

Sports Medicine Services, Consent to Treat, Assumption of Risk & Health Disclosure

Trinity Washington University Athletics Department

Student-Athlete's Last Name _____ First Name _____ Middle Name _____ Sport(s) _____

Note to Parent/Guardian: Please read, sign and return with other Sports Medicine paperwork.

A. Sports Medicine Services

I understand that the sports medicine staff's primary focus is preventing injury as well as treating and rehabilitation of injuries. I also understand that they will develop a rehabilitation program to fit the student-athletes' needs for a quick recovery and are assigned to attend practices and competitions with priority given to in-season, collision or high-risk sports.

I acknowledge that all athletic injuries and illnesses are to be reported immediately to the sports medicine staff for evaluation, care, and referral. The Certified Athletic Trainer assesses the immediate needs and gives authorization to receive medical care from one of the following: Team Physicians, Student Health Services, and Outside Physicians. No one else within the Athletics Department is allowed to authorize any type of care or referral. The student-athlete is responsible to report back to the sports medicine staff with information regarding the doctors' visit and follow-up care. Failure to do so will result in being withheld from participation.

Student-athlete initials

B. Assumption of Risk

In consideration and as a condition of my participation at Trinity Washington University in activities with an athletic team, which include but are not limited to training, trying out, practicing, competing, and traveling, I freely acknowledge that I am aware of and accept the risks associated with such participation and that my participation in such activities is voluntary.

I fully realize the dangers of participating in such activities and fully assume the risks associated with such participation, which may include, but are not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, and which may be caused in whole or in part by numerous factors, including my medical or physical condition, the actions or inactions of other student-athletes, the conditions of premises, and the negligence of entity or individuals released hereby. I waive, release and discharge for myself, my heirs, executors, administrators, legal representatives, assignees and successors in interest any and all rights or claims for injuries or losses of any description that I may have or which may hereafter accrue to me against Trinity Washington University, its Trustees, the Board or regents, employees, or agents, in connection with my participation in activities associated with Trinity Washington University athletic teams.

Student-athlete initials

C. Consent to Treat

I grant permission to Trinity Washington University athletic trainer, physicians, and/or other medical practitioners to render any preventative, emergency, surgical, or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being, and to arrange for my hospitalization where reasonable and necessary, in circumstances connected with my participation in activities with a Trinity Washington University athletic team which I am a participant.

Student-athlete initials

D. Disclosure of Health Conditions

I authorize the Sports Medicine staff or any such person that they may designate, permission to contact and discuss my health or medical condition with my parents, guardian or immediate family member in the case of a health emergency on my part. A health emergency shall include, but is not limited to, experiencing serious physical or mental difficulties, requiring hospitalization or treatment for any serious physical or mental ailment, injury, disorder or other health condition which the Head Athletic Trainer or the Head Coach believes in good faith to be of a serious nature.

Student-athlete initials

E. Health Insurance Information/Waiver

The Trinity Washington University Department of Athletics' accident policy provides insurance for student-athletes with **injuries occurring only when participating in the play or practice of intercollegiate athletics**. This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filled with the group insurance company providing coverage. Only after all available benefits have been exhausted will the Trinity Washington University Department of Athletics' insurance carrier consider payment for any remaining balances. This policy is an "add-on" policy to the university's policy. The university's policy will pay up to \$2500 then the athletic policy will take effect. I hereby authorize the Trinity Washington University Athletic Department, and associated physicians and hospitals, to furnish information to insurance carriers concerning any illness, injury, and treatments, and I hereby assign the party to the party all payments for medical services to the student-athlete. I agree to supply any and all information requested by associated insurance companies in a timely manner. I hereby authorize the Trinity University Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness. A photocopy of this authorization shall be deemed as effective & valid as the original. I agree to notify the Trinity University Sports Medicine Unit immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred. I hereby certify that I have read and understand the above statements,

that any and all questions have been answered to my satisfaction, and that the answers provided are true, complete, & correct to the best of my knowledge.

Student-athlete initials

In the event of any injury or emergency medical condition, I hereby authorize Trinity Washington University Sports Medicine staff or Team Physician(s) to contact my parent(s)/guardian(s). Agree Disagree

By signing below I have read, understand and approve of Part A, B, C, D & E above.

Student-Athlete Signature _____
Date

Parent/Guardian Signature _____
Relationship _____
Date
(Required regardless of student-athlete's age)