Office of Sports Medicine

Dear ***NEW 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, 2023

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

___Athletic Medical History *(4 pages)* MUST be completed by your family physician (MD, DO) or a Nurse Practitioner (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 recognize mental health issues.
___Athletic Physical *(1 page)* MUST be completed by your family physician (MD, DO) or a Nurse Practitioner (CRNP) **ONLY**. **NO** Physician's Assistant or Chiropractors.
___NCAA ADHD/ADD form (**ONLY** if diagnosed with ADD/ADHD) *(1 page)*
___Athletic Insurance Information Form: See link on Web Page
(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.
___FERPA Acknowledgement Form, Medical Consent/Release Form, Medical Disclosure Form, Medical Bills Letter of Responsibility form *(Return all pages)*
___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 University 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 Print this athletic medical history form to the scale of 4 pages.
Please complete this form in **Black Ball Point Pen**; mark the **month & year** of all items.

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.

(PRINT)

Name _____ Sport(s) _____
Last First Mi.

Date of Birth _____

(Circle) Student-Athlete's Status: Freshman or Transfer

Student- Athlete's Initials: _____

Date Completed: _____

****

Important: Please circle your responses below.

FAMILY HISTORY:

1. Has any relative died suddenly before 50 years old? Yes No
   If YES, explain: _____
2. Is there a history of heart disease in any relative(s) less than 50 years old? Yes No
   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.

Have you ever had or do you have now:

1. **Heart Trouble (*)** Chest Pain/Palpitations Yes No
   Murmur Yes No
   High Blood Pressure Yes No

   A. Have you ever had any tests to evaluate your heart? Yes No

If YES, please list:	Mo/Year	Reason		
Stress Test	_____	_____	Yes	No
EKG	_____	_____	Yes	No
Echocardiogram	_____	_____	Yes	No
Other	_____	_____	Yes	No
please list:	_____			

2. **Stomach Trouble** Yes No
   If YES, please explain: _____
   _____

3. **Nervous System Problems (*)**

	Mo/Year		
Fainting Problems	_____	Yes	No
Seizure(s)	_____	Yes	No
Head Injury (i.e., Concussion)	_____	Yes	No
Head Injury w/ Unconsciousness	_____	Yes	No
Migraines	_____	Yes	No

4. **Respiratory Problems**
   A. Asthma Yes No
   List medication(s): _____
   ****Please include physician note with limitations, if any.**
   B. Allergies General: _____ Yes No
   To Medication: _____ Yes No

5. **Bleeding Problems (*)** Mo/Year _____ Yes No
   Please specify: _____

6. **Diabetes (*)** Yes No
   Date of Diagnosis: _____

7. **Sensory Deficit**
   A. Hearing Yes No
   Please explain: _____
   B. Sight Yes No
   Please explain: _____
   Contact(s): Yes No

8. **Heat Illness Disorders (*)**

	Mo/Year		
Heat Exhaustion	_____	Yes	No
Heat Stroke	_____	Yes	No
Other Environmental Problems	_____	Yes	No

9. **Dental History**
   Have you had or do you have now:
   Caps: _____ Yes No
   Crowns: _____ Yes No
   Plates: _____ Yes No
   Fractures, please explain: _____ Yes No

10. **Medication History**
Are you taking ANY medications now and/or on a regular basis? Yes No
If YES, please provide Name, Dose, Frequency, Reason: _____
_____
_____
_____

11. **Have you ever had ANY surgery, including the removal of a major organ?** Yes No
If YES, provide brief explanation and include month & year. (Submit surgical and rehab notes.)
_____
_____
_____
_____

12. **Have you been seen by a physician for any condition (physical 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.** Yes No
(Submit ALL related medical notes. Examples: HIV, Sickle Cell, Ringworm, Herpes, etc.)
_____
_____
_____
_____

13. **Have you ever been diagnosed with having ADHD/ADD?** Yes No
(Attention Deficit Hyperactivity Disorder)
Date of Diagnosis: _____
Current Medications: _____
_____

14. **Covid-19 questions:** (Submit ALL related medical notes)

Have you ever been diagnosed with having Covid-19 virus?	Yes	No
If YES, were you hospitalized? Date: _____	Yes	No
Do you have a clearance letter for Return to Sport from your Physician?	Yes	No
Did you complete a graded return to sport protocol?	Yes	No
Have you been Vaccinated for Covid-19?	Yes	No
Have you received a booster for the Covid-19 vaccine?	Yes	No

ORTHOPEDIC HISTORY:

1. If you ever had a broken bone(s)? Yes No
If YES, please explain, give date of injury. **(Submit ALL medical notes.)**
_____
_____
_____

2. Have you been seen by a physician/athletic trainer/another medical professional for a non-fracture injury, which lasted more than a week, in the **last year** (i.e., shin splints, back problems, joint sprain, orthopedic injuries)? Yes No
If YES, please explain, give date of injury. **(Submit ALL medical notes.)**
_____
_____
_____
_____
_____
_____

3. Are you now suffering from any injury (old or new). Yes No
If YES, please explain, give date of injury. **(Submit ALL medical notes.)**

_____
_____
_____
_____
_____
_____
_____

4. Have you been seen by a physician/athletic trainer/another medical professional for a non-fracture injury, **more** than 12 months ago, which lasted more than a week? (i.e., shin splints, back problems, joint sprain, orthopedic injuries)? Yes No
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 PROVIDED.

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

Student-Athlete Signature: _____ Date: _____

Parent/Guardian (If Minor): _____ 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.

****

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!)** *PA's must have Physician co-sign form
Physician's Signature (please circle)

KUTZTOWN UNIVERSITY
Office of Sports Medicine

124 Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085

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 paperwork, 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,

Sports Medicine Staff

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: _____ + _____ + _____ + _____.

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>

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 Practitioner(CRNP) may perform this physical on the prospective 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 (required for male athletes)			
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 questionnaire used are considered part of the student-athletes pre-participation exam. Enclosed is the PHQ-9 screening tool, which is recommended by the NCAA. Please included this in your determination of this athlete's 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 #:_____

Disposition (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 paperwork, 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,

Sports Medicine Staff

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 University. 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)

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.

Office of Sports Medicine

Keystone Hall, Sports Medicine
Kutztown, PA 19530

Office: (610) 683-4085

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USEDAND 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 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

Medical Consent, Release, and Shared Responsibility Policy

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, the 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.

By permitting necessary treatment, I am authorizing the Sports Medicine 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 realize that, by giving consent for 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.

- **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 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 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.

- **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.

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.

Athletic Related Medical Bills Letter of Responsibility Policy

A. We, the student-athlete and the Insurance Policy Holder- (i.e., 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/are responsible for any and all medical bills**.

B. 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 entriken@kutztown.edu or at (610)683-4085 regarding this option.

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

D. 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.

E. 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**.

F. 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.

G. 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.

H. 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.

I. 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 result in the denial from the KUSSI Supplemental Athletic Accident Insurance.

J. 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.

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

****ACKNOWLEDGMENT:**

I acknowledge receipt of and agree to the information concerning the following policies: 1. Notice of Privacy Practices (FERPA), 2. Medical Consent, Release, and Shared Responsibility Policy, 3. Medical Disclosure Policy, and 4. Athletic Related Medical Bills Letter of Responsibility Policy from Kutztown University Sports Medicine.

Student Athlete Name	**Date of Birth**	**Sport(s)**
Student Signature	**Date**	
Parent/Guardian: If Student is under 18 years of age (Print Name)	Parent/Guardian: If Student is under 18 years of age (Sign Name)	Date

Kutztown University of PA

Sickle Cell Trait - Reporting Form for New & Incoming Student-Athletes

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 new and incoming Division II student-athletes provide proof of their Sickle Cell Trait status or be tested for Sickle Cell Trait before participating in any 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, Kutztown University Sports Medicine Office, Keystone Hall 124, 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 elsewhere in the United States, you can refer to the following link for state specific contact information.

https://www.cdc.gov/genomics/resources/h.htm

B. _____A copy of my Sickle Cell Trait test results from a physician or other authorized medical care provider is attached.

I am aware and acknowledge the results of the test to be:
(please initial one of the following)

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

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 must 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