Office of Sports Medicine

Dear ***NEW Minor Student-Athlete/Parent/Guardian,***

PRINT Forms!

Please review all the forms in this packet. Each of the forms contain information important to the student-athlete. Please PRINT, complete, sign and date each form. **Please return forms to Kutztown University Sports Medicine Office only!**

Please read all of the information and instructions prior to completing the forms. Please review all of the forms for completeness. Incomplete forms or information found to be incomplete are unacceptable. Student-Athletes will not be allowed to practice or compete until all requested information is provided.

PLEASE HAVE THE FOLLOWING FORMS COMPLETED AND RETURNED BY

JULY 15th, 2020

Please PRINT the forms on the following pages, read thoroughly, complete and return all making sure to follow the instructions:

___Athletic Medical History *(5 pages)* MUST be completed by your family physician (MD, DO) or a Nurse Practicioner (CRNP), whomever performs your Athletic Physical. See below.
___Mental Health *(1 page)* MUST be completed by your family physician (MD, DO) or other appropriate health care profession trained to recognioze mental health issues.
___Athletic Physical *(1 page)* MUST be completed by your family physician (MD, DO) or a Nurse Practicioner (CRNP) **ONLY**. **NO** Physician's Assistant or Chiropractors.
___NCAA ADHD/ADD form (**ONLY** if diagnosed with ADD/ADHD) *(1 page)*
___Athletic Insurance Information Form ***(Type info in document BEFORE Printing)****(1-2 pages)*
_____*Attach a copy of the Front & Back of Insurance card after printing as directed*
___Medical Bills Letter of Responsibility form *(1 page)*
_____Secondary Insurance Exemption /Waiver Form *(for Tricare & Medicaid)* where applicable.
___Medical Disclosure Form *(1 page)*
___Medical Consent/Release Form *(1 page)*
___FERPA Acknowledgement Form *(1 page)*
___Student-Athlete Injury & Illness Acknowledgement Form *(1 page)*
___Sickle Cell Trait Reporting Form **(NCAA Policy)** (see instructions for submitting)

Reminder: New Student's (who are Minors) **Must** also complete 'Required Medical Forms' for the Health & Wellness Services

(Do NOT FAX) Mail Completed Forms to:
Kutztown University of PA
Attn: Athletic Physical Info-New-Minor
Kutztown Unniversity of PA
Sports Medicine Office
Keystone Hall Rm 124
Kutztown, PA 19530

Please address any of your questions to: Faculty Athletic Trainer, Jack Entriken, via email at entriken@kutztown.edu.

Thanks for your cooperation!

KUTZTOWN UNIVERSITY OF PA
Athletic Medical History

DIRECTIONS FOR COMPLETION:

Please complete this form in **Black Ball Point Pen**; mark the **month & year** of all items.

Mark the appropriate column representing the year of participation in KU Athletics.
(Freshmen, transfers & 1st Time Student-athletes use the 1st column)

Note on Faxes: This form **will not** be accepted as complete if faxed.
This form is part of your **permanent record** for participation in KU Athletics at Kutztown University. The **original copy** of all materials faxed is **required** for FULL clearance.

For Office Use Only

_____

_____

_____

_____

_____

(PRINT)
Name _____ Sport(s) _____
last first mi.

Social Security # _____ Date of Birth _____

(Circle)

Student-Athlete's Status:	Freshman/Transfer / 1st Yr Student-athlete	2nd	3rd	4th	5th Yr
Student-Athlete's Initial:	_____	_____	_____	_____	_____
Date Completed:	_____	_____	_____	_____	_____

****

TO BE SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER, ONLY,
AFTER REVIEWING WITH STUDENT-ATHLETE:

I have reviewed this **Athletic Medical History** form and accompanying documentation.

_____ _____
Physician's Name (Print) Date

_____ **MD, DO or CRNP (ONLY!)**
Physician's Signature (please circle)

last revised 11/17

IMPORTANT: Please **circle** your response in the appropriate column.

	1ST		2ND		3RD		4TH		5TH	

FAMILY HISTORY:

1 Has any relative died suddenly before 50 years old? | Y | N | Y | N | Y | N | Y | N | Y | N |

If YES, explain: _____

2 Is there a history of heart disease in any relative(s) less than 50 years old | Y | N | Y | N | Y | N | Y | N | Y | N |

If YES, explain: _____

PERSONAL HISTORY:

*** If **YES** to any section marked by an **asterisk(*)** , copies of all medical reports **MUST** be submitted along with this form. If you have previously submitted reports for these conditions, print **KU** next to the item.*

Have you ever had or do you have now:

1 **Heart Trouble(*)** Chest Pain/Palpitations | Y | N | Y | N | Y | N | Y | N | Y | N |

Murmur | Y | N | Y | N | Y | N | Y | N | Y | N |

High Blood Pressure | Y | N | Y | N | Y | N | Y | N | Y | N |

A. Have you ever had any tests to evaluate your heart?

If YES please list: Mo/Year Reason

Stress Test _____ _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

EKG _____ _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Echocardiagram _____ _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Other _____ _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

please list: _____

2 Stomach Trouble | Y | N | Y | N | Y | N | Y | N | Y | N |

If YES, please explain: _____

_____

3 **Nervous System Problems (*)** Mo/Year

Fainting Problems _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Seizure(s) _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Head Injury(ie. Concussion) _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Head Injury w/ Unconsciousness _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

Migraines _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

4 Respiratory Problems

Asthma List medication(s): _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

****Please include physician note on limitations, if any.**

Allergies General: _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

To Medicine: _____ | Y | N | Y | N | Y | N | Y | N | Y | N |

5 **Bleeding Problems(*)** | Y | N | Y | N | Y | N | Y | N | Y | N |

Please specify: _____

Mo/Yr

6 **Diabetes(*)** | Y | N | Y | N | Y | N | Y | N | Y | N |

Date of Diagnosis: _____

7 Sensory Deficit

Hearing | Y | N | Y | N | Y | N | Y | N | Y | N |

please explain: _____

Sight Contact(s): YES_____ NO_____ | Y | N | Y | N | Y | N | Y | N | Y | N |

8 **Heat Illness Disorders(*)** Mo/Year

	1ST	2ND	3RD	4TH	5TH
Heat Exhaustion _____	Y N	Y N	Y N	Y N	Y N
Heat Stroke _____	Y N	Y N	Y N	Y N	Y N
Other Environmental Problems _____	Y N	Y N	Y N	Y N	Y N

9 Dental History

Have you had or do you have now:

Caps: _____	Y N	Y N	Y N	Y N	Y N
Crowns: _____	Y N	Y N	Y N	Y N	Y N
Plates: _____	Y N	Y N	Y N	Y N	Y N
Fractures, please explain: _____	Y N	Y N	Y N	Y N	Y N

10 Medication History

Are you taking **ANY** medications now and/or on a regular basis? Y N

If YES, please give Name, Dose, Frequency, Reason: _____

11 Have you ever had **ANY** surgery, including the removal of a major organ? Y N

If YES, give brief explanation and include month & year. (**Submit surgical and rehab notes)**

12 Have you been seen by a physician for any illness (physical and/or mental) lasting more than a week in the last year and/or have you ever tested positive for **ANY** medical condition(s) during your life? If YES, give brief explanation. Y N

(Submit ALL related medical notes. Examples: HIV, Sickle Cell, Ringworm, Herpes, etc.)

13 Have you ever been diagnosed with having **ADHD/ADD?** Y N

(Attention Deficit Hyperactivity Disorder)

Date of Diagnosis: _____

Current Medications: _____

14 **Covid-19 questions:**

Have you ever been diagnosed with having **Covid-19 virus?** Y N

If YES please give Date of Diagnosis: _____

If YES, were you hospitalized? Y N

If YES, were you treated with Oxygen and/or a Ventilator? Y N

Have you had any of the following undiagnosed symptoms?

Fever greater than 100.2?	Y N	Y N	Y N	Y N	Y N
Difficulty breathing?	Y N	Y N	Y N	Y N	Y N
Consistent Cough?	Y N	Y N	Y N	Y N	Y N
Loss of taste or smell?	Y N	Y N	Y N	Y N	Y N

14 **Covid-19 questions continued:**

Have you had direct contact with anyone diagnosed with Covid-19 virus?	Y	N	Y	N	Y	N	Y	N	Y	N
Have you or anyone in your household been told to self-isolate due to suspected Covid-19 virus?	Y	N	Y	N	Y	N	Y	N	Y	N
Since March 7, 2020, have you traveled internationally or to an area considered a Covid-19 'Hotspot'?	Y	N	Y	N	Y	N	Y	N	Y	N

If YES, please give the date of travel and location.

Date of Travel: _____

Location: _____

ORTHOPEDIC HISTORY:

If **YES to any questions below, copies of **ALL** medical reports for surgeries and any other condition which happened within the previous **four(4) years MUST** be submitted along with this form. If you have previously submitted medical reports on these conditions, print **KU** next the to the date.

1 Have you ever had a broken bone(s)?	Y	N	Y	N	Y	N	Y	N	Y	N

If YES, please explain, give date of injury. **(Submit ALL medical notes)**

_____

_____

_____

	1ST		2ND		3RD		4TH		5TH	
2 Have you been seen by a ***physician/athletic trainer/*** **other medical professional** for a **non-fracture injury**,which lasted more than a week, in the **12 MONTHS!** (ie. shin splints, back problems, joint sprain, orthopedic injuries)?	Y	N	Y	N	Y	N	Y	N	Y	N

If YES, please explain, give date of injury. **(Submit ALL medical notes)**

_____

_____

_____

_____

_____

_____

_____

_____

3 Are you now suffering from any injury (old or new).	Y	N	Y	N	Y	N	Y	N	Y	N

If YES, please explain, give date of injury. **(Submit ALL medical notes)**

_____

_____

_____

_____

_____

_____

4 **NEW/TRANSFER Students ONLY**

Have you been seen by a ***physician/athletic trainer/*** **other medical professional** Y | N

for a **non-fracture orthopedic injury**, more than 12 MONTHS AGO, which lasted more than a week?

(ie. shin splints, back problems, joint sprain, etc.)If YES, please explain, give date of injury. (Submit ALL medical notes)

_____

_____

_____

_____

_____

I CERTIFY THAT THE ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO DISCLOSE ACCURATE INFORMATION CAN/WILL RESULT IN MY MEDICAL INELIGIBILITY. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY INJURIES OR ILLNESSES SUSTAINED AS RESULT OF INACCURATE INFORMATION I MAY HAVE GIVEN.

Student Signature: If the student is a minor(under 18 yrs old) at the time this folder is completed, a parent or guardian MUST sign & date this folder.

1st: _____ Date: _____

Parent/Guardian: _____ Date: _____

2nd: _____ Date: _____

3rd: _____ Date: _____

4th: _____ Date: _____

5th: _____ Date: _____

I/WE UNDERSTAND THAT KUTZTOWN UNIVERSITY WILL NOT BE HELD FINANCIALLY RESPONSIBLE FOR ANY INJURIES/ILLNESS OCCURING OUTSIDE OF INTERCOLLEGIATE ATHLETIC PARTICIPATION OR AS A RESULT OF MY/OUR FAILURE TO FOLLOW THE POLICIES & PROCEDURES REGARDING ATHLETIC PARTICIPATION, INJURIES, ILLNESS AND MEDICAL CARE.
A COPY OF THIS DOCUMENT IS AVAILABLE ONLINE AND IN THE OFFICES OF ATHLETICS AND SPORTS MEDICINE.

KUTZTOWN UNIVERSITY
Office of Sports Medicine

124 Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085
Fax: (610) 683-4664

Dear Health Care Provider:

Your patient, a student-athlete at Kutztown University of Pennsylvania, will be participating on one or more intercollegiate athletic teams. The National Collegiate Athletic Association (NCAA) requires all student-athletes undergo a pre-participation Mental Health Screening by a medical provider who has the professional training to perform such an exam. **This is critical for their participation in NCAA Sports.**

THIS IS AN ANNUAL REQUIREMENT FOR ALL STUDENT-ATHLETES.

Please administer, at minimum, the attached Personal Health Questionnaire-9 (PHQ-9). If there are other screening tools you feel are necessary to adequately assess the patient, please include them and their results, in addition to the PHQ-9. By completing this paper work, you acknowledge you have reviewed the patient's health history and have discussed the results of the mental health screening with the patient. Based on your professional exam, should the student-athlete require medication or mental health services for any mental health condition, please indicate this on the form provided, and provide the necessary corresponding documentation. If you require a follow-up with this student-athlete, please indicate this on the form.

Thank you for taking the time to complete this screening. We greatly appreciate your assistance as we complete the necessary NCAA requirements to ensure the mental health of our student-athletes.

Sincerely,

Eugene Fellin, D.O.
Medical Director, Head Team Primary Care Physician
Health & Wellness Services, Kutztown University

By Postal Service to:

Attn: Athletic Physical Packet
Kutztown University of PA
Office of Sports Medicine
Keystone Hall Rm 124
Kutztown, PA 19530

Kutztown University Sports Medicine
Pre-Participation Mental Health Screening Form

As part of the NCAA's Mental Health Guidelines, every student-athlete must complete a Mental Health Screening. This must be completed annually, at a minimum. <u>This screening tool MUST be completed in the presence of a medical provider who is trained to recognize and/or treat mental health issues.</u>

NAME:_____ DOB:____/____/____ SPORT(S):_____
(PRINT) Last First MI

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Over the **<u>last 2 weeks</u>**, how often have you been bothered by any of the following problems? (Please **<u>circle</u>** your answer to each question)

		Not at all	Several Days	More than half the days	Nearly Every Day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tires or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself-or that you are a failure or have let yourself or others down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Office Coding: 0 + _____ + _____ + _____.

TOTAL SCORE: _____

If you checked off any problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle the amount of difficulty)

Not Difficult at all **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Has the individual ever received any treatment (i.e., Psychotherapy, counseling, or pharmacotherapy) in the past? YES _____ NO _____
<u>If yes, please explain diagnosis and provide documentation of type of treatment type, length of treatment, etc.:</u>

_____

_____

****

<u>AFTER REVIEWING THE RESULTS OF THIS MENTAL HEALTH SCREENING TOOL WITH THE INDIVIDUAL, THE HEALTH CARE PROVIDER MUST ANSWER THE FOLLOWING QUESTIONS:</u>

Does this individual have any condition which would preclude them from participating in an intercollegiate sport? YES _____ NO _____
If yes, please explain:

_____

_____

Based on the score of the mental health screening tool, does the individual require any further treatment? YES _____ NO _____
<u>If yes, please circle the individual's proposed treatment plan, and provide all documentation which corresponds to the recommended treatment plan.</u>

Watchful Waiting **Considering counseling, follow-up and/or pharmacotherapy** **Active treatment and/or psychotherapy** **Immediate Referral**

<u>Medical Provider's Name</u>

_____
(PRINT)

_____
(SIGNATURE)

_____
(DATE)

<u>Medical Provider's Address:</u>

_____

_____

_____

Phone: _____ FAX: _____

KUTZTOWN UNIVERSITY OF PA
ATHLETIC PARTICIPATION EXAMINATION

Instructions For Completion: **ONLY** a Physician(MD or DO) or Nurse Practioner(CRNP) may perform this physical on the prpspective student-athlete and **MUST** complete this form in its entirety. Remember to **REVIEW** their KU Athletic Medical History Form with them and **SIGN** it.

(Print)
Name_____ Date of Birth_____ Sport(s) M / W_____

Height_____ Weight_____ Pulse_____ Blood Pressure_____

I have reviewed the enclosed **Athletic Medical History** and accompanying documentation with the individual. **YES / NO**

Are there any abnormalities of the following systems?	**NO**	**YES**	Condition
1. Head, ears, eyes, nose or throat			
2. Skin			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Metabolic/ Endocrine			
9. Lymphatic			
10. Musculoskeletal			

Mental Health Check: The NCAA requires that all current and prospective student-athletes be screened for mental health disorders. The questionaires used are considered part of the student-athletes pre-particpation exam. Enclosed is the PHQ-9 screening tool, which is recommended by the NCAA. Please included this in your dertermination of this athletes playing status.

I have screened this individual using the Mental Health Tool (PHQ-9) enclosed and
I have submitted all documentation which corresponds to the recommended treatment plan. **YES / NO**

ON THE BASIS OF THIS PHYSICAL EXAMINATION
Does this individual have any condition which would preclude taking part in any intercollegiate sport? **YES / NO**
If yes, please list and explain:

_____

_____

PHYSICIAN'S NAME:

_____
(Print)

_____ MD, DO or CRNP
(Signature) (Circle) ***ONLY***

_____
(Date)

PHYSICIAN'S ADDRESS:

_____

_____

Telephone #:_____

Dispostion (Check Box): Full Participation ☐ Provisional/Limitations ☐ Fail ☐

NOTES: _____

_____

_____

_____

KUTZTOWN UNIVERSITY
Office of Sports Medicine

Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085
Fax: (610) 683-4664

Dear Health Care Provider:

Your patient, a student-athlete at Kutztown University, plans to or already participates in intercollegiate athletics at our institution. The NCAA (National Collegiate Athletic Association) requires that all athletes on stimulant medication for the treatment of ADD/ADHD provide adequate documentation of diagnosis and treatment to allow for a medical exemption. Stimulant medications are typically banned for use by NCAA athletes unless medical necessity is clearly documented by the host university. Kutztown University's Office of Sports Medicine is requesting the following information in order for your student-athlete to continue or begin their NCAA participation. **This is critical for their participation in NCAA sports**.

Please complete the enclosed form that **will be required annually** if your patient participates in NCAA athletics and continues to require stimulant medications for their treatment. In completing this paper work, you acknowledge that you have reviewed the patient's health history and have informed them at some time of the safety information regarding stimulant use as well as misuse guidelines. Please attach any consult letters or notes that may clarify their diagnosis and the need to use stimulant medications for treatment.

Thank you for taking the time to do this. We greatly appreciate your assistance as we all try to comply with NCAA requirements!

Sincerely,

Eugene Fellin, D.O.
Medical Director, Head Team Physician
Health & Wellness Services, Kutztown University

If not submitting along with your Pre-Participation Physical Paperwork,
Mail to:

Attn: Athletic Physical packet
Kutztown University of PA
Office of Sports Medicine
Keystone Hall 124
Kutztown, PA 19530

Medical Exception ADHD / ADD

Date:_____/_____/20___

Name:_____ Date of Birth:_____/_____/_____

Provider: Your patient is a student athlete (SA) participating in Intercollegiate Athletics at Kutztown Univerity. The NCAA bans the use of some stimulant medications and requires that the following documentation be submitted to support a request for a medical exception in the case of a positive drug test for such use. For additional information, please visit the NCAA Health & Safety website http://www.ncaa.org/wps/ncaa?ContentID=481

Date of Clinical Evaluation:_____/_____/20___

Required ADHD evaluation components: **Comments:**

Comprehensive clinical evaluation (using DSM-IV criteria) _____

Adult ADHD Rating Scale (e.g., Adult ADHD self report scale (ASRS), CONNER's Adult ADHD reporting scale (CAARS) Score: _____ _____

Monitored blood pressure1 and pulse _____

Alternative non-banned medications have been considered _____

****please submit copies of test results for the SA's medical record & NCAA purposes****

Additional ADHD evaluation components

Reporting of ADHD symptoms by other significant individual(s); _____

Other Psychological testing; _____

Physical exam date: ____ / ____ / ____ Results: _____

Laboratory/Other testing; _____

Previous documentation of ADHD diagnosis: _____

Other/Comments: _____

_____

Current Diagnosis: _____

Medication(s) and Dosage: _____

The Student-Athlete will follow-up with me in (circle one): 3 months, 6 months, 12 months, other _____

Physician Name (Printed): _____ Date: _____/____/_____

Physician Signature:_____ Specialty:_____ (M.D./ D.O.)

Office Address: _____ Office #: _____

_____ Office Fax#: _____

Please feel free to attach any clinical SOAP notes that may help clarify your patient/ our student-athlete's diagnosis of ADHD/ADD and the need for stimulant medications. THANK YOU FOR YOUR TIME!

Student Athletes: Please complete the following;

I, _____, give _____Dr._____ permission to release all information regarding my treatment for ADHD/ADD to the Kutztown University Office of Sports Medicine, and the National Collegiate Athletic Association. This authorization will be valid for one calendar year beginning on the date I sign this authorization. I may revoke this authorization at any time by submitting a letter in writing to the Director of Sports Medicine or another member of the University Health & Wellness Services, understanding that all information released prior to my revocation is excluded.

My signature below indicates that I have read and understand the above statement.

Signature:_____ Date: _____

Parent/Guardian signature: _____Date:_____ (if under 18 years)

2020-21 Student-Athlete Insurance Information form instructions

1. TYPE all requested information first. Handwritten forms will NOT be accepted as completed.

2. Type in N/A (non-applicable) for anything that doesn't pertain.

3. PRINT this form after entering ALL information.

4. The Policyholder MUST sign this form below along with the student-athlete.

5. Submit this completed form with the remaining Pre-Participation documents.

Note 1: All information is kept confidentional.

Note 2: You should SAVE this form to a safe location

KUTZTOWN UNIVERSITY OF PA

Student-Athlete Insurance Information 2020-21

The following information will be utilized solely by the ***Office of Sports Medicine*** for arranging medical care and services.
(Please ENTER information in the FIELDS below and then PRINT when complete)

Student's Name_____ Sport(s)_____

Permanent Address_____ Soc. Sec. #_____

City_____ State_____ Zip_____ Birth Date_____

KU ID #_____ Cell Phone #_____ Cell Provider_____

KU Email_____@live.kutztown.edu Home Email:_____

Emergency Contact_____ Relationship_____

Home Phone #_____ Work Phone #_____ Cell Phone_____

Father/ Guardian Name_____

Address_____

Phone_____

E-mail_____

Employer_____

Phone_____

Mother/ Guardian Name_____

Address_____

Phone_____

E-mail_____

Employer_____

Phone_____

Primary Insurance Plan: Every student-athlete **MUST** show proof of having **PRIMARY** Medical/Health Insurance.

Policy Holder's Name_____ **Policy Holder's** Birth Date: _____

Does this plan have a **Deductible**? ☐ YES ☐ NO List Amount: **Individual** $_____ **Family** $_____

What type of Plan is this? ☐ HMO ☐ PPO ☐ Military ☐ Medicaid ☐ Other (list)_____

*****The Policy holder MUST sign this form below***

A **photocopy (front & back)** of the student-athlete's or parent/guardian's **CURRENT / VALID** insurance card **MUST** be supplied below.

Tape the Front Copy of Your Insurance Card Here

(Tape down the full length of all four sides)

Tape the Back Copy of Your Insurance Card Here

(Tape down the full length of all four sides)

I hereby authorize Kutztown University and its Insurance Agent 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 photo static copy of this authorization shall be deemed as effective and valid as the original.

We authorize KU and its Insurance Agent to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by KUSSI.

I/We agree that all information provided in this document is accurate and complete to the best of my knowledge and that I/we will update any changes immediately. I/we understand that any incorrect or undisclosed information can result in the improper management of injury(ies) and also duplicate payments. I/we accept all financial responsibility for any injury(ies) improperly managed as a result of incorrect or undisclosed information or failure to follow the procedures listed in the '**Policies & Procedures Regardig Athletic Participation Injury, Illness and Medical Care.**

Signatures ***(after printing form, sign and date below)***

POLICY HOLDER_____ DATE_____

STUDENT ATHLETE_____ DATE_____

Student-Athlete Insurance Information 2020-21

This page **MUST** be completed if the student-athlete has ***Secondary Insurance*** through a parent/guardian or self .
(Please ENTER information in the FIELDS below and then PRINT when complete)

Student's Name_____ Sport(s)_____

Permanent Address_____ Soc. Sec. #_____

City_____ State_____ Zip_____ Birth Date_____

Secondary Insurance Plan:

Policy Holder's Name_____ **Policy Holder's** Birth Date: _____

Does this plan have a **Deductible**? ☐ YES ☐ NO List Amount: **Individual** $_____ **Family** $_____

What type of Plan is this? ☐ HMO ☐ PPO ☐ Military ☐ Medicaid ☐ Other (list)_____

*****The Policy holder MUST sign this form below***

A **photocopy (front & back)** of the student-athlete's or parent/guardian's **CURRENT / VALID** insurance card **MUST** be supplied below.

Tape the Front Copy of Your Insurance Card Here **(Tape down the full length of all four sides)**	**Tape the Back Copy of Your Insurance Card Here** **(Tape down the full length of all four sides)**

I hereby authorize Kutztown University and its Insurance Agent 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 photo static copy of this authorization shall be deemed as effective and valid as the original.

We authorize KU and its Insurance Agent to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by KUSSI.

I/We agree that all information provided in this document is accurate and complete to the best of my knowledge and that I/we will update any changes immediately. I/we understand that any incorrect or undisclosed information can result in the improper management of injury(ies) and also duplicate payments. I/we accept all financial responsibility for any injury(ies) improperly managed as a result of incorrect or undisclosed information or failure to follow the procedures listed in the '**Policies & Procedures Regardig Athletic Participation Injury, Illness and Medical Care.**

Signatures ***(after printing form, sign and date below)***

POLICY HOLDER_____ DATE_____

STUDENT ATHLETE_____ DATE_____

(PRINT this form after entering ALL information. You will not be able to save this form, so make sure the information is CORRECT.)

KUTZTOWN UNIVERSITY

Office of Sports Medicine

ATHLETIC RELATED MEDICAL BILLS LETTER OF RESPONSIBILITY

We, _____ and _____,
(Student-Athlete) (Insurance Policy Holder-ie. Parent, Guardian)

hereby understand that there may be medical bills resulting from an injury/illness incurred while participating as a member of **Kutztown University's Intercollegiate Athletics Program**. I/We acknowledge that **I/we am responsible for any and all medical bills**. I/We also agree to the following:

A. I/we understand that I/student-athlete must be covered by a Primary Health Insurance policy that covers Intercollegiate related athletic injuries and I am/we are responsible for providing proof of that primary policy to the KU Office of Sports Medicine and notifying them if there is/are any change(s) in that policy.

Government-funded insurance plans (such as Tricare, Medicaid, etc.) are NOT considered primary medical insurance. If a student-athlete has a government-funded insurance plan, the student-athlete may sign a waiver to decline the secondary medical insurance provided by Kutztown University. Please contact the Director of Sports Medicine via email at sacco@kutztown.edu or at (484) 646-4287 regarding this option.

B. I/we have read the "Policies and Procedures Regarding Athletic Participation, Injuries, Illnesses and Medical Care" document and fully understand its content.

C. I/we understand that Kutztown University Student Services, Inc. (KUSSI) has a Supplemental Accident Insurance plan and that plan has a $1,500 Deductible per Injury Claim, which I/we or my/our 'Primary' insurance plan will be responsible for satisfying before using the KUSSI Supplemental plan.

D. I/we understand that for an athletically related injury/illness to be eligible for coverage under the KUSSI Supplemental Athletic Accident Insurance, I/the student-athlete MUST report the injury/illness to the Sports Medicine Staff **within 30 days of its onset**.

E. I/we understand that Kutztown University's Office of Sports Medicine will assist me/us in filing injury claims but has no liability for the accuracy or payment of the claims.

F. I/we further understand that the Commonwealth of Pennsylvania, Kutztown University, KUSSI and/or any University employee is in no way liable for payment of any medical bills.

G. I/we accept the responsibility of ensuring any insurance claims are submitted correctly and in a timely manner. I/we also accept that it is my/our responsibility to follow up on medical claims with both the medical providers and insurance companies involved with any bills.

H. I/we understand that there is a limitation on the time in which medical bills must be submitted to my/our insurance company(ies) and failure to address any medical bills within that time could affect my credit record and also result in the denial from the KUSSI Supplemental Athletic Accident Insurance.

I. I/we understand that all Intercollegiate Athletic related medical services by "Outside Physician/Specialist": 1) MUST follow my Primary Health Insurance process; 2) MUST be done "In-Network"; and 3) MUST be approved in writing by a member of the Sports Medicine staff, to be considered for secondary payment thru KUSSI insurance program.

J. I understand that any costs associated with the failure to follow the above will be my responsibility alone.

Student Full Name (PRINT)	Birth Date	Sport
Student Signature	Date	
Policy Holder Full Name (PRINT)		
Policy Holder Signature	Date	

EXEMPTION AND RELEASE FORM FROM KUTZTOWN UNIVERSITY'S INTERCOLLEGIATE ATHLETIC SECONDARY INSURANCE POLICY FOR STUDENT-ATHLETES WITH TRICARE OR MEDICAID MEDICAL INSURANCE

I understand and acknowledge that Kutztown University requires student-athletes to have primary medical insurance to participate in intercollegiate athletics. The primary medical insurance policy must provide coverage for an injury sustained during participation in intercollegiate athletics.

I understand and acknowledge that student-athletes who have Tricare or Medicaid as their primary medical insurance **are NOT eligible for coverage under the intercollegiate athletic secondary insurance policy provided by Kutztown University for an injury sustained during their participation in intercollegiate athletics.**

I verify that I have medical insurance with TriCare or Medicaid. Based on this verification, I agree that any costs associated with an injury sustained during participation in intercollegiate athletics at Kutztown University will be the sole responsibility of TriCare or Medicaid and, in the event that TriCare or Medicaid do not cover those costs, I or my parent(s)/legal guardian(s) will be responsible for any and all costs.

By signing this form I acknowledge and relinquish my enrollment in the intercollegiate athletic secondary insurance policy provided by Kutztown University. I understand that I will be responsible for any and all costs which are associated with any injury sustained during participation in intercollegiate athletics at Kutztown University.

I expressly release and discharge from responsibility and liability Kutztown University, Kutztown University Student Services, Inc., the Department of Athletics, and the Department of Sports Medicine along with employees, officials or agents of the foregoing, from costs associated with any injury I sustain during participation in intercollegiate athletics at Kutztown University.

I, the undersigned, am at least 18 years of age, and competent to sign this exemption and release form. By signing this exemption and release from, I hereby acknowledge that I understand and voluntarily accept the risks, rights and responsibilities set forth in this form. In addition, if the student-athlete is covered under his/her parents'/guardians' TriCare or Medicaid policy, the parent/guardian must acknowledge and sign this document prior to participation in intercollegiate athletics at Kutztown University.

Student Full Name (PRINT)	Birth Date	Sport

Student Signature	Date

Policy Holder Full Name (PRINT)

Policy Holder Signature	Date

If the student-athlete is not 18 years of age, please have parent(s) or legal guardian(s) sign the exemption and release form

KUTZTOWN UNIVERSITY
Office of Sports Medicine

Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085

Medical Disclosure Policy

- I understand that I am responsible for reporting all 'athletic-related' injuries to a member of the Kutztown University Sports Medicine Team as soon as possible. For an injury to be submitted for coverage under KUSSI's Supplemental Athletic Accident Insurance, the student-athlete MUST report the injury to the Sports Medicine Team **within 30 days of its onset**.

- I understand that I am responsible for reporting to a member of the Kutztown University Sports Medicine Team (address below), any/all injury(ies) and illnesses I may suffer that requires medical attention throughout the year, whether athletic-related or non-athletic-related as soon as possible. I understand this includes the summer months and all break periods. I understand this allows the Sports Medicine Team adequate time to review medical documentation and contact individuals for further information, if necessary.

- I understand that I am responsible for submitting my personal Primary Health Insurance policy coverage information and report any changes immediately the Kutztown University Sports Medicine Team.

- I understand that failure to do any of the above may delay my ability to Pass an Athletic Pre-Participation Examination and/or delay subsequent return to active participation in Kutztown University Intercollegiate Athletics.

- I understand that any costs associated with the failure to follow the above policy will be my responsibility alone.

My signature below indicates that I have read the above information and agree to any and all provision therein. Failure to sign will result in my ineligibility for the up-coming sports season.

Student-Athlete (Print Name)	**Birth Date**	**Sport**
Signature of Student-Athlete	Date	
Signature of Parent/Guardian (if the student-athlete is a minor)	Date	

**Direct all correspondence to: Jack Entriken, MS, ATC Faculty Athletic Trainer.

E-mail: **entriken@kutztown.edu**
Address: **Office of Sports Medicine, 124 Keystone Hall**
Kutztown, PA 19530

NOTE: If you downloaded this form, please keep a copy for your records.

KUTZTOWN UNIVERSITY

Office of Sports Medicine

Medical Consent, Release, and Shared Responsibility Information

A. MEDICAL CONSENT

I give permission to the Kutztown University (KU) Sports Medicine Team, which includes the following: the Sports Medicine Athletic Trainers and staff, the University's Health & Wellness Services staff, our University Team Physicians, including our consulting physicians, the University Counseling Services and the Office of Disability Services, to render any treatment that may be necessary regarding my health and well-being. Additionally, I give permission for the sharing of confidential health information within the Sports Medicine Team to the extent necessary to assure continuity of care during an illness, physical or psychological, or injury. In the case of a parent/guardian signing this form for a minor, this permission is granted regarding that minor.

I authorize the KU Sports Medicine Team to render the necessary medical services. I understand that this may include treatment such as medical or surgical care that may need to be provided by the caring team physician or consulting physician. In the case of a parent/guardian signing this form for a minor, this authorization is granted regarding that minor.

Also, by permitting necessary treatment, I realize that I am authorizing the Sports Medicine licensed athletic trainers to render any treatment including, but not limited to, preventive first-aid, rehabilitation, and emergency treatment. During these instances, the athletic trainer will be working under the supervision of the Kutztown University team physicians and/or consulting physicians. In the case of a parent/guardian signing this form for a minor, this authorization is granted regarding that minor.

I also realize that, by giving consent for proper care, I am giving permission for hospitalization when necessary at an accredited hospital. In the case of a parent/guardian signing this form for a minor, this permission is granted regarding that minor.

B. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Sports Medicine Team to release medical information pertinent to my playing status to my University team coach(es). I also authorize the release of medical information to my parents/guardians concerning my health status and medical welfare, including that information required to process athletic-related injury claims. I also authorize the release of any medical information to appropriate on-campus individuals, if the release of that information benefits my health and welfare. No other Protected Health Information (PHI) will be released without my written approval. In the case of a parent/guardian signing this form for a minor, this authorization is granted regarding that minor.

C. SHARED RESPONSIBILITY FOR SPORTS SAFETY

Participation in sport requires an acceptance of risk of injury. Athletes, along with their parent/guardian if applicable, rightfully assume that those who are responsible for the conduct of sport have taken reasonable precaution to minimize such risk and that their peers participating in the sport will not intentionally inflict injury upon them.

The NCAA and individual sport-governing bodies make periodic analysis of injury patterns, refinements in the rules, and other safety decisions. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule book is as insufficient as to rely on warning labels to produce compliance with safety guidelines. "Compliance" means respect on everyone's part for the intent and purpose of a rule or guideline.

I have read the above shared responsibility for sports safety statement. I understand that there are certain inherent risks involved in participating in intercollegiate athletics, including serious or catastrophic injury. I acknowledge the fact that these risks exist and am willing to assume responsibility for such risks while participating at Kutztown University. In the case of a parent/guardian signing this form for a minor, this shared responsibility is acknowledged regarding that minor.

My signature below indicates that I have read all the above information and agree to any and all provision therein. Failure to sign will result in my ineligibility for the up-coming sports season.

Student-Athlete (Print Name)	**Birth Date**	**Sport**

Signature of Student-Athlete	Date

Signature of Parent/Guardian (if the student-athlete is a minor)	Date

KUTZTOWN UNIVERSITY
Office of Sports Medicine

Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

THE REQUIRED ACKNOWLEDGEMENT OF RECEIPT OF THIS FORM IS FOUND AT THE BOTTOM OF THE DOCUMENT.

The staff members of Kutztown University Sports Medicine (KUSM) follow privacy practices that are based on the Family Educational Rights and Privacy Act (FERPA). FERPA is the law that protects the privacy of your education records at Kutztown University, including records maintained by KUSM.

• FERPA also provides you with access to information. Health and Wellness Services (H&WS) may send you reminders about appointments and provide you with other information in order to inform you of treatment alternatives or benefits or services related to your health. In addition, under FERPA, you have the right to inspect and review your education records; if you wish to review education records maintained by KUSM, you must submit a written request to KUSM.

• FERPA also permits the University to share your medical information with other individuals or entities when you have provided written consent. Examples of these situations are as follows:

- You may want the University to provide information to your insurance company, so that it will reimburse you for expenses.
- You may want the University to provide information to your family physician.
- You may need to provide proof of an immunization or another record to an entity for licensure or employment purposes.

• FERPA also identifies the situations in which the University may disclose education records without your prior consent:

- Health and Safety Emergencies: The University may disclose student information on an emergency basis when that information is necessary to protect the health and/or safety of the student or University community.
- School officials with legitimate educational interest: FERPA permits the University to share information with other school officials who have a legitimate educational interest. This sharing of information does not require your consent. A legitimate educational interest is an interest directly related to the academic environment. Therefore, KUSM may share information with other members of Kutztown University's team of healthcare providers, as well as Student Affairs professionals, who are school officials who may have a legitimate educational interest in the information.
- Judicial Order or Subpoena: FERPA also permits the University to provide information when it is required by a subpoena or court order. The University will make every effort to provide advance notice to the student unless the subpoena or order prohibits such notification. Educational records will be disclosed to the U.S. Attorney General or his/her designee in response to an order concerning an authorized investigation or prosecution of domestic or international terrorism without prior notice to the student.
- Parents of a student who is dependent for federal tax purposes may have access to information from student records maintained by KUSM. The University's FERPA policy provides information about how parents may demonstrate that the student is dependent.

• Most of the records maintained by KUSM are treatment records under FERPA. Treatment records are records on students that are made or maintained by a physician, psychiatrist, psychologist, Athletic Trainer or other recognized professional or paraprofessional acting or assisting in that capacity are not subject to the provisions of access, disclosure and challenge. Such records, however, must be made, maintained, or used only in connection with the provision of treatment to the student and are not available to anyone other than the persons providing treatment or a substitute. Such records may be personally reviewed by a physician or other appropriate professional of the student's choice.

For more information about FERPA visit: https://www.kutztown.edu/FERPA

****ACKNOWLEDGMENT:**

I acknowledge receipt of and agree to the information concerning the Notice of Privacy Practices from Kutztown University Sports Medicine.**

Student-Athlete (Print Name)	**Birth Date**	**Sport**

Signature of Student-Athlete	Date

Signature of Parent/Guardian (if the student-athlete is a minor)	Date

KUTZTOWN UNIVERSITY
Office of Sports Medicine

Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085

Student-Athlete Injury and Illness Reporting Acknowledgement Form

I acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the Sports Medicine Team at Kutztown University of Pennsylvania (KU), which includes the Team Physician(s), Athletic Training staff, Health & Wellness Center staff and KU related consulting physicians. I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed any prior medical conditions on my Athletic Medical History form and will also disclose any future injury/illness to the Sports Medicine Team at my earliest opportunity.

Concussion Notice: I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided with educational materials about head injuries, including provided online video and a fact sheet. I and understand the importance of immediately reporting symptoms of a head injury/concussion to the Kutztown University sports medicine staff.

By signing below, I acknowledge that Kutztown University has provided me with specific educational materials on what a concussion is and provided me with an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, _____, have read the above and agree that the statements are accurate.
Student-Athlete's Full Name (PRINT)

_____ _____ _____
Signature of Student-Athlete Date Sport

If the Student-Athlete is a Minor, please complete.

_____
Parent/Guardian's Full Name (PRINT)

_____ _____
Signature of Parent/Guardian Date

KUTZTOWN UNIVERISTY OF PA
Sickle Cell Trait - Reporting Form

About Sickle Cell Trait:

- Sickle Cell Trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle Cell Trait is a common condition (> three million Americans)
- Although Sickle Cell Trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South/Central American ancestry, persons of all races and ancestry may test positive.
- An undiagnosed trait can be dangerous, even fatal. During intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood and possible death. Twenty-one college football players with Sickle Cell Trait have collapsed and died over the past decade.
- If an athlete tests positive, he or she will still be able to participate in athletics activities with certain precautions.
- More information on Sickle Cell Trait may be found at the following NCAA website: http://www.ncaa.org/sport-science-institute/sickle-cell-trait

Sickle Cell Trait Testing:1

- The ***NCAA*** has mandated that all Division II student-athletes be tested for Sickle Cell Trait, show proof of a prior test, or sign a waiver releasing the school from liability if they decline to be tested before participating in athletic-related activities, including intercollegiate athletics events, strength and conditioning sessions, practices, competitions, etc.
- **Please PRINT your name, date of birth, and sport(s) below. Select one of the options below and return this form to: Kutztown University, Attn: Athletic Physical Info, Health & Wellness Services, PO Box 730, Kutztown, PA 19530 on or before July 15.**

Name: _____

DOB: _____ **SPORT(S):** _____

If this form is NOT returned by the date set forth above or returned incomplete, you will be placed on Medical HOLD.

A. _____ A copy of my newborn screening records pertaining to Sickle Cell Trait are attached *(this test was mandated for all Pennsylvania newborns beginning in September 1992. If you were born in another state, you will have to check their statute).*

B. _____ A copy of my Sickle Cell Trait test from a physician or other authorized medical care provider is attached. I acknowledge the results of the test to be: (please initial one of the following)

Sickle Cell Trait Positive *Initial*_____ Sickle Cell Trait Negative *Initial*_____

C. _____ I voluntarily decline to be tested, understand that an undiagnosed trait can be dangerous, even fatal, and agree to sign the waiver below. ****IF YOU CHOSE THIS OPTION YOU MUST SIGN THE WAIVER BELOW.**

****

Sickle Cell Testing Waiver ***(only needed if option "C" is selected above)*:**

I, _____, understand and acknowledge that the NCAA mandates that all Division II student-athletes be tested for Sickle Cell Trait, show proof of a prior test, or sign a waiver releasing the University from liability if they decline to be tested before participating in athletic-related activities. 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 other disabilities experienced. I hereby affirm that I have fully disclosed in writing any knowledge of Sickle Cell Trait status to the KU Sports Medicine Staff.

I am aware that if I have Sickle Cell Trait, I am at an increased risk for serious illness or injury, including death – especially during physical exertion. I have reviewed materials regarding Sickle Cell Trait, and have been informed of these risks.

I do not wish to undergo Sickle Cell testing as part of my pre-participation physical exam. I voluntarily agree that in consideration for being granted the opportunity to participate in Intercollegiate Athletics at Kutztown University without agreeing to be tested for Sickle Cell Trait, and in full recognition and appreciation of the risks associated therewith, I, for myself, my executors, administrators and assigns, do hereby release, discharge, indemnify and hold harmless the Commonwealth of Pennsylvania, Kutztown University, its officials, employees, representatives, volunteers and agents from any and all costs, liabilities, expenses, claims, demands, charges, or causes of action on account of any loss or personal injury that might result from my voluntary decision not to be tested.

I have read and signed the document with full knowledge of its significance. If I am under 18 years of age, my parent and/or guardian has also signed below.

_____ _____

Student – Athlete Signature Date

_____ _____

Parent or Guardian Signature (if under 18) Date

Newborn Screening in Pennsylvania

We highly suggest **you** request a copy of your newborn screening information/results from your Birth State.

For students born in **PA (*PA Dept of Health*)** you may do so by one of two ways:

1) Phone: 717-783-8143 ; or
2) By **faxing** the following form to 717-724-6995.
   Please use the next two pages of this document if requesting your Newborn Screening Results.

For information regarding Newborn Screening in Pennsylvania you can go to the following website.

PA Newborn Screening & Follow-up Program.

If born outside of PA, check with your Pediatrician or consider getting a new test.

Facsimile Cover Sheet

To Newborn Screening

Company PA Department of Health

Fax (717) 724-6995 **Pages**

Phone (717) 783-8143 **Date**

From: **Name**

Address

Phone:

Comments: Enclosed is my Authorization to Obtain my Newborn Screening Results and disclose those results to my Team Physician at Kutztown University.
Please fax the results of the enclosed request to Eugene Fellin, DO, Kutztown University of PA, at (610) 683-4664.

Commonwealth of Pennsylvania, Department of Health

Authorization to Obtain Newborn Screening Results and for Disclosure of Protected Health Information

1. **I authorize the Pennsylvania Department of Health (Department) to use/disclose individual newborn screening information/results obtained from the records of: (Please Print)**
   Name at Birth:_____
   Date of Birth:_____ Sex: M F
   Telephone:_____
   Address:_____
   Hospital of Birth:_____
   Mother's Full Name:_____
   Mother's Maiden Name:_____
   Mother's Social Security Number (optional): _____

2. **Reason for disclosure of Department Newborn Screening Results:**(Describe each specific purpose – such as: use for direct patient care or college application)

   College/University Athletic Physical : **Sport Name:** _____

3. **I understand that:**

   a. This authorization may be revoked at any time by writing to the Department except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

   b. The Department will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

   c. Information disclosed pursuant to this authorization may be subject to re-disclosure by the organization identified in section below and is no longer protected by federal privacy regulations.

   d. The Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

   e. I may refuse to sign this authorization.

4. **This information is to be disclosed to:**

   Eugene Fellin, D.O. Kutztown University Team Physician { Fax to: 610-683-4664 }
   (Insert name or title of the organization to whom disclosure is to be made)

5. **This authorization expires when results have been obtained.**

****

_____

Signature of Parent/Guardian, Individual or Personal Representative Date

If personal representative, state relationship to individual: _____

_____

Signature of Witness Date

_____

If individual is physically unable to sign, signature of second witness Date