

Bellarmino University Department of Athletics

I, _____, age _____ while participating in the Bellarmine University Athletic Program hereby consent to be treated by the Student Health Service, Team Physicians, members of the Bellarmine University Athletic Training Staff or any other medical provider recommended by the Team Physician or Athletic Trainer.

I understand that participation in intercollegiate athletics does have risks and may result in injury. I understand that these injuries could be severe and possibly result in permanent disability or death. I further pronounce that unless specifically stated at the time of my athletic physical that to my knowledge I do not have any type of incapacitating condition that may adversely affect my ability to safely participate in intercollegiate athletics. I will be subject to forfeiture of any financial awards from the athletic department for any false or misleading information.

I expressly authorize (in accordance with HIPAA) the Student Health Service and such hospital and/or medical doctor or medical staff that might render treatment to me while participating in the Bellarmine University Athletic Program to release my medical records to the Bellarmine University Athletic Trainer, the head coach of my sport, and/or Bellarmine's Insurance Carrier so that they will be better informed of my medical condition and capabilities.

I further authorize the Team Physician and Athletic Trainer of Bellarmine University to disclose complete information to any other University or professional sports organizations, and the news media concerning injuries, medical findings, and any treatment I might undergo during this period. This shall remain in effect for one calendar year or until revoked in writing by me and directed to the Athletic Trainer at Bellarmine University.

I understand that Bellarmine University will endeavor to assist me in hospital, medical and physicians expenses that are the result of participation in intercollegiate athletics. Bellarmine, however, will not be responsible for any expenses incurred by an athlete who seeks care other than that provided, or authorized by Bellarmine University. I have read and understand the information concerning the insurance coverage Bellarmine University carries on its athletes. I also understand that not following the outlined procedures may result in claims not being paid by Bellarmine's insurance carrier.

A Photo static or Faxed copy of this authorization will be considered as effective and valid as the original.

Signed _____ Date _____

Social Security Number _____ Date of Birth _____

Parent/Guardian Signature _____

(Required if athlete is less than 18 years of age)