STUDENT-ATHLETE ACKNOWLEDGEMENT AND CONSENT

_______________________ (Student-Athlete) and _________________________ (Student Athlete’s parents or legal guardian if Student-Athlete is under age eighteen) understand and acknowledge the following:

PART I: ACKNOWLEDGMENT OF RISK

I am aware that there is a risk of injury involved in Student-Athlete’s participation in intercollegiate athletics at Stevens Institute of Technology (“Stevens” or the “University”). I understand that the risks include permanent injuries, including but not limited to: musculoskeletal injuries; head, neck, spinal cord and brain injury; paralysis; and death. I understand that such risks exist during all aspects of athletic participation, including but not limited to practices, training sessions, conditioning sessions, and competitions.

In addition to the risks listed above, which exist for all Stevens’ sports, the following are risks increased by the nature of certain sports:

- For aquatic sports, I understand that specific risks include cramping, intake of water, and drowning.
- For contact sports (e.g., wrestling, basketball, lacrosse, soccer, baseball, softball, field hockey), I understand that the risk of injury is increased by the nature of the contact and collision that exists in the sport.
- For sports involving objects traveling at a high rate of speed (e.g., baseball, softball, tennis, volleyball, golf, field hockey, lacrosse, track and field), I understand that the impact of such objects against the body could produce injury.
- For the sport of fencing, I understand that the use of blades for thrusting and slashing movements could cause injury and also understand that blades may be subject to breakage increasing the risk of injury.
- For cross country, track and field, and equestrian sports, I understand that traversing uneven terrain or obstacles may cause a fall or injury.
- For equestrian sports, I understand that risk of injury is increased by the potential for falls or erratic movement by the horse.

I understand and acknowledge that protective equipment must be worn properly at all times during practices and competitions and that, if Student-Athlete has a question or is concerned about the proper use, fit, or condition of any equipment, Student-Athlete is responsible for immediately addressing such concerns with the coach or an athletic director.

I understand any health-related restrictions on Student Athlete’s activities and will follow them while participating in Stevens’ athletic programs.
I acknowledge that Student-Athlete has responsibility for preventing potential injuries, complying with safety rules and guidelines, ceasing activities and seeking medical treatment if a potential injury occurs, complying with medical recommendations and rehabilitation programs, and reporting any changes in health status to the Head Athletic Trainer.

I assume responsibility for the risks of Student-Athlete participating in intercollegiate athletics at Stevens.

PART II: CONSENT TO TREAT

I hereby give my consent for any diagnostic procedures or therapeutic treatment for Student-Athlete by Stevens-affiliated physicians, nurses, healthcare professionals, athletic trainers, sports medicine staff, or emergency responders, as well as physicians and healthcare professionals referred by the University, that they deem reasonably necessary to Student-Athlete’s health, safety, and well-being.

In the event of a serious illness or injury, I understand that an attempt will be made to notify Student-Athlete’s parent/guardian or other emergency contact person. If a medical provider is unable to communicate with Student-Athlete, the treatment deemed necessary for Student-Athlete’s best interest may be provided. I consent to surgical and other invasive care in the event that Student-Athlete suffers an injury or illness that is reasonably deemed to require such care. I consent to hospitalization at an accredited hospital or treatment at another medical facility in the event that Student-Athlete suffers an injury or illness that is reasonably deemed to require such care. I hereby grant permission for transportation to and treatment at such local hospital or other healthcare facility.

I hereby also give my consent for routine or non-emergency health examinations, preventative care, diagnostic procedures, therapeutic treatment, and rehabilitative care by Stevens-affiliated physicians, nurses, healthcare professionals, athletic trainers, and sports medicine staff, as well as physicians and healthcare professionals referred by the University.

PART III: AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Student-Athlete’s health information is protected by federal regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) and may not be disclosed without authorization.

I hereby authorize Stevens-affiliated physicians, nurses, healthcare professionals, athletic trainers, sports medicine staff, athletic administrators, coaches of the Student-Athlete, as well as physicians and medical staff representing or referred by the University, to release protected health information concerning Student-Athlete’s past, present or future participation in intercollegiate athletics at Stevens to the following people:
- Each other (i.e., physicians, nurses, healthcare professionals, athletic trainers, sports medicine staff, athletic administrators, coaches of the Student-Athlete, as well as physicians and medical staff representing or referred by the University);
- Other health care providers;
- Hospitals and/or medical clinics and laboratories involved in Student-Athlete’s diagnosis or treatment;
- Medical insurance coordinators and carriers;
- Academic counselors (limited to information regarding illness or injuries and fitness to participate in coursework);
- University administrators;
- NCAA injury surveillance program;
- Sports information staff and members of the media (limited to information regarding illness or injuries and fitness to participate in intercollegiate athletics).

I also authorize any health care provider or facility that has attended to Student-Athlete to disclose any and all protected health information to the following people upon request: Stevens’ physicians, nurses, healthcare professionals, athletic trainers, sports medicine staff, athletic administrators, coaches of the Student-Athlete, as well as physicians and medical staff representing or referred by the University.

The protected health information referenced in this Part III may include but is not limited to Student-Athlete’s medical condition, history of illness or injuries, consultation, diagnosis or diagnostic tests, prognosis, treatment, recommendations, and ability to participate in athletic activities, including copies of all hospital and other medical records.

I understand that if the recipient of the protected health information is not a health care provider or part of a health plan covered by federal or state privacy regulations, Student-Athlete’s health information may be re-disclosed by this recipient and may no longer be protected by HIPPA.

If the requested portion of the record contains information pertaining to the treatment for physical or psychological abuse, mental illness, drug or alcohol abuse or treatment, or contains HIV-related information, you must specifically authorize the release of such information by initialing the following:

- I understand that if Student-Athlete’s medical record contains information concerning treatment for physical, psychological, or emotional abuse such information will be released pursuant to this consent. _______(initial)

- I understand that if Student-Athlete’s medical record contains information concerning mental illness such information will be released pursuant to this consent. _______(initial)

- I understand that if Student-Athlete’s medical record contains information concerning abuse of alcohol or drugs or treatment for such abuse, such information will be released pursuant to this consent. _______(initial)
- I understand that if Student-Athlete’s medical record contains confidential HIV-related information, such information will be released pursuant to this consent. Confidential HIV-related information is any information indicating that a person had an HIV-related test, or has HIV-infection, HIV-related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. ______(initial)

I understand that I may revoke this authorization for disclosure of protected health information at any time by written notification to the Head Athletic Trainer and such revocation will be effective at the time of receipt. I understand that such revocation will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. This authorization for disclosure of protected health information expires four hundred fifty (450) days from the date it is signed.

SIGNATURES:

I have had the opportunity to ask questions regarding this document and all of my questions have been answered to my satisfaction. Having understood each of the above three Parts, I freely sign with respect to each and every one of the three Parts:

Date: _______________________

Student-Athlete Signature: ____________________________

Printed Name: ____________________________

Date of Birth: ____________________________

Sport(s): ____________________________

Required if Student-Athlete is under age eighteen:

Parent/Guardian Signature: ____________________________

Printed Name: ____________________________

PLEASE RETURN ALL PAGES OF THE SIGNED DOCUMENT

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS VALID AND EFFECTIVE AS THE ORIGINAL