Framingham State University | Student Involvement & Leadership Development

Club Sport Participant Packet

2011-2012

Sports:
Cheerleading –for camp – DUE JULY 15, 2011
Men’s Rugby – DUE JULY 29, 2011
Women’s Rugby – DUE JULY 29, 2011

Dear Student:
Thank you for your interest in club sports at Framingham State! In order to provide a safe playing environment for all participants in registered club sports, individuals must be medically cleared to participate. Please read the instructions and review the submission check-list to understand the requirements for participation. All participants must complete a pre-concussive screening with our contracted trainer. Details will be made available for scheduling this screening.

Please note: In the event that a student is injured or seeks medical attention during the season, medical documentation may be required to return to play.

Instructions:
Read and complete **all pages** in the packet. Leave no sections or answers blank. For questions that do not apply, write “n/a”. Make sure to have all appropriate signatures. Do NOT staple the packet. Keep all pages in order.
Returning participant is defined as those individuals cleared to participate during the 2011-2012 academic year.
New participant is defined as any student who has previously NOT participated in a Framingham State club sport.

Framingham State University | Student Involvement & Leadership Development

CLUB SPORT PARTICIPANT PACKET CHECKLIST

☐ **Returner** ☐ **New** ☐ **Cleared Varsity Athlete** **(see SILD staff)**

Participant Name:______________________________ **Sport:**__________________________________

Phone:____ **Email:** _________________________________

CHECKLIST FOR SUBMISSION:

- ☐ Read and Review Health Insurance Coverage Memo
- ☐ Parent and Student Acknowledgement of Insurance Requirements
- ☐ Copy of front and back of insurance card
- ☐ Emergency Contact and Insurance Information Form
- ☐ Read and Review Privacy Practices
- ☐ Acknowledgement of Receipt of Privacy Practices
- ☐ Authorization for Disclosure of Health Information (Questions 1 – 10)
- ☐ Hold Harmless
- ☐ Availability of Services for Club Sport Participants/Equipment Notice
- ☐ Club Sport Participant Medical and Injury History Questionnaire*
- ☐ Informed Consent
- ☐ Medical Information Release Waiver
- ☐ **FOR NEW PARTICIPANTS ONLY:** A copy of the Health Form submitted to Health Services. For new participants, upon receipt of the completed packet, Student Involvement will obtain a copy of your Health Form (per your signed release waiver) and contact you and/or your physician of record as needed.

*In certain circumstances, additional medical documentation may be required for clearance to participate.

SILD STAFF ONLY:

Received by:________________________________ Time Stamp:___________________________

Cleared for Participation Signature and Date:____

Notes:____

____

Framingham State University | Student Involvement & Leadership Development

TO: Framingham State University Club Sport Participants and Guardians

FROM: Rachel Lucking, Director of Student Involvement

SUBJECT: Health Insurance Coverage for the 2011-12 Academic Year

Registered Framingham State University club sports have insurance coverage through a policy carried by the Athletic Department. Please note that all Framingham State University Student-Athletes/Club Sport Participants must provide evidence of health insurance that includes coverage for athletically-related injuries. 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 Framingham State University Office of Student Involvement. The enclosed *Acknowledgement of Insurance Requirements* forms and a current insurance card, or photocopy of both sides of a current insurance card, must be on file before a student can participate. Insurance coverage must have a limit of at least $90,000 and cover athletically-related injuries. If your insurance does not meet these requirements, Framingham State University will review the individual circumstances to determine if the insurance meets the insurance coverage requirement. Framingham State University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in club sports at Framingham State University. If you have questions regarding the terms of your coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions in your policy regarding athletically-related injuries.

The NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a $90,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Framingham State University. It is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's website at www.ncaa.org. If you have any questions with regard to this insurance requirement or how to completely and correctly fill out the forms, please contact Student Involvement at 508-626-4615.

YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD, THE COMPLETED EMERGENCY CONTACT FORM AND THE INSURANCE INFORMATION FORM.

Parent Acknowledgement of Insurance Requirements

This page must be signed if health insurance is provided to the student-athlete by the parent or legal guardian regardless of the age of the student-athlete.

I, ________________________ (parent name, please print) , as the parent/guardian or legal representative, attest that ________________________ (club sport participant name) has insurance coverage under a current, in-force insurance policy for injuries that occur while he/she is participating in intercollegiate athletics. I understand and agree that Framingham State University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating intercollegiate athletic at Framingham State University.

____ _____________

(Parent signature) (date)

YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD, THE COMPLETED EMERGENCY CONTACT FORM AND THE INSURANCE INFORMATION FORM.

Student-Athlete Acknowledgement of Insurance Requirements

I, ________________________ (club sport participant name), attest that I have insurance coverage under a current, in-force insurance policy for injuries that occur during my participation in intercollegiate athletics. I understand and agree that Framingham State University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Framingham State University.

____ _____________

(Club Sport Participant signature) (date)

FRAMINGHAM STATE UNIVERSITY
EMERGENCY CONTACT AND INSURANCE INFORMATION FORM

Name ____ Sport __________________________________

Date of birth ___________________________________

*Acknowledgement of Insurance Requirements must be read and understood and this form completed **PRIOR** to the student athlete participating in practice and competitions.*

Parent/Guardian Name ____

Address ____

____

Home Phone # _________________________________ Work Phone # __________________________

Policy Holder Name ____

Relationship to Student Athlete ____

Address ______________________________________ Home Phone ___________________________

Work Phone ___________________________________

Insurance Company ____

Insurance Co. Address ____

Group# ______________________________________ ID# __________________________________

Effective Date of Policy _________________________ Expiration Date ________________________

Primary Physician ______________________________ Office Phone # _________________________

Policy Limit _______________ Policy Deductible __________ Policy Co-Pay ___________________

Does the policy cover athletically-related injuries? _____________________

I have read and agree to comply with the provisions of the Acknowledgement of Insurance Requirements.

_________________________________ ____

Parent/Guardian Signature and Date Club Sport Participant Signature and Date

Please include a photocopy (front and back) of your current health insurance card.

Framingham State University | Student Involvement & Leadership Development

NOTICE OF PRIVACY PRACTICES - HIPPA

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

The following is the Notice of Privacy Practices of every health care component at Framingham State University, as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. For the purpose of this notice, the health care components shall be referred to collectively as “the Health Center.” HIPAA requires the Health Center to maintain the privacy of your personal health information and to provide you with notice of the Health Center’s legal duties and privacy policies with respect to your personal health information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The Health Center understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Health Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Health Center, whether made by Health Center personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the use and disclosure of your medical information created in the doctor’s office or clinic.

This notice will tell you about the ways in which the Health Center may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

YOUR PERSONAL HEALTH INFORMATION

The Health Center collects personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information. The Health Center must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information will be available for release to you, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

HOW WE MAY USE OR DISCLOSURE YOUR PERSONAL HEALTH INFORMATION

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we may only use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

USES AND DISCLOSURES WITHOUT YOUR EXPRESS PERMISSION

- **TREATMENT:** For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

- **PAYMENT:** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help you receive payment for your medical bills.
- **HEALTH CARE OPERATIONS:** We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of

your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

 APPOINTMENT REMINDERS: Unless you object, we may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Health Center.

 TREATMENT ALTERNATIVES: Unless you object, we may use and disclose medical information to tell you about or recommend possible treatment options or new services.

 HEALTH-RELATED BENEFITS AND SERVICES: Unless you object, we may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

 TO THOSE INVOLVED WITH YOUR CARE OR PAYMENT FOR YOUR CARE: If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency.

 AS REQUIRED OR PERMITTED BY LAW: Sometimes we must report some of your health information to state or federal legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

 FOR PUBLIC HEALTH ACTIVITIES: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

 FOR HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefits programs.

 FOR ACTIVITIES RELATED TO DEATH: We may disclose your health information to coroners, medical examiners or funeral directors so they can carry out their duties related to your death, such as identifying the body, determining the cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

 FOR ORGAN, EYE OR TISSUE DONATION: We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.

 FOR RESEARCH: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

 TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your health or safety or that of the public.

 FOR MILITARY, NATIONAL SECURITY, OR INCARCERATION/LAW ENFORCEMENT CUSTODY: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties.

 FOR WORKERS' COMPENSATION: We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs.

 LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, subpoena or discovery request only if we have first given you notice of the order, subpoena or discovery request and provide an opportunity to quash it.

OTHER USES AND DISCLOSURES

Uses and disclosures for purposes other than described above require your express authorization. For example, the Health Center must obtain your authorization before disclosing your medical information to a life insurer or to an employer, except under special circumstances such as when a disclosure to the employer is required by law. You have the right to revoke an authorization at any time, except to the extent that we have already relied on it in making an authorized use or disclosure. Your revocation of an authorization must be in writing. The Health Center hopes that if you choose to revoke an authorization, you will help us comply with your wishes by identifying the authorization you are choosing to revoke. Ways of telling us which authorization you are revoking might include indicating who you authorized to receive information or the approximate timeframe in which you signed the authorization.

DISCLOSURES TO BUSINESS ASSOCIATES

The Health Center contracts with outside companies that perform business services for us, such as billing companies, management consultants, quality assurance reviewers, accountants and attorneys. In certain circumstances, we may need to share your medical information with a business associate so it can perform a service on your behalf. The Health Center will limit the disclosure of your information to a business associate to the amount of information that is the minimum necessary for the company to perform services for the Health Center. In addition, we will have a written contract in place with the business associate requiring it to protect the privacy of your medical information.

YOUR HEALTH INFORMATION RIGHTS

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact:

Melinda Stoops, Dean of Students
100 State Street,
Framingham, MA 01701
(508) 626-4596

Specifically, you have the right to:

 INSPECT AND COPY YOUR HEALTH INFORMATION: With a few exceptions, you have the right to inspect and obtain a copy of your health information. Usually, this includes medical and billing records, but does not include psychotherapy notes or information gathered for judicial proceedings. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to:

Melinda Stoops, Dean of Students
100 State Street,
Framingham, MA 01701
(508) 626-4596

We may deny your request in very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Health Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

 REQUEST TO AMEND YOUR HEALTH INFORMATION: If you believe your health information is incorrect, you may ask us to correct the information for as long as it is kept by the Health Center. To request an amendment, you must make your request in writing to:

Melinda Stoops, Dean of Students
100 State Street,
Framingham, MA 01701
(508) 626-4596

You must also give a reason as to why your health information should be changed. We may deny your request for an amendment if it is not in writing or if does not include a reason to support the request. We may also deny your request if we did not create the health information that you believe is incorrect; if we disagree with you and believe your health information is correct; if the information is not part of the information which you would be permitted to inspect or copy (*i.e.*, psychotherapy notes); or, if the information is not kept by or for the Health Center.

 REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES: You have the right to ask for restrictions on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to limit the health information provided to family or friends involved in your care or the payment of medical bills. For example, you could ask that we not use or disclose information about a particular procedure you underwent. You may also want to limit the health information provided to authorities involved with disaster relief efforts. To request a restriction, you must make your request in writing to:

Melinda Stoops, Dean of Students
100 State Street,
Framingham, MA 01701
(508) 626-4596

However, we are not required to agree in all circumstances to your requested restriction. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

 AS APPLICABLE, RECEIVE CONFIDENTIAL COMMUNICATION OF HEALTH INFORMATION: You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive

information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

 RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION: In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2001. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year.

We may deny your request if the disclosures made by the Health Center pertain only to:
(a) treatment payment and health care operations;
(b) individuals who request their own health information;
(c) include in the facility's directory or to those involved in the patient's care;
(d) comply with national security or intelligence;
(e) for correctional institutions or law enforcement officials; or
(f) have only disclosures made prior to April 14, 2001.

OBTAIN A PAPER COPY OF THIS NOTICE: Upon your request, you may at any time receive a paper copy of this notice from any Health Center staff member, even if you earlier agreed to receive this notice electronically. This notice is also fully accessible at
http://www.framingham.edu/healthservices/
 COMPLAIN: If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. To file a complaint with either entity, please contact the privacy officer listed below, who will provide you with the necessary assistance and paperwork.

Melinda Stoops, Dean of Students
100 State Street,
Framingham, MA 01701
(508) 626-4596

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, we will post the revised notice (with the effective date marked clearly in the top right hand corner of the first page) at our service delivery sites and make the revised notice available to you at your

request. We will also post the revised notice at http://www.framingham.edu/healthservices/

IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR PRIVACY RIGHTS OR THE INFORMATION IN THIS NOTICE, PLEASE CONTACT MELINDA STOOPS, DEAN OF STUDENTS , AT (508) 626-4596, FOR FURTHER INFORMATION AND RECEIPT OF COMPLAINTS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and read the Framingham State University NOTICE OF PRIVACY PRACTICES from the Framingham State University, Office of Student Involvement. I understand how I my medical information may be use and disclosed, and how I may gain access to this information. I am aware that I can obtain additional copies of this Notice of Privacy from the Framingham State Office of Student Involvement or from the Framingham State University Web site at http://www.framingham.edu/healthservices/.

Club Sport Participant's Date of Birth: ____________________________________

Club Sport Participant's Name (Please print): ______________________________

Club Sport Participant's Signature: ___________________________Date: ________

*Parent/Guardian's Signature: ______________________________Date: ________

*Required only if student athlete is under 18 years of age

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This Authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996, and the regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA"). This Authorization affects your rights regarding the privacy of your personal healthcare information. Please read it carefully before signing. The College will not base treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

This Authorization shall expire on the earlier occurrence of:
(a) revocation of the Authorization;
(b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this Authorization is not in compliance with requirements of HIPAA;
(c) complete satisfaction of the purposes for which this Authorization was originally obtained, to be determined at the reasonable discretion of the College or,
(d) six (6) years from the date this Authorization was executed.

Framingham State University | Student Involvement & Leadership Development

By signing this Authorization, you acknowledge and agree that any information used or disclosed pursuant to this Authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

1.______________________________ ______________________
NAME OF PATIENT Date of Birth

______________________________ ______________________
Street Address City, State, Zip

2. AUTHORIZES:
Framingham State University
Health Services
100 State Street, PO Box 9101
Framingham MA 01701

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
Framingham State University
Student Involvement
100 State Street, PO Box 9101
Framingham MA 01701

4. INFORMATION TO BE RELEASED

_X_ Medical History, Examination, Reports
_X_ Surgical Reports
_X_ Treatment or Tests
_X_ Hospital Records Including Reports
_X_ Immunizations
_X_ Allergy Records
_X_ X-ray Reports
_X_ Prescriptions
_X_ Laboratory Reports
___ Consultations
___ Entire Record
Other (Specify):__________

In compliance with Massachusetts laws, which require special permission to release otherwise privileged information, please release records pertaining to:
___ Mental Health ___ Developmental Disabilities ___ Alcoholism
___ Drug Abuse ___ HIV (AIDS) ___ Sexually Transmitted Diseases
___ Other (Specify):____

FOR THE FOLLOWING DATE(S):______________________________________

5. PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

_X_ Further Medical Care   _X_ Personal

_X_ Insurance Eligibility/Benefits   _X_ Changing Physicians

___ Legal Investigation or Action   ___ Other (Specify):______________________

6. 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 the 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.

7. 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 Melinda Stoops, Dean of Students, at (508)626-4596.

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 who I am authorizing to use and/or disclose my information may not base 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: Melinda Stoops, Dean of Students at (508)626-4596. 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.

8. Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information

I understand that the following person(s) and/or organization(s):____________________________

___ will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

___ will be receiving payment, as described below, in connection with the use or disclosure of my health information (describe amount or nature of any direct or indirect payment):____

9. Expiration Date: This authorization is good until the following date(s) **August 1, 2012** or event(s) (specify event). 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.

10.________________________________ ____________________

Signature of Patient: Date:

(If signed by person other than patient, state relationship and authority to do so.)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

(Optional) Legal Authority:

☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased

☐ Power of Attorney for Healthcare ☐ Authorized Legal Representative

HOLD HARMLESS AGREEMENT

In consideration of the sponsorship of the Framingham State University ____________________ ______ by the Student Government Association of Framingham State University; And in further consideration of my participation in the **2011-2012 season**________, I hereby release and hold harmless Framingham State University, its directors, regents, agents, employees and the Framingham State University Student Government Association for any personal injuries as a result of my participation in the activities of the Framingham State University _______________ ___________________

In addition, I understand that if I am a Student of Framingham State University I have been given the opportunity to purchase group health insurance.

_____________________________________ *Student Signature and Date*

If student is under eighteen years of age, a parent or legal guardian must sign below.

As a parent/legal guardian of ____,

I hereby sign this Hold Harmless Agreement on behalf of my son/daughter/ward.

____

Parent/Legal Guardian and Date

AVAILABILITY OF SERVICES for CLUB SPORT PARTICIPANTS

EQUIPMENT NOTICE

By signing below I acknowledge that as a participant of Framingham State University club sports, medical services outside of those provided by Health Services and the contracted athletic trainer for club sports are not available to me. Any injuries sustained during the season will be treated independently of the College through my own means, and will require clearance to return to participation. On a limited basis, contingent upon funding, a contracted athletic trainer is available on campus for club sport related injuries and treatment. Additionally, registered club sports are funded directly by the Student Government Association. Therefore, equipment required for participation is based upon the registered club's funding request on an annual basis. Club Sport participants may be responsible for purchasing, managing and caring for his/her own equipment necessary to participate, as dictated by league rules.

________________________________ __________________________

Participant Signature Date

________________________________ __________________________

If under 18, parent/guardian signature Date

Framingham State University | Student Involvement & Leadership Development

FRAMINGHAM STATE UNIVERSITY
CLUB SPORT PARTICIPANT MEDICAL AND INJURY HISTORY QUESTIONNAIRE
Please complete all sections, leaving no lines blank. Use "n/a" if necessary. Further documentation may be requested.

Name: ______________________________ Date: ____________________

FSU ID #: ___________________________ Date of Birth: _______________

Home Address: ____

Local Address/Dorm: _______________________________________

Home Phone: _________________________ Cell Phone: ________________

Email Address: ____

Sport(s): ____

Please list on the lines below all injuries and illnesses, including the date(s), specific description, medical professional's diagnosis (if any), and any treatment received. **Returners:** please list injuries sustained during the previous academic year only.
<EXAMPLE: fractured right ankle, 12/2009, physical therapy 2x a week, returned to play 4/2010. > ____

____

____

____

____

Please list all allergies and all allergies/sensitivities to medications:

____

____

____

____

Please list all medications that you are presently taking and why: ______________________

____

Have you ever been diagnosed with either of the following:
Asthma yes_____ no_____ Inhaler/Medication? ______________

PLEASE READ AND SIGN BELOW

If you have any questions, do not sign until you fully understand the answers.

I certify that the preceding questionnaire has been filled out to the best of my knowledge. I understand that I will be held liable for any omissions and falsehoods. I also understand that the contracted athletic trainers, Health Services and Student Involvement staff have the right to ask for more information about any injury or condition that I have listed above. Furthermore, I realize that any of these injuries/illnesses may inhibit me from participating until I have been cleared to return to club sports from the appropriate health care provider, as deemed by the Framingham State Student Involvement staff.

______________________________ ______________

Signature Date

______________________________ ______________

Parent/Guardian Signature (If athlete is under age 18) Date

Framingham State University | Student Involvement & Leadership Development

Name: ______________________________________ Date: ____________________

Sport(s): ____________________________________

INFORMED CONSENT

I understand that injuries can, and do, occur in athletic practice and competition. Such injuries can result in, but are not limited to, temporary or permanent disability, paralysis, or death to my opponent or myself. These injuries may occur with or without any intent to violate any rules of the specific event. All such injuries cannot be prevented. Improper or unauthorized alteration of any protective equipment is in violation of league rules and can contribute to injuries. By signing this form I understand the risks that are involved in participating in club sports at Framingham State University as well as ones that may cause harm due to illegal equipment.

______________________________________ ____________________

Signature Date

______________________________________ ____________________

Parent/ Guardian Signature (If athlete is under age 18) Date

MEDICAL INFORMATION RELEASE WAIVER

I, ____,age ______________ while participating in Framingham State University intercollegiate club sports, give my consent for contracted athletic training staff and the Framingham State University Health Center to provide me with appropriate health care. I permit any health care provider I might see due to an injury or illness to share any and all related information with the team physician, athletic training staff, health center, coaches, and my parents/guardians as appropriate. This information is only to be used in order that they are properly informed about my condition and capabilities while I am participating as a club sport participant at Framingham State University. A photostatic copy of this authorization shall be considered, as valid and effective as the original, for the duration of my intercollegiate club sport career at Framingham State University.

______________________________________ ____________________

Signature Date

______________________________________ ____________________

Parent/Guardian (If athlete is under age 18) Date