount not covered by your insurance plan will be billed to the Department of Athletics.

I understand and acknowledge by signing this document that I give the University of Miami- Student Health Service permission to file a claim to my health insurance carrier for the purpose of payment for services received. I further understand that the Student Health Service may not be a contracted provider with my individual health insurance plan and that there may be services not covered by my insurance plan and that charges for these services will be billed to the Department of Athletics.

____ ___________________________

Student-Athlete’s Signature Date

Emergency Medical Treatment Authorization

I, the undersigned parent or legal guardian of _________________________, do hereby authorize the Athletic Training Staff and/or coaching staff of the University of Miami Department of Athletics to secure any and all emergency medical treatment for my student athlete in the event that I cannot be contacted.

I, ________________________, do hereby authorize the Athletic Training Staff and/or coaching staff of the University of Miami Department of Athletics to secure any and all emergency medical treatment for myself in the event that I am incapacitated.

I further authorize any hospital or dispensary, and attending physician, and/or medical personnel to render any and all emergency medical care which may be deemed necessary.

It is understood that in any event, an attempt will be made to contact the parent or guardian before treatment is initiated.

Verification

I have read the above and foregoing Emergency Medical Treatment Authorization and understand the statements therein, that I authorize the University of Miami staff to secure any and all emergency medical treatment and that I authorize any hospital and/or attending medical personnel to render emergency medical treatment for my son/daughter or for myself.

____ ____________________

Parent/Legal Guardian or Student-Athlete Signature Date

Emergency Contact: ______________________________ Relationship: _____________________

Home Phone: __________________ Work: __________________ Cell: ______________________

Someone else who may be contacted if the above cannot be reached:

Name: ____________________________________ Phone: _________________________

Student-Athlete Injury/Illness Release

I, the undersigned, do hereby authorize the head coach, Team Physician(s) and/or Athletic Trainer(s) to release verbally and/or in writing, all information for purposes pertaining to injuries/illnesses that affect my sports participation to sports information and/or the media,

____ ____________________

Signature of Student-Athlete Date

____

Witness

Release of Information Authorization

I, ____________________________________, give my consent for the Team Physician, Athletic Trainer, or other medical personnel of the University of Miami, to release such information regarding my medical history, record of injury or surgery, record of serious illness, and rehabilitation results as may be requested by the scout or representative of any professional or amateur athletic organization seeking such information.

This information is normally confidential and except as provided in the release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by me in writing.

____ ____________________

Signature of Student-Athlete Date

Waiver of Liability and Hold Harmless Agreement

In consideration for being allowed to participate in the following sport, ____________________ , I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE the University of Miami, the Board of Trustees, or any officers, servants, agents, or employees (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, as a result of the risks and dangers associated with this activity, my negligence, intentional act or omission or that of a third party.

To the best of my knowledge, I am physically fit and medically able to participate as anticipated. I am fully aware of risks and hazards connected with this activity, and I hereby elect to VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING PARALYSIS OR DEATH, NOT OTHERWISE COVERED BY INSURANCE (WHETHER PAID FOR ME OR BY THE UNIVERSITY OF MIAMI FOR MY BENEFIT) that may be sustained by me, or any loss or damage to property owned by me, as a result of being engaged in such sport.

It is my expressed intent that this Release and Hold Harmless Agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the bylaws of the State of Florida.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability and Hold Harmless Agreement, understand it, and sign if voluntarily as my own free act and deed; no oral representations, statements, or inducement, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent or, if under 18, that my parent or guardian shall also sign; and I execute this release for full, adequate and complete consideration, fully intending to be bound by same.

________________________________	________________________________
Signature of Student-Athlete	Parent/Guardian Signature (if under 18)
________________________________	________________________________
Date	Date

Player Agency to Athletic Trainer

I authorize my Athletic Trainer to act as my agent to procure, store and administer if necessary, any medications which are prescribed for me by a Team Physician.

________________________________ ____________________

Signature of Student-Athlete Date

Prescribed Treatments and Rehabilitation Programs Adherence

I understand that it is my responsibility to attend all treatment and rehabilitation appointments prescribed by the Athletic Training Staff, Physical Therapy Staff, and Team Physicians when deemed necessary for recovery from injury or illness. It is also my responsibility to inform the Athletic Training Staff when it may be necessary to miss or reschedule an appointment due to a valid and reasonable situation (ie. family death, car accident) occurring which cannot be avoided.

________________________________ ____________________

Signature of Student-Athlete Date

Exit Physical/Interview Requirement

I understand that I must complete an exit physical/interview with my Athletic Trainer once my participation in intercollegiate athletics as a student-athlete has ceased. Failure to complete the exit physical/interview with my Athletic Trainer within a 4-week period shall constitute a waiver of my ability to receive any medical treatment from the University and shall release the University from any further financial responsibility or obligation to me for medical treatment.

________________________________ ____________________

Signature of Student-Athlete Date

Completion Date:

Attachment 46
Authorization for 3rd Party Disclosures

UNIVERSITY OF MIAMI
MILLER SCHOOL of MEDICINE

I authorize the use or disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use or disclose the information **(e.g., UHealth medical records, physician):**
Uhealth medical records, physcians, medical personnel

2. Person(s) or class of persons authorized to receive the information **(e.g., name & relationship: family, attorney, employer, etc.):**
Any member of UM athletics department or any other individual relevent to my participation as a SA

If you would like your records to be sent to a third party, please provide an address or fax where you would like us to send the information. Please attach additional pages if more than one third party.

Name: ______________________ Address: ______________________

City: ______________________ State: ______________ Zip: __________

Phone: ______________________ Fax: ______________________

3. Description of information that may be used or disclosed **(e.g., all information related to a specific type of treatment):**
All information related to my participation as a student-athlete

The following must be separately initialed by you if applicable to your authorization:

____ HIV/AIDS STATUS – HIV related information, which includes any information indicating that I have had an HIV-related test, or HIV infection, HIV-related illness or AIDS, or any information which would indicate that I have been potentially exposed to HIV.

____ Sexually transmitted diseases

____ Sexual assault information

X Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment). *Mental health records may include substance abuse information.*

X Substance abuse (drug and alcohol) treatment records. *Substance abuse information may be part of mental health records.*

4. The information will be used or disclosed for the following purposes **(Note: if a patient initiates the request, the statement "at the request of the patient" is sufficient):**
The information will be used for my participation as a student-athlete.

5. *[If applicable]* The disclosure of my information for marketing purposes is expected to result in a direct or indirect financial benefit to [none] *[insert the name of the disclosing covered entity].*

6. This authorization expires when I am no longer a student-athlete at the University of Miami *[insert a date or describe an event or activity related to the patient or purpose of the authorization].* If not completed, this authorization will expire one year from date signed.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment, or my eligibility for benefits. I understand that I may revoke this authorization at any time by sending a written request to the University of Miami Office of HIPAA Privacy and Security, PO Box 019132 (M-879) Miami, FL. 33101, except to the extent that action has been taken in reliance on this authorization.

Signature of Patient or Representative ______________________ Date ______________________

Patient Name ______________________ Patient Address ______________________

Patient Contact Phone Number ______________________ Last 4 Digits of SSN __________ Date of Birth __________

Name of Personal Representative (if applicable) ______________________ Relationship to Patient ______________________

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

AUTHORIZATION FOR 3RD PARTY DISCLOSURES

Form D3900052E

Revised 6/03/14

NAME:
MRN:
LAST 4 DIGITS OF SSN:
DOB: / /
DATE: TIME:

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Request for Release of Medical Information

I, ______________________________, hereby give my consent to the University of Miami Athletic Training Facility to obtain a copy of my medical record(s) from your Hospital, Office, or Institution to include:

Surgical Reports/Records
Physician, Emergency Room, Dental, or Vision Reports
Copy of Reports on MRI, X-Ray, CT Scans, or other Special Tests
Rehabilitation Notes, Illness Reports/Records

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Please send/fax this requested information to the following:
University of Miami
C/O Athletic Trainer
Hecht Athletic Center
5821 San Amaro Drive
Coral Gables, FL 33146-0820

Phone (305) 284-4131
Fax (305) 284-3008

Thank you in advance for your attention regarding this matter. This information will be kept confidential and will not be released without authorization from above mentioned individual. If you have any questions, please call the phone number listed above.

______________________________ ______________________________
Student-Athlete's Name (Print) Social Security Number

______________________________ ______________________________
Signature of Student-Athlete Date

Medical Treatment Authorization for Minors

I, the undersigned parent or legal guardian of _________________________________, do hereby authorize the Athletic Training Staff and/or coaching staff of the University of Miami Department of Athletics to secure any and all medical treatment for my student-athlete in the event that I am not present. This includes diagnostic testing, physical exams, and hospital procedures. I further authorize any hospital or dispensary, and attending physician, and/or medical personnel to render any and all medical care.

I have read the above and foregoing Medical Treatment Authorization and understand the statements therein, that I authorize the University of Miami staff to secure any and all medical treatment and that I authorize any hospital and/or attending medical personnel to render medical treatment for my son/daughter.

__________________________________ Signature of Parent/Legal Guardian

_________________________ Date

__________________________________ Name of Parent/Legal Guardian (Print)

__________________________ Home Phone

_________________________ Work Phone

__________________________ Cell Phone

Someone else who may be contacted if the above cannot be reached:

__________________________________ Emergency Contact Name

__________________________ Phone

CONCUSSION

A fAct sheet for student-Athletes

What is a concussion?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

hoW can i prevent a concussion?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

Don't hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

it's better to miss one game than the Whole season. When in doubt, get checked out.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.

Concussion and Injury Reporting Acknowledgement

_____ I understand that it is my Responsibility to report all injuries and illnesses to my athletic trainer and
Initial or team physician.

_____ I have read and understand the NCAA Concussion Fact Sheet.
Initial

After reading the NCAA Concussion Fact Sheet, I am aware of the following information:

_____ A concussion is a brain injury, which I am responsible for reporting to my team physician or
Initial athletic trainer.

_____ A concussion can affect my ability to perform everyday activities, and affect reaction time,
Initial balance, sleep, and classroom performance.

_____ You cannot see a concussion, but you might notice some of the symptoms right away. Other
Initial symptoms can show up hours or days after the injury.

_____ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team
Initial physician or athletic trainer.

_____ I will not return to play in a game or practice if I have received a blow to the head or body that
Initial results in concussion-related symptoms.

_____ Following concussion the brain needs time to heal. You are much more likely to have a repeat
Initial concussion if you return to play before your symptoms resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, and even death.
Initial

I, the undersigned student-athlete at the University of Miami, acknowledge the NCAA requirement that Student-athletes at the University of Miami accept the responsibility for reporting their personal injuries and illness to the University of Miami Athletic Training Staff, which may include, but is not limited to, signs and symptoms of concussions. Furthermore, I acknowledge that I have received the NCAA concussion education materials.

_________________________________ _______________________
Signature of Student-Athlete Date

____
Witness

NCAA®

CELL TRAIT

What is sickle cell trait?

sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

- During intense exercise, red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or "sickle."
- Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles.
- During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.
- Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

Do you know if you have sickle cell trait?

People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

- Sickle cell trait occurs in about 8 percent of the U.S. African-American population, and between one in 2,000 to one in 10,000 in the Caucasian population.
- Most U.S. states test at birth, but most athletes with sickle cell trait don't know they have it.
- The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.
- Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, allowing you to thrive in your sport.

How can I prevent a collapse?

- Know your sickle cell trait status.
- Engage in a slow and gradual preseason conditioning regimen.
- Build up your intensity slowly while training.
- Set your own pace. Use adequate rest and recovery between repetitions, especially during "gassers" and intense station or "mat" drills.
- Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.
- If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.
- Maintain proper asthma management.
- Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.
- Beware when adjusting to a change in altitude, e.g., a rise in altitude of as little as 2,000 feet. Modify your training and request that supplemental oxygen be available to you.
- Seek prompt medical care when experiencing unusual physical distress.

For more information and resources, visit www.NCAA.org/health-safety

U ATHLETIC TRAINING

Sickle Cell Trait Education Acknowledgement

_____ Initial — I have read and understand the NCAA Sickle Cell Trait Fact Sheet.

After reading the NCAA Sickle Cell Fact Sheet, I am aware of the following information:

_____ Initial — I understand that I may ask any member of the University of Miami Department of Sports Medicine if I have any questions or would like further information.

_____ Initial — I understand that the Sickle Cell Trait testing is a part of the University of Miami pre-participation examination.

_____ Initial — I understand that I have the option to waive the testing and may ask to do so. I understand that if I choosing to waive the testing, it will not affect my eligibility but I may be require undergo further education.

I, the undersigned student-athlete at the University of Miami, acknowledge the NCAA requirement that student-athletes receive mandatory education about sickle cell trait and that, unless I request otherwise, I will be tested for the sickle cell trait as a part of the University of Miami pre-participation examination. Furthermore, I acknowledge that I have received the NCAA Sickle Cell Fact Sheet.

______________________________ ______________________

Signature of Student-Athlete Date

____

Witness

Football Helmet Warning

I understand that football is a contact/collision sport and I am aware there is a risk of injury. A NOCSAE (National Operating Committee for Standards of Athletic Equipment) helmet warning label is on the back of each helmet, to remind football players of the potential danger involved with using a football helmet, especially with poor technique.

WARNING

Keep your head up. Do not butt, ram, spear, or strike an opponent with any part of this helmet or faceguard. This is a violation of football rules and may cause you to suffer severe brain or neck injury, including paralysis or death and possible injury to your opponent. Contact in football may result in concussion/brain injury which no helmet can prevent. Symptoms include: loss of consciousness or memory, dizziness, headache, nausea or confusion. If you have symptoms, immediately stop and report them to your coach, athletic trainer, and parents. Do not return to a game or contact until all symptoms are gone and you receive medical clearance. Ignoring this warning may lead to another and more serious or fatal brain injury. NO HELMET SYSTEM CAN PROTECT YOU FROM SERIOUS BRAIN AND/OR NECK INJURIES INCLUDING PARALYSIS OR DEATH. TO AVOID THESE RISKS, DO NOT ENGAGE IN THE SPORT OF FOOTBALL.

I understand that a football helmet cannot prevent all head, neck, and brain injuries. Ignoring this warning may lead to a serious or fatal brain and/or neck injury.

I agree to use only proper and safe blocking and tackling techniques.

I understand the consequences of using a helmet in an improper manner such as butting, ramming, or spearing.

The helmet issued and fit to me is intended for my use only, and not to be used by any other individual. In addition, another teammate's helmet is not safe for my use. The Equipment Manager and/or Certified Athletic Trainer may approve another helmet for use if necessary.

I also understand that a change in hairstyle, use of hair products, and/or additional headwear can have an effect on the fit of the football helmet.

It is my responsibility to inspect my helmet daily, and report any damage to any parts of the helmet including screws, brackets, chinstraps, facemasks, bladder(s) or other structural problems to the Equipment Manager and/or Certified Athletic Trainer.

It is also my responsibility to ensure that the helmet fits securely, and will report otherwise to the Equipment Manager and/or Certified Athletic Trainer.

I have read and fully understand the helmet-warning label placed on the helmet and the above information.

______________________________ ____________________

Signature of Student-Athlete Date

____

Witness