



UMASS LOWELL ATHLETIC HEALTH CARE
Personal Information Form

Sport: _____ Date: _____

I. General Information (Please Print or Type)

Name: _____ Age: _____

Home Address: _____

Phone: _____

Local Address: _____

Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ SS#: _____

Marital Status: _____ Year In School: _____

Height: _____ Weight: _____

High School Attended: _____

College or Jr. College Attended (if a transfer, include dates attended): _____

Previous Participation at UMASS Lowell (include dates): _____

Parent's Name: _____

Parent's Address: _____

Phone: _____

Parent's Business Address: _____

Phone: _____

Person to notify in case of emergency (Name, Relation): _____

Address and Telephone: _____

Family Doctor's name, address & phone: _____

II. Family History (If living, state age and general health. If deceased, state age at death and cause)

Father: _____

Mother: _____

Brothers & Sisters: _____

Family History of (Please circle and give relation)

TB

Diabetes

High Blood Pressure

Cancer

Heart Disease

III. Past Medical History/Record of Illness- Circle the appropriate response:

Have you ever had?

Appendicitis	Yes	No	Heat Exhaustion	Yes	No	Mumps	Yes	No
Appendectomy	Yes	No	Heat Stroke	Yes	No	Polio	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Pneumonia	Yes	No
Asthma	Yes	No	Hernia	Yes	No	Rheumatic Fever	Yes	No
Bronchitis	Yes	No	Hives	Yes	No	Scarlet Fever	Yes	No
Chicken Pox	Yes	No	Bone-Joint Disease	Yes	No	Skin Disease	Yes	No
Convulsions	Yes	No	Influenza	Yes	No	Smallpox	Yes	No
Diabetes	Yes	No	Kidney Disease or	Yes	No	Tonsillitis	Yes	No
Epilepsy	Yes	No	Bladder Problems	Yes	No	Tonsillectomy	Yes	No
Frequent Colds	Yes	No	Malaria	Yes	No	Tuberculosis	Yes	No
Hay Fever	Yes	No	Measles(type)	Yes	No	Ulcer	Yes	No
Heart Trouble	Yes	No	Mononucleosis	Yes	No	Whooping Cough	Yes	No
Heart Murmur	Yes	No	EKG/Stress Test	Yes	No	Echocardiogram	Yes	No

If you circled "yes" to any of the above please explain in detail:

Females: Menstrual History:

Menstrual Cycle: Regular _____ Irregular _____ Pain _____

IV. Record of Symptoms- Circle the appropriate response:

Have you ever had?

Aching Eyes	Yes	No	Persistent Cough	Yes	No	High Blood Pressure	Yes	No
Sties	Yes	No	Frequent Headaches	Yes	No	Painful Urination	Yes	No
Blurred Vision	Yes	No	Blackouts	Yes	No	Blood in Urine	Yes	No
Inflamed eyelids	Yes	No	Fainting Spells	Yes	No	Sugar in Urine	Yes	No
Ringing in ears	Yes	No	Painful Joints	Yes	No	Abdominal Pains	Yes	No
Difficulty hearing	Yes	No	Backache	Yes	No	Jaundice	Yes	No
Discharging ear	Yes	No	Leg Pains	Yes	No	Boils	Yes	No
Sinus Infection	Yes	No	Shortness of breath	Yes	No	Acne	Yes	No
Nose Bleeds	Yes	No	Chest Pains	Yes	No	Eczema	Yes	No

If you circled "yes" to any of the above please explain in detail:

V. Previous Sports Injuries

<u>Head/Neck</u>	<u>Yes</u>	<u>No</u>
1. Did you ever have spasms or convulsions as an infant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does anyone in your immediate family (parents, brother or sister) have seizures, fits, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a seizure, convulsion, fit, or epileptic attack?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had or has it been suggested that you should have a brain wave test?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been unconscious? If YES , check which one:	<input type="checkbox"/>	<input type="checkbox"/>
a. Knocked out	<input type="checkbox"/>	<input type="checkbox"/>
b. Passed-out, fainted, or blacked-out	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a concussion? If YES , when?		
a. How many times?_____		
b. How long to make a complete recovery?_____		
c. How many games missed following?_____		
7. Have you ever had a skull fracture?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had a neck injury?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a fractured neck or spine?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had an x-ray film taken of your neck or spine?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had an injury producing weakness or numbness of either your arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a "pinched nerve"?	<input type="checkbox"/>	<input type="checkbox"/>

List all injuries that resulted in your missing a game or several consecutive practices;(sprains, strains, fractures, dislocations, concussions, cartilage injuries to the knee, etc.). Indicate left or right. Give the appropriate dates of injury and if you have had surgery as a result of an injury or condition. Please indicate approximate time missed.

Face/Dental (include fractured teeth, facial fractures)

Back (strains, stress fractures, disc injuries)

Shoulder (A-C sprains, dislocations, strains and any weakness or numbness)

Chest and/or Abdomen (strains, rib fractures, S-C sprains)

Arm (include elbow, wrist, hand and fingers and any weakness or numbness)

Leg (include hip, groin, thigh, calf, shin, and stress fractures, tendonitis any weakness or numbness)

Skin (herpes, ringworm)

Knee (sprains, cartilage tears, patella-femoral pain, patella dislocations)

Ankle and/or Foot (sprains, stress fractures, arch pain)

Are there any other medical problems we should be aware of for your safety? If so, list:

Are there any special pads or taping procedures needed for participation?

VI. Cardiovascular Screening

	Yes	No
1. Have you ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has any family member or relative died of a heart problem or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>

If “**yes**” to any of the above please explain in detail:

VII. Current Medical Information

Allergies

Do you have any allergies? Yes No If yes, please specify:

Medications: _____ Insect Bites: _____ Food: _____

Plants: _____ Hay Fever: _____ Other: _____

Medications:

Do you take any prescription drugs or any other medication on a daily or a regular basis? YES NO
If yes, please indicate what, how much, and when: _____

Immunizations (date of last injection)

Tetanus Toxoid: _____

Influenza: _____

Mumps: _____

Weight History

Highest: _____ Lowest: _____

Happy with present weight? _____

If not, what is your ideal weight? _____

Previous history of eating disorder (if yes, what, when?) _____

Food History

Number of meals/snacks eaten during day: _____

Any foods you never eat (forbidden): _____

Any food allergies: _____

VIII. Vision

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1. Do you wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you play in glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have an extra pair of glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you play in contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have an extra pair of contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Name, address, and phone number of your optometrist: | _____ | |

Name

Street

City

State

Zip Code

Phone

Please attach contact lens prescription if possible

IX. Authorization for Release of Records

I, _____ do hereby authorize the Athletic Health Care Office to disclose my health care records in regard to athletic injuries/illnesses sustained at UMass Lowell for the purposes of treatment, payment, and health care operations to: Coaches, University Health Service, Team Physicians, Sports Information Office, Insurance Companies, health care providers associated with my care, and the media, if requested.

Signature of Athlete

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

X. Authorization and Consent for Treatment

I do hereby give permission to the medical staff of the University of Massachusetts Lowell to render me whatever procedure is necessary for first aid and/or emergency treatment, rehabilitation, and injury evaluation and to obtain any medical records or information pertaining to myself.

Athlete's Signature

Date

Parent's Signature
(must sign if athlete is under 18 years of age)

Date

To the best of my knowledge, the information provided herein to the Athletic Training Department via this form is true.

Athlete's Signature

Date

Parent's Signature
(must sign if athlete is under 18 years of age)

Date

Comments: _____

UMASS LOWELL ATHLETIC HEALTH CARE OFFICE

Student-Athlete Nutritional Supplement Disclosure Review Form

I, _____ am taking or intend to take the following nutritional supplement. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in any substance that I may take, regardless of the reason or purpose for taking such supplements.

I acknowledge and understand that the labeling on these products can be misleading and inaccurate, and that sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as “healthy” or “naturally occurring” do not necessarily mean safe to take or use, or that the NCAA endorses a product or approves its usage.

Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by my institution’s head athletic trainer for the purposes of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I understand that I should not take or use these products until my institution’s head athletic trainer has reviewed my usage.

Brand Name	Listed Ingredients	Banned Substances
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____

Signatures:

Student-Athlete Date

Head Athletic Trainer Date

UNIVERSITY OF MASSACHUSETTS LOWELL
Department of Athletics

Shared Responsibility for Sport Safety

Participation in sport requires an acceptance of risk of injury. Athletes rightfully assume that those who are responsible for the conduct of sport have taken reasonable precautions to minimize the risk of significant injury. Periodic analyses of injury patterns continuously lead to refinements in the rules and/or other safety guidelines. However, to legislate safety via the rulebook and equipment standards, while often necessary, is seldom effective in and by itself. To rely on officials to enforce compliance with the rulebook is as insufficient as to rely on warning labels to produce behavioral compliance with safety guidelines. By compliance is meant respect on everyone's part for the intent and purpose of a rule or guideline, not merely technical satisfaction with some of its phrasing.

Some sport safety problems lend themselves readily to identification and solution (e.g. poor field conditions, faulty equipment, excessive heat). Some safety problems remain problems because of questionable compliance with the legislated solutions (e.g. mouthpiece used).

Because of the great stresses and forces in athletics, even proper coaching techniques, officiating and adequate protective gear is no guarantee against injury. It is the responsibility of the athlete in conjunction with the athletic department to be aware of the potential for injury and take the steps necessary to decrease the risk of exposure.

I _____ have read and understand the above statement.
Print Name

SIGNED: _____

DATE: _____

July 1, 2007

Dear Parents/Guardians:

Please note all University of Massachusetts Lowell students must provide evidence of insurance. This is a pre-requisite for practice and competition. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the University of Massachusetts Lowell department of athletics. The enclosed Parent's Insurance Form and an insurance card, or photocopy of both sides must be on file before a student can participate.

The University of Massachusetts Lowell, for the benefit of its student-athletes, provides athletic accident insurance. This coverage is offered on an "excess" basis for student-athletes. Under the terms of the provision, this coverage is considered to be excess to all other valid and collectible medical insurance policies for athletic injuries only. All claims must be initially sent through the primary Health Insurance Coverage, most notable the family health insurance coverage through your place of employment under which the student-athlete is covered as an eligible dependent. **If being a full-time student is a requirement for maintaining coverage, be sure to file the appropriate documentation with your insurance carrier, otherwise coverage may be terminated. Documentation of student status may be obtained from the Office of Registrar. If covered by an HMO and your son/daughter will be out of your network area while attending school, it is recommended that you change their primary care physician to one in the Lowell area.** All eligible expenses not covered or outstanding co-payment amounts are then eligible for payment under the sports policy. UMass Lowell is responsible for bills for 15 months from the date of service.

If the student-athlete is not covered under your family Health Insurance Coverage, the sports accident policy will act as their payment insurance coverage. This policy covers medical expenses related to **Athletic Injuries Only**, sustained during the academic year, which resulted from their participation in a sanctioned/supervised intercollegiate sport activity. Illness coverage is provided through the student health insurance plan. Information regarding the school health insurance plan may be obtained through the Office of Student Services, the Student Health Service, or the Accounts Payable Offices.

In the event that your son/daughter is injured while participating in a covered sport activity, it is important for us to know about any medical coverage you may have in force to avoid delays in claim processing. On the reverse of this letter you will find the insurance filing procedures for injuries sustained, as a result of athletic participation at the University. Therefore, it is vital that all requested information be completed entirely. Both parents should sign and date the parent's information form at the bottom and return it to me. **Please include a copy, both front and back, of your son/daughter's health insurance card with the enclosed insurance form. They will not be allowed to participate without this information.**

If you have any questions or concerns, please feel free to contact me at (978) 934-2321

Sincerely,

Arthur Poitras, Med.,LATC
Head Athletic Trainer



ATHLETIC INSURANCE CLAIM FILING PROCEDURES

The University of Massachusetts Lowell provides “excess” insurance for all participating student-athletes. The insurance is in excess of all other valid and collectible insurance policies. All medical bills resulting from an athletic injury, sustained during participation in intercollegiate athletics, must first be filed with the student’s primary insurance carrier. If an athlete does not have any primary insurance, the athletic insurance becomes his/her primary insurance with respect to athletic injuries. ***All claims must be submitted to NACDA Insurance within 12 months of the date of injury. Failure to do so may result in non-payment of medical expenses.**

The University of Massachusetts Lowell is not responsible for medical bills denied for this reason.

CLAIMS PROCESS (if covered by primary insurance)

1. File all medical bills with primary insurance carrier.
 2. Upon completion of payments; bring itemized bills with corresponding explanation of benefits statements (EOB) or denial of benefits statements from primary insurance carrier to the athletic training office, to Artie Poitras. **(Insurance will not accept “balance forward” bills)**
 3. Fill out and sign school insurance claim form, NACDA Insurance Co.
 4. Athletic training office will submit the following to school Insurance:
 - a. Completed claim form, signed by student athlete.
 - b. Copy of parent’s insurance information form.
 - c. Itemized bills or HCFA with corresponding EOBs or Denials.
 - d. Operative report, if surgical claim.
 - e. Completed claim ledger.
 - f. If bills submitted are additional bills, a supplement claim ledger must be submitted.
 - g. Claims will be submitted to NACDA Insurance Co., Salt Lake City, UT.
 - h. Upon payment of bill the University will receive payment voucher/EOB from NACDA.
- **All claims must be submitted to NACDA Insurance within 12 months of the date of injury. Failure to do so may result in non-payment of medical expenses. The University of Massachusetts Lowell is not responsible for medical bills denied for this reason.**
 - **Failure to file bills in a timely manner may result in denial of payment by the insurance company. This will be at the insurance company’s discretion. The University of Massachusetts Lowell is not responsible for medical bills denied for this reason.**

CLAIMS PROCESS (if no other insurance)

1. The student-athlete will be billed directly for all medical services rendered.
 2. Bring itemized the athletic training office, immediately upon receipt to Artie Poitras. **(Insurance will not accept “balance forward” bills)**
 3. Fill out and sign school insurance claim form, NACDA Insurance Co.
 4. Athletic training office will submit the following to school insurance:
 - a. Completed claim form, signed by student athlete.
 - b. Copy of parent’s insurance information form.
 - c. Itemized bills or HCFA with corresponding EOBs or Denials.
 - d. Operative report, if surgical claim.
 - e. Completed claim ledger.
 - f. If bills submitted are additional bills, a supplement claim ledger must be submitted.
 - g. Claims will be submitted to NACDA Insurance Co., Salt Lake City, UT.
 - h. Upon payment of bill the University will receive payment voucher/EOB from NACDA.
- **All claims must be submitted to NACDA Insurance within 12 months of the date of injury. Failure to do so may result in non-payment of medical expenses. The University of Massachusetts Lowell is not responsible for medical bills denied for this reason.**
 - **Failure to file bills in a timely manner may result in denial of payment by the insurance company. This will be at the insurance company’s discretion. The University of Massachusetts Lowell is not responsible for medical bills denied for this reason**

PARENT'S INSURANCE FORM

Athlete's Name _____ SS# _____ Sport _____

Dear Parent:

Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports is "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, **DO NOT** HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE

1. Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED; please circle the individual listed as the insured on your primary/personal plan and complete all requested information. Please include a copy of your son/daughter's health insurance card (front and back).

Father/Guardian/Spouse/Self (circle one)

Name _____ Social Security # _____

Home Address _____

(Street)

(City, State & Zip Code)

Employer's Name _____

Employer's Address _____

(Street)

(City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of group Insurance Company _____ Group# _____ Policy# _____

Mailing Address for Claims _____ Telephone# _____

(Street)

(City, State & Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES _____ NO _____

Does your insurance company require?

A second opinion for surgery? YES _____ NO _____

Is your primary insurance an HMO? YES _____ NO _____

Pre-authorization for services? YES _____ NO _____

Is your primary insurance a PPO? YES _____ NO _____

MOTHER/GUARDIAN/SPOUSE/SELF (circle one)

Name _____ Social Security # _____

Home Address _____

(Street)

(City, State & Zip Code)

Employer's Name _____

Employer's Address _____

(Street)

(City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of group Insurance Company _____ Group# _____ Policy# _____

Mailing Address for Claims _____ Telephone# _____

(Street)

(City, State & Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES _____ NO _____

Does your insurance company require?

A second opinion for surgery? YES _____ NO _____

Is your primary insurance an HMO? YES _____ NO _____

Pre-authorization for services? YES _____ NO _____

Is your primary insurance a PPO? YES _____ NO _____

_____ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by _____

_____ My son/daughter is NOT covered under my group insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. A photo static copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____



REPORT OF HEALTH EVALUATION

TO THE EXAMINING PRACTICIONER: Please review the student's history and complete this form. Please comment on all positive answers. It will be used as medical clearance for athletic participation and as a background for providing health care, if this is necessary. This information is strictly used for the use of the athletic training and will not be released without student consent.

Last Name _____ First Name _____
 Sex: M F

BP _____ / _____ Pulse: _____ Height: _____ inches Weight _____ lbs.

Corrected Vision:
 Right 20/ _____ Left 20/ _____ Mantoux Test: Postive _____ Negative _____ Date _____

URINARLYSIS (if indicated)	Chest X-Ray Needed If Mantoux Results Are Positive
Sugar _____	Date _____ Results _____
Albumin _____	
Micro _____	
HEMAGLOBIN (if indicated)	
_____ gms/%	

Are these abnormalities of the following systems? If yes, describe fully. Use additional space on back if needed

	Yes	No	Description
1. Head, Ears, Throat			
2. Respiratory			
3. Gastrointestinal			
4. Hernia			
5. Eyes			
6. Genitourinary			
7. Musculoskeletal/Orthopedic			
8. Metabolic/Endocrine			
9. Neuropsychiatric			
10. Skin			

Is there loss or seriously impaired function of any paired organ? _____ Yes _____ No
 Have you any general comments? _____
 Recommendations for participation in intercollegiate athletics: Unlimited _____ Limited _____ Explain: _____
 Do you have any recommendations regarding the care of this student? Yes _____ No _____
 Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____
 Health Care Provider's Signature _____ Print Last Name _____
 Address _____
 Telephone # _____ Date _____

Return All Information To: Athletic Training Office, UMASS LOWELL, Costello Gym, 1 University Ave., Lowell, MA 01854

Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information
to the
National Collegiate Athletic Association

I, _____ hereby authorize UMASS LOWELL
Name of Student-Athlete Name of my Institution

and its physicians, athletic trainers, and health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the National Collegiate Athletic Association (NCAA) and its employees or agents.

I understand that my protected health information will be used only by NCAA's Injury Surveillance System (ISS) for the purpose of conducting the research on injuries resulting from training for or participation in athletics. The ISS is a longitudinal research database that provides the NCAA, NCAA sports rules committees, athletic conferences, researches and individual schools with summary (aggregate) injury and participation information that does not identify individual athletes or schools. The summary data provide the Association and other groups with an information resource upon which to base health and safety rules and policy and to examine the effectiveness of such efforts.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

I understand that while HIPAA regulations do not apply to the NCAA's use or disclosure of my injury/illness information, the NCAA is committed to protecting my privacy. I understand that the protected health information will be encoded before being transmitted from my institution to the NCAA and that neither the NCAA nor the ISS will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at the NCAA national office in Indianapolis, Indiana.

This authorization/consent expires in 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at my institution. I understand that a revocation effect on its request date and does not affect any action taken prior to that date.

Printed Name of Student-Athlete

Signature

Date

UMASS LOWELL ATHLETIC HEALTH CARE

Authorization for Use, Disclosure, and Release of Health Information

Student-Athlete

SSN

Date of Birth

Authorization For Use and/or Disclosure of Health Information:

I authorize the following persons (or class of persons) to make authorized use and/or disclosure of my protected health information: Team Physician(s), consulting physician, UML athletic trainers and assistants, physical therapists and assistants, UML Student Health Services, physicians, nurse practitioners, counselors, and support staff.

Release of Protected Health Information to:

I authorize the following persons (or class of persons) to receive my protected health information for playing status, insurance eligibility/benefits, legal investigations/action, and diagnosis or treatment purposes (please check):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Parents/Guardians | <input type="checkbox"/> Spouse | <input type="checkbox"/> Coaches | <input type="checkbox"/> UML Athletic Trainers |
| <input type="checkbox"/> UML Student Health Service | <input type="checkbox"/> Team Physician(s) | <input type="checkbox"/> UML Athletic Administrators | |
| <input type="checkbox"/> Third-parties for insurance and billing purposes | | <input type="checkbox"/> Insurance Companies | |
| <input type="checkbox"/> UML Athletic Media Relations | <input type="checkbox"/> Media (if requested) | | |

Information To Be Released (please check):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Entire Record (excluding special permission records) | <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Records | |
| <input type="checkbox"/> Treatment or Tests | <input type="checkbox"/> Hospital Records/Reports | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Consultations | <input type="checkbox"/> Immunizations |

In compliance with Massachusetts and Federal Statutes, which may require special permission to release otherwise privileged information; I **authorize the release of records pertaining to (please check):**

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Surgical Records |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Alcoholism |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization. However, redisclosure by school officials may be subject to student education privacy laws.

Your Rights with Respect to This Authorization:

Right to Inspect or Copy the Health Information to be Used or Disclosed- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Head Athletic Trainer.

Right to Receive Copy of this Authorization- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Refuse to Sign this Authorization- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment, in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw this Authorization- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Head Athletic Trainer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student-Athlete Signature

Date

Parent Signature (if under 18)

Date

Witness Signature

Witness (print name)