



m. Have you had or do you now have:

	YES	NO
Hernia	( )	( )
Kidney problems	( )	( )
Loss of a kidney	( )	( )
Loss of function or absence of a testicle (men only)	( )	( )
Stomach or peptic ulcer	( )	( )
Migraine headaches	( )	( )

n. Have you had or do you now have:

	YES	NO
Weight problems	( )	( )
Disordered eating	( )	( )
Dieting problems	( )	( )

Explain all "yes" answers. \_\_\_\_\_

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r. Have you had or do you now have:

	YES	NO
High blood pressure	( )	( )
Heart trouble or murmur	( )	( )
Persistent cough	( )	( )
Tendency to faint	( )	( )
Dizziness/faintness with exercise	( )	( )
Chest pain/discomfort with exercise	( )	( )

s. Have you had or do you now have:

	YES	NO
Recurrent rash	( )	( )
Fungus infection	( )	( )
Athlete's foot	( )	( )
Recurrent boils (skin infections)	( )	( )

Explain all "yes" answers. \_\_\_\_\_

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o. Have you had or do you now have:

	YES	NO
Hay fever	( )	( )
Exercised induced asthma	( )	( )
Asthma	( )	( )
Allergies to bites/stings	( )	( )
Do you need /use an Epi pen	( )	( )
Do you need /use an inhaler	( )	( )

p. Are you allergic to:

	YES	NO
Penicillin	( )	( )
Other medications	( )	( )
Any food	( )	( )
Other substances	( )	( )

Explain all "yes" answers. \_\_\_\_\_

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t. Have you ever had an electrocardiogram (EKG)? ( ) ( )

Explain. \_\_\_\_\_

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u. Do you wish to discuss an emotional problem with the doctor? ( ) ( )

v. Do you have a loss of a paired organ ( ) ( )

Explain. \_\_\_\_\_

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w. Have you ever been told to give up sports because of a health problem? ( ) ( )

Explain. \_\_\_\_\_

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q. Do you:

	YES	NO
Smoke	( )	( )
Take any medication regularly	( )	( )
Take any medication for emergency use	( )	( )

if YES, name of medication \_\_\_\_\_

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x. Do you use any special equipment (pads, braces, neck rolls, mouth guards, eye guards, etc)? ( ) ( )

Explain. \_\_\_\_\_

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y. Do you take any vitamins? Please List.

\_\_\_\_\_

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z. Do you take any supplements or herbs? Please list.

\_\_\_\_\_

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<b>WOMEN ATHLETES ONLY</b>					
Age at the onset of menstruation _____					
Have you ever had or do you now have:					
Amenorrhea (loss of menses)	yes	no	Dysmenorrhea (very painful menses, cramping)	yes	no
Oligomenorrhea (irregular menses)	yes	no	Endometriosis	yes	no
Do you currently use:					
Birth control pills	yes	no	Implanted uterine device/Depo-Provera	yes	no
Name/Brand of Birth control Pills _____					
Date of last menstrual period _____					
How Many Periods have you had in the last year? _____					
Date of last women's health exam _____					

I hereby state that to the best of my knowledge my answers to the above questions are complete and correct.

Signature \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

FOR THE FOLLOWING QUESTIONS, BE AS SPECIFIC AS POSSIBLE. DETAIL WHAT HAPPENED, WHEN IT HAPPENED, RIGHT OR LEFT, CASTED OR IMMOBILIZED, HOW LONG, ANY REHABILITATION, DOCTOR'S NAME AND CITY.

- Yes No 1. Have you had a finger, hand or wrist injury? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 2. Have you had a sprain, dislocation, fracture, or other injury to the forearm or elbow? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 3. Have you had a shoulder dislocation, separation, or other injury? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 4. Have you had an injury to your hip or pelvis area? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 5. Have you had knee arthroscopy or surgery? What other injuries have you had to your knees? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 6. Have you experienced a severe ankle sprain or injury to your foot or ankle? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 7. Have you had an injury to your upper or lower back? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 8. Do you experience pain in your back? Seldom \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_
- Yes No 9. Do you wear orthotics in your shoes? Why? Who prescribed them and when? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 10. Have you had any problems with muscles strains or pulls? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 11. Have you had any other significant injuries? \_\_\_\_\_  
\_\_\_\_\_
- Yes No 12. Have you had any other operations in the past five years? Explain in detail: \_\_\_\_\_  
\_\_\_\_\_
- Yes No 13. Are you currently on prescribed medication? Indicate drug, doctor, why it was prescribed and dosage. \_\_\_\_\_  
\_\_\_\_\_
- Yes No 14. Are you currently under the care of a physician? Give length of time and reason for care. \_\_\_\_\_  
\_\_\_\_\_

I HAVE READ AND ANSWERED ALL OF THE ABOVE QUESTIONS COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ATC Reviewed \_\_\_\_\_



# Pre-participation Physical Evaluation

## La Sierra University

### PHYSICAL EXAMINATION

Name _____	Date of birth _____
Height _____ Weight _____ %Body fat (optional) _____	Pulse _____ BP ____/____ (____/____, ____/____)
Vision: R 20/____ L 20/____ Corrected: Y N Pupils: Equal ____ Unequal ____ PPD Date: given _____ read: _____ result: _____	

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

### CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_ MD or DO \_\_\_\_\_

### Immunizations:

Hepatitis B Date of Vaccination

Measles- Mumps Rubella 1<sup>st</sup> Dose \_\_\_\_\_ 2<sup>nd</sup> Dose \_\_\_\_\_ 3<sup>rd</sup> Dose \_\_\_\_\_

Tetanus-Diphtheria-Pertussis (within 10 years) \_\_\_\_\_

Meningococcal Vaccination (Recommended) \_\_\_\_\_

DATE: June 1, 2011  
TO: LSU Student-Athletes and Parents  
FROM: Brian Murphy, MSS, ATC  
Head Athletic Trainer  
SUBJECT: LSU Intercollegiate Athletics Requirements

## ATHLETIC CLEARANCE POLICY

In order to try out or participate in the Athletics program at La Sierra University, every student must complete the required athletic training forms that are available online. Please refer to the scenarios below to clarify what is needed for each individual. All forms and documentation must be turned into the athletic trainer's office prior to the student being allowed to try out or practice. Please note: A fall quarter student-athlete who arrives for preseason without paperwork completed and submitted will not be allowed to try out or practice.

Submit all required paperwork by Aug. 1, 2011 to:  
Athletic Trainer - Medical Forms  
La Sierra University  
4500 Riverwalk Pkwy  
Riverside CA 92515

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### New Students

#### Scenario 1

New students with a benign medical history - no previous significant injuries or illnesses requiring treatment or the athlete to sit out.

1. Go online and complete all required insurance forms at:  
<http://www.lasierra.edu/departments/athletics/> .

Submit all required form:

- ❖ Medical History Questionnaire completed and signed by the student and parent/guardian if student is a minor.
- ❖ Physical Examination Form signed by the treating physician. The physician must be a board certified Doctor (MD) or Osteopathic Doctor (DO). (Women only must submit a current hemoglobin value).
- ❖ Emergency Contact and Insurance Information form.
- ❖ Acknowledgement of Insurance Requirements form.
- ❖ Insurance card--photocopy front and back of your insurance card.
- ❖ Athletic Consent Form signed by the student and parent/guardian if athlete is a minor.
- ❖ Parental Consent for medical treatment for a Minor signed by the student and parents, if student is under 18.

- ❖ Shared Responsibility for Risk form signed by student and parents.
- ❖ Student-Athlete Nutritional Supplement Disclosure and Review form signed by the student and parent/guardian if student is a minor.
- ❖ Pre-Participation Information form administered by the athletic training staff at the time of medical clearance.

#### Scenario 2

New students with a significant previous injury or illness that required treatment. This includes incompletely healed injuries.

- Complete and submit all forms as described in Scenario 1.
- ❖ Submit all documentation for injuries, surgeries, etc. that required medical care. Documentation includes the following: operative notes, copies of x-rays, MRI's, bone scans, doctor's office visit notes and radiology reports.
  - ❖ Submit a letter of release for full, unrestricted participation in the specific sport (s) that the student is trying out for at the University. This letter must be written by the treating physician or surgeon.

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### Returning Students

#### Scenario 1

Returning student with no significant injury or illness requiring medical treatment during the off-season.

1. Go online and complete all insurance forms at:  
<http://www.lasierra.edu/departments/athletics/>

Submit all required forms:

- ❖ Emergency Contact and Insurance Information form.
- ❖ Acknowledgement of Insurance Requirements form.
- ❖ Insurance card--photocopy front and back of your insurance card.
- ❖ Athletic Consent form signed by the athlete.
- ❖ Nutritional Supplement Disclosure and Review form signed by the athlete.
- ❖ Shared Responsibility for Risk form signed by the student administered by the athletic training staff.

- ❖ Pre-Participation Information form administered by the athletic training staff.

#### Scenario 2

Returning student with an injury or illness occurring over the summer requiring medical treatment. This includes any incompletely healed injuries.

- Complete and submit all forms described in Scenario 1.
- ❖ Submit all documentation for injuries, surgeries, etc. that required medical care. Documentation includes the following: operative notes, copies of x-rays, MRI's, bone scans, doctor's office visit notes and radiology reports.
  - ❖ Submit a letter of release for full, unrestricted participation in the specific sport (s) that the student is trying out for at La Sierra University. This letter must be written by the treating physician or surgeon.

POLICY REGARDING  
INSURANCE COVERAGE

The primary responsibility for insurance coverage for injuries incurred while participating in intercollegiate athletics rests with the individual student-athlete and his or her family.

What is the insurance requirement at La Sierra University?

Every student must have medical insurance that is comparable to La Sierra University Intercollegiate Sports, Health and Accident insurance coverage plan. Annually, students and their parents must go on-line complete and submit proof of primary insurance coverage.

What is the Department of Athletics insurance requirement for participation on an intercollegiate athletic sports team, and how can I satisfy this requirement?

Every student-athlete must have medical insurance that is comparable to La Sierra University Intercollegiate Sports, Health and Accident insurance coverage. The insurance requirement for participation in intercollegiate athletics may be satisfied by:

1) Carry insurance coverage that is comparable to the University's Intercollegiate Sports, Health and Accident insurance coverage plan.

What is La Sierra University Department of Athletics insurance agreement?

All full-time student-athletes of La Sierra University who participate in covered sports. Covered sports played in NAIA and there is no football coverage. Covered Sports are: basketball, volleyball, soccer, softball and baseball. In order to assure that student-athletes seek prompt care for any injuries sustained while participating on an intercollegiate athletic team, the Department of Athletics will assist the athlete in obtaining emergency treatment and by assisting in the completion of the AIG medical claim form. It is the responsibility of the athlete to submit all medical billing invoices to the AIG insurance company.

Does this reimbursement policy apply to illnesses or medical conditions that may affect athletic participation?

The \$75,000 maximum medical benefit is only for University athletic injuries. Many medical conditions such as asthma, diabetes, sickle-cell anemia, allergies, eating disorders, etc. and illnesses such as flu and strep throat may affect a student's ability to continue practicing and competing. Tests, treatments, prescriptions, etc. for medical conditions and illnesses are the sole responsibility of the student-athlete and are not covered under the departmental athletic insurance coverage.

What happens if I choose to cover my son/daughter with an insurance policy that is not comparable to the University's Athletic insurance plan?

If you choose to cover your son/daughter under your insurance policy and your insurance is not comparable to La Sierra University's insurance plan, the Department of Athletics will not be responsible for any medical bills for injuries directly related to athletic sport participation incurred by your son/daughter.

What injuries are covered by La Sierra University Department of Athletics?

The University Athletic Department covers activities while participating in any regularly scheduled, sponsored and supervised athletic game, competition or a practice session for an athletic team, while traveling to and from a game, competition or practice session, while traveling with the athletic team as a group, under the direct supervision of the athletic team, or an adult chaperone authorized by the athletic team during the NAIA defined playing and practice season.

What is not covered by La Sierra University Department of Athletics?

The University Athletic department does not and cannot cover any personal illnesses (at any time), diagnostic tests or surgery for preexisting conditions, or injuries incurred by a student-athlete outside of the NAIA practice and competition season. This includes injuries incurred in high school, recreational or intramural sports participation and during summer training. See pre-existing condition waiver and release form.

What do I need to provide if my son/daughter has an insurance claim directly related to an injury sustained while practicing or competing in a La Sierra University Intercollegiate sport sponsored event?

If there is a balance due on any bills from an injury that falls within the "Covered Injuries" category after the student/athlete's insurance company has made payment to the maximum allowable limit, the student and parents must provide the athletic trainers with copies of all original itemized bills and copies of all insurance company Explanation of Benefits Statement (EOBs) within 90 days of treatment. The EOBs should indicate original charges, amount paid by the insurance company and balance still due. Any bills and EOBs submitted after 2 years of the date of treatment will be the responsibility of the student/parents.

Itemized Bills and Insurance Explanation of Benefits Statements must be submitted to:

*Athletics Department - Insurance Claims*

*4500 Riverwalk Pkwy*

*Riverside CA 92515*

What must I do if my son/daughters insurance policy changes at any time throughout the school year?

If at any time during the school year there are any changes in insurance coverage, the student-athlete must notify the athletic training staff immediately. A new Emergency Contact and Insurance Information form must also be re-submitted within 30 days of this change. You are also required to notify the Insurance Representative for the University within 30 days of your insurance changes.

What must I do if my insurance policy requires pre-certification or pre-authorization for any services?

If the student-athlete's insurance requires preauthorization for any (outpatient/inpatient) services, the student/athlete or parents are responsible for obtaining this approval.

How is my son/daughter covered if there is a catastrophic injury while participating in intercollegiate athletics at La Sierra University?The Department of Athletics participates in the "NAIA Catastrophic Athletic Injury Insurance Program". This program provides medical benefits to student-athletes who are catastrophically injured during competition, practice or travel related to intercollegiate athletic participation. More information on this program may be found on the NAIA's web site at [www.naia.org](http://www.naia.org)

**LA SIERRA UNIVERSITY  
EMERGENCY CONTACT and INSURANCE INFORMATION FORM**

Name \_\_\_\_\_  
Last Name (print) \_\_\_\_\_ First Name (print) \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ (DD/MM/YYYY) Sport \_\_\_\_\_  
LSU ID# \_\_\_\_\_ SSN# \_\_\_\_\_ Academic Year \_\_\_\_\_

This Acknowledgement of Insurance Requirements must be read and understood and this form completed **PRIOR** to the student-athlete in practice and/or competition.

**Emergency Information**

Contact Name \_\_\_\_\_ Relation \_\_\_\_\_ Email Address \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Medical Information**

Primary Physician \_\_\_\_\_ Office Phone \_\_\_\_\_  
Address \_\_\_\_\_

**Medical Insurance Information**

Policy Holder Name \_\_\_\_\_  
Relationship to Student Athlete \_\_\_\_\_  
Address of Policy Holder \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Group # \_\_\_\_\_ I.D. # \_\_\_\_\_  
Effective Date of Policy \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Policy Limit \_\_\_\_\_  
Policy Deductible \_\_\_\_\_  
Policy Co-Pay \_\_\_\_\_  
Does the policy cover athletically-related injuries? YES NO (circle one)

I, \_\_\_\_\_, attest that I have insurance coverage under a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics.

**If there is a material change in coverage or expiration of coverage, I agree to notify La Sierra University of this development and update the insurance information I have on file with La Sierra University.**

I understand and agree that La Sierra 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 La Sierra University.

\_\_\_\_\_  
Student-Athlete Signature and Date

\_\_\_\_\_  
Parent/Guardian Signature and Date

**THIS FORM MUST BE SIGNED AND RETURNED TO THE DEPARTMENT OF ATHLETICS BY AUGUST 1, 2011**

**LA SIERRA UNIVERSITY ATHLETIC DEPARTMENT  
ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS**

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All La Sierra University student-athletes must provide evidence of 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 La Sierra University department of athletics. The Acknowledgement of Insurance Requirements form and your insurance card, or photocopy of both sides, must be on file before a student can participate.

**Insurance coverage must have a limit of at least \$75,000 and cover athletically-related injuries.**

If your insurance does not meet these requirements, La Sierra University will review the individual circumstances to determine if the insurance meets the insurance coverage requirement.

La Sierra University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics at La Sierra 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 NAIA'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 \$75,000 maximum limit and a \$100 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at La Sierra University. It is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NAIA's web-site at [www.naia.org](http://www.naia.org).

To be signed by policy holder:

I, \_\_\_\_\_, as policy holder attest that  
Name (please print)

\_\_\_\_\_ has insurance coverage under a current, in force insurance policy that  
(student -athlete name)

meets the above requirements for injuries that occur while he/she is participating in intercollegiate athletics.

**If there is a material change in coverage or expiration of coverage, I agree to notify La Sierra University of this development and update the insurance information I have on file with La Sierra University.**

I understand and agree that La Sierra 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 La Sierra University.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

**THIS FORM MUST BE SIGNED AND RETURNED TO THE DEPARTMENT OF ATHLETICS BY AUGUST 1, 2011**

La Sierra University  
Department of Athletics  
Attn: Brian Murphy, MSS, ATC  
Head Athletic Trainer  
La Sierra University  
4500 Riverwalk Parkway  
Riverside, CA 92515

## Informed Consent Form

**The student athlete and/or a parent or guardian, if the student athlete is a minor, must read carefully and sign.**

Name: \_\_\_\_\_

Sport(s): \_\_\_\_\_

I am aware that playing, or practicing to play, any sport can be dangerous, involving many risks of injury. I understand that the dangers and risks of participating in the above sport(s) may include, but are not limited to; serious bodily injury which may include loss of limb, loss of sensory function (i.e. sight, hearing, etc.), permanent physical impairment, paralysis, or even death. With this understanding I assume the risk of participation in the above sport(s) at La Sierra University.

Because of the dangers of participating in the above mentioned sport(s), I recognize the importance of following the La Sierra University's Team Physicians', Certified Athletic Trainer and Coaches' instructions concerning playing techniques, conditioning, rehabilitation, and team rules. I agree to report all injuries to the La Sierra University Certified Athletic Trainer and to follow the recommendations of the Team Physician and/or Certified Athletic Trainer regarding participation.

I understand that my personal medical information may be discussed amongst the La Sierra University Student Health Services, Team Physician, Certified Athletic Trainer, and Coaches as they deem necessary.

Student-Athlete Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Signature (if athlete is under 18 years of age) \_\_\_\_\_

### Consent to Treat

The La Sierra University Medical Staff, including Certified Athletic Trainer, Team Physician and others deemed necessary, have my permission to seek and provide necessary care and treatment for any illness or injury that may occur during participation in intercollegiate athletic practices, games, and conditioning. This permission remains in effect for one year from the date it is signed.

Student-Athlete Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Signature (if athlete is under 18 years of age): \_\_\_\_\_

Emergency Contact Person Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

LA SIERRA UNIVERSITY  
SHARED RESPONSIBILITY FOR SPORTS SAFETY

WARNING:  
PARTICIPATION IN INTERCOLLEGIATE ATHLETICS INVOLVES  
THE INHERENT RISK OF INJURY, THE SEVERITY OF WHICH MAY  
RANGE FROM MINOR TO CATASTROPHIC, OR FROM  
TEMPORARY IMPAIRMENT TO PERMANENT DISABILITY,  
INCLUDING PARALYSIS OR DEATH.

Since the participation in sports requires an acceptance of the risk of injury by the student-athlete, he or she rightfully assumes that reasonable precaution will be taken to minimize the risk of serious injury. Student-athletes have this informed awareness of the risks and share the responsibility for minimizing those risks.

STUDENT-ATHLETES MUST COMPLY WITH ALL SAFETY GUIDELINES AND FOLLOW TRAINING ROOM RULES AND PROCEDURES; REPORT ALL PHYSICAL PROBLEMS TO THE ATHLETIC TRAINER; ADHERE TO SOUND CONDITIONING PROGRAMS AND INSPECT THEIR EQUIPMENT DAILY.

Having read the above statement I am aware of the inherent risk of injury involved in athletic participation. Finally, I understand that in accepting the risks associated with athletic participation I will also share the responsibility of minimizing those risks.

\_\_\_\_\_  
Athlete's name (please print)

\_\_\_\_\_  
SPORT(S)

\_\_\_\_\_  
Athlete's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's name, if under 18 (please print)

\_\_\_\_\_  
Guardian's signature

\_\_\_\_\_  
Date

LA SIERRA UNIVERSITY  
DEPARTMENT OF ATHLETICS  
CONSENT FOR MEDICAL TREATMENT FOR MINORS

I hereby authorize a medical facility (when my son/daughter is traveling with a La Sierra University varsity sports team) to provide medical care for my son/daughter for the period of time noted below:

NAME OF MINOR \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

SPORT(S) \_\_\_\_\_

PERIOD OF TIME \_\_\_\_\_ TO \_\_\_\_\_

NAME OF PARENT OR GUARDIAN \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

SIGNATURE OF PARENT OF GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_ DATE \_\_\_\_\_

All forms should be mailed to:  
La Sierra University  
Department of Athletics  
Attention: Brian Murphy, MSS, ATC  
Head Athletic Trainer  
4500 Riverwalk Pkwy  
Riverside CA 92515





# Authorization for Use, Disclosure, & Release of Health Information

**Athletics**

4500 Riverwalk Parkway  
Riverside, CA 92515  
(951)785-2534  
bmurphy@lasierra.edu

Student Athlete Print Name

Date of Birth

Home Address

City

State

Zip Code

**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 physicians, consulting physicians, athletic trainers and assistants, physical therapists and assistants, LSU Sports medicine department personnel and support staff.

**Release of Health information to:**

I authorize the following persons (or class of persons) to receive my protected health information: La Sierra University Athletic Director, Assistant athletic directors, coaches, athletic department staff, LSU athletic trainers and assistants, third parties for insurance and billing purposes, and other healthcare providers for diagnosis and/or treatment purposes.

**Information that may be released:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Entire record      | <input type="checkbox"/> Medical history, examination, reports | <input type="checkbox"/> Surgical records |
| <input type="checkbox"/> X ray reports      | <input type="checkbox"/> Treatment and tests                   | <input type="checkbox"/> Prescriptions    |
| <input type="checkbox"/> Consultations      | <input type="checkbox"/> Hospital records including reports    | <input type="checkbox"/> Immunizations    |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Other _____                           |   |

**Purpose for disclosure:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Further medical care                                    | <input type="checkbox"/> Legal investigation or action | <input type="checkbox"/> Changing physicians                    |
| <input type="checkbox"/> Medical ability and fitness to participate in athletics |  | <input type="checkbox"/> Health and injury Status for athletics |
| <input type="checkbox"/> Insurance eligibility/benefits                          |  |   |

I understand that if the persons and/or organizations 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. However, redisclosure by school officials may be subject to student education records privacy laws.

**Your rights with respect to this authorization:**

- 1. Right to inspect or copy the health information to be used or disclosed** – I understand that I have the right to inspect and copy the health information that I have authorized to be disclosed by this authorization form. I may arrange to inspect my information or make copies by contacting the Athletic Director.
  - 2. Right to receive a copy of this authorization** – I understand that if I agree to sign this form, which I am not required to do, I must be provided with a signed copy of the form
  - 3. Right to refuse to sign this authorization** – I understand that I am under no obligation to sign this form and that the persons and/or organizations listed above who I am authorizing to use and or disclose my information may not condition treatment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization
  - 4. Right to withdraw authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, or obtain a copy of my withdrawal, I may contact the Athletic Director. I am aware that my withdrawal will not be effective as to uses or disclosures of my health information that have already been made by the persons and/or organizations listed above in reference to this authorization.
- Expiration Date** – this authorization is good for one year from the date signed.

Student Athlete Signature

Date

Witness Signature

Witness Print Name