

**Office of Athletic Training**  
**University of the Cumberlands**  
**7790 College Station Drive**  
**Williamsburg, KY 40769-1390**

**CONSENT TO TREAT**

I, \_\_\_\_\_, age \_\_\_\_\_, while participating in the intercollegiate Athletic Program at the University of the Cumberlands, here by consent to be treated by the Health Services Office, Team Physician(s), Members of the University of the Cumberlands Athletic Training Staff or any other Medical Doctor or Medical Facility recommended by the Team Physician(s) or Certified Athletic Trainer(s) of the University of the Cumberlands.

A photocopy of this consent shall be considered as effective and valid as the original.

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone Number:( \_\_\_\_\_ ) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

(Only if student under 18 years of age)

Alternate Person and Phone Number to be called in case of Emergency:

\_\_\_\_\_

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**CONDITIONED AUTHORIZATION FOR CLAIMS**

I, \_\_\_\_\_, while participating in the intercollegiate Athletic Program at the University of the Cumberlands, expressly authorize the (1) Health Services Office of the college; (2) any Hospital, Medical Doctor, Medical Facility or Pharmacy, which has rendered treatment or services to me; (3) the University of the Cumberlands athletic insurance provider; and (4) my personal health insurance provider to disclose my protected health information to the Athletic Training Department of the University of the Cumberlands or to the designated team physician. I authorize the Athletic Training Department of the University of the Cumberlands to use or to disclose my protected health information to my coach(es) or to other medical providers.

The purpose of this authorization is to facilitate medical care for myself that is provided by and/or coordinated by the Athletic Training Department of the University of the Cumberlands.

If I decline to sign this authorization, I may not be eligible for benefits under the University of the Cumberlands athletic insurance program.

By signing this authorization, I understand that my protected health information that is used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by the HIPAA Privacy Rule.

This authorization will expire one year from the end of the current University of the Cumberlands academic year.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Athletic Training Department of the University of the Cumberlands. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before my written notice of revocation was received.

I, \_\_\_\_\_, have had full opportunity to read and to consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described above.

Student Signature: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the student, complete the following:

Personal Representative's Name: \_\_\_\_\_

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

Relationship to student: \_\_\_\_\_

A photocopy of this authorization shall be considered as effective and valid as the original

**YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION**

SELF/PARENT/GUARDIAN TO COMPLETE AND RETURN TO:

Office of Athletic Training  
University of the Cumberlands  
7790 College Station Drive  
Williamsburg, KY 40769-1390

**INSURANCE INFORMATION FORM**

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE:

Complete all blanks. If information is not applicable, indicate the reason it is not (i.e.: deceased, divorced, unknown).

UC Student ID#: \_\_\_\_\_ Year In School: FR SO JR SR 5

Name of Athlete: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

College Address: \_\_\_\_\_ School Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I. FATHER/GUARDIAN:** \_\_\_\_\_

**MOTHER/GUARDIAN:** \_\_\_\_\_

SS #: \_\_\_\_\_

SS #: \_\_\_\_\_

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

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

Birthday: \_\_\_\_\_

Birthday: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

**II. EMPLOYER:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

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

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

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

*(If Self-Insured, Please indicate in Section III under Father's Medical Insurance and circle "SELF".)*

**III. FATHER'S/ SELF MEDICAL INSURANCE COMPANY**

**MOTHER'S MEDICAL INSURANCE COMPANY**

**OR PLAN:** \_\_\_\_\_

**OR PLAN:** \_\_\_\_\_

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

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

Policy Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

1 - 800 - \_\_\_\_\_

1 - 800 - \_\_\_\_\_

*Is the company or plan listed above considered an HMO or PPO? (please circle one) YES NO*

*Is preauthorization required to obtain treatment? YES NO*

*Does your insurance or plan require a second Opinion before surgery? YES NO*

*Does your policy provide coverage for Intercollegiate Sport Injuries? YES NO*

I hereby authorize the University of the Cumberlands to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the University of the Cumberlands or its insurance agent pay the medical vendor directly for any bills incurred from accidents that are covered under the plan purchased by the University of the Cumberlands .

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(required if under age 18)

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

University of the Cumberland  
Re-Examination Health History For Returning Athletes

Date: \_\_\_\_\_ UC ID #: \_\_\_\_\_ Sport: \_\_\_\_\_ Age: \_\_\_\_\_

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

Last First Middle

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_ Year at UC: SO/JR/SR/5<sup>th</sup>

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

**Please complete the following form in regard to your physical health since your last medical evaluation for the University of the Cumberland Intercollegiate Athletics Program.**

**NOTE: SINCE YOUR LAST PHYSICAL EXAMINATION:**

1) **Have you had any illness? If yes please list them:**

YES	NO

\_\_\_\_\_

2) **Have you been taking any medications? If yes please list them:**

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\_\_\_\_\_

3) **Have you been hospitalized since your last physical examination?**

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4) **Have you been unconscious for any reason?**

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5) **Have you had any dental work done?**

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6) **Are you now taking any supplements? If yes, please list:**

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\_\_\_\_\_

7) **Have you had an injury to any of the following areas:**

	YES	NO
Head		
Shoulder – R or L		
Arm/Hand – R or L		
Neck		
Ribs		
Back		

	YES	NO
Hip – R or L		
Thigh – R or L		
Knee – R or L		
Leg – R or L		
Ankle – R or L		
Foot – R or L		
Other		

**If you checked yes to any of the orthopaedic questions please explain the injury and action taken:**

8) **I have asthma or an EIA and use an inhaler**

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9) **I am allergic to insect bites/stings and use an epi-pen**

10) **Do you wear contacts/glasses to participate in sports?**

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11) **Have you had any physical problems since your last physical examination which have not been mentioned? If yes, please list and explain:**

\_\_\_\_\_

Daily Medications: (Asthma Inhalers of any kind, allergy shots, Epi-pen for allergic reactions, Blood sugar issues, etc)

\_\_\_\_\_

I do hereby state, to the best of my knowledge and belief, my answers are correct.

Athlete's Signature: \_\_\_\_\_

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

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**CONTACT LENSE PRESCRIPTION FORM**

The Athletic Training Department of the University of the Cumberland is dedicated to providing the highest level of care to our athletic participants. In order to help us with this task we request that student athletes wearing contact eye correction provide us with a copy of your current lens prescription information.

**NAME:** \_\_\_\_\_ **Sport:** \_\_\_\_\_

	<b>Brand</b>	<b>BC</b>	<b>DIAM.</b>	<b>POWER</b>
<b>O.D. (Right)</b>	_____			
<b>O.S. (Left)</b>	_____			

**Rx Expires:** \_\_\_\_\_ **Last Exam:** \_\_\_\_\_

**Name of Eye Care Provider:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Office Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Office Phone:** ( \_\_\_\_\_ ) \_\_\_\_\_

**\*As with other specialized athletic prescriptions we are requesting that you provide your supervising Certified Athletic Trainer (ATC) with a spare pair of your current lens prescription, which will be carried in your teams athletic training kit and available for your use in the event that you lose or damage one of your lenses during your sport activity. These lenses will be returned to you at the end of the school year.**

The prescription listed above will be kept in your medical file and in the event that you need local assistance in obtaining additional lenses it will be used to help expedite the process.