



STUDENT-ATHLETE INFORMATION FORM

To Be Used for Emergency Contact and Insurance Information

Academic Year _____ / _____

Athletic Eligibility: Freshman Sophomore Red Shirt Gender: Male Female Sport(s): _____

Athlete Name _____ SS# _____ L# _____ Birthdate _____
College Address _____ College Phone _____
Home Address _____ Home Phone _____

Father/Guardian _____ Mother/Guardian _____
Address _____ City _____ Address _____ City _____
ST _____ Zip _____ Home Phone (____) _____ ST _____ Zip _____ Home Phone (____) _____
Work Phone (____) _____ Cell (____) _____ Work Phone (____) _____ Cell (____) _____

In case of emergency and parents cannot be contacted whom should we contact?

Name _____ Phone _____

****PARENT(S): IS STUDENT-ATHLETE COVERED UNDER YOUR MEDICAL INSURANCE POLICY? YES NO if yes please complete the following**

****STUDENT-ATHLETE: IF YOU CARRY YOUR OWN MEDICAL INSURANCE COVERAGE PLEASE COMPLETE THE FOLLOWING.**

Primary Medical Insurance Co _____
Address _____
City _____ ST _____ Zip _____
Phone _____
Policy # _____ Circle One: HMO PPO
Plan _____ Group # _____
Policy Holder _____ SS# _____

Secondary Medical Insurance Co _____
Address _____
City _____ ST _____ Zip _____
Phone _____
Policy # _____ Circle One: HMO PPO
Plan _____ Group # _____
Policy Holder _____ SS# _____

*****INSURED IS RESPONSIBLE FOR DEDUCTIBLE(S) WITH PRIVATE OR SCHOOL INSURANCE*****

****PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD****

Does insurance require pre-authorization admission for hospital admission? _____ If yes, phone number _____
Is student-athlete covered by the present surgical and hospital insurance policy? _____ Does insurance require a second medical doctor's opinion? Y/N

To the best of my knowledge the above information is accurate and complete. In the event of a change it is the responsibility of the student-athlete to notify the Head Athletic Trainer.

I have received, read and understand the DISCLOSURE OF CLINICAL INFORMATION the INFORMED ACKNOWLEDMENT OF HAZARDS AND RISKS CONNECTED WITH ATHLETIC PARTICIPATION the ACKNOWLEDGEMENT OF ELIGIBILITY RULES the CODE OF CONDUCT and the RESPONSIBILITIES AS AN ATHLETE.

Student-Athlete Signature _____ Date _____

Parent/Legal Guardian Signature (if under 18) _____ Date _____

Lane Community College Center for Sports Medicine Consent to Use or Disclose Clinical Information

I authorize the use and/or disclosure of my health information as provided for below:

1. This authorization applies to all health information about me that is now (or, during the period covered by this authorization, may be) in the possession, custody or control of the persons or entities (or classes of persons or entities) identified in Paragraph 2 below. As used in this authorization, “health information” means my entire health or medical record, including but not limited to, all information relating to any injury, sickness, disease, condition, medical history, medical or clinical status, diagnosis, treatment or prognosis, and includes (without limitation) clinical notes, test results, laboratory, reports, x-rays and diagnosis imaging results.
2. I authorize the following persons and entities (or classes of persons and entities to use and/or disclose (to the individuals specified in Paragraph 3 below) any health information about me that is (or, during the period covered by authorization, may be) in their possession, custody or control for the purposes described in Paragraph 3 below: All health care providers (including but not limited to physicians, laboratories, clinics, athletic trainers and athletic personnel) with whom I have consulted.
3. I authorize the persons and entities (or classes of persons and entities) described in Paragraph 2 to disclose any of the health information about me that is (or, during the period covered by this authorization, may be) in their possession, custody or control, for any purpose relating to athletics at Lane Community College to physicians and their designees, Athletic Trainers seen with relationship to any relationship to any illness or injury for the life of this authorization.
4. I acknowledge that there exists the potential that information disclosed pursuant to this authorization might be subject to re-disclosure by the recipient and thus no longer be protected by HIPAA in certain circumstances.
5. I understand that I have the right to revoke this authorization at any time, but that my revocation will not be effective to the extent that any of the persons or entities (or classes of persons or entities) I have authorized to use and/or disclose my health information have acted in reliance upon this authorization. My revocation must be in writing and be sent to the Athletic Trainer at Lane Community College. I further understand that my right to revoke this authorization shall not serve to excuse any failure on my part to comply with policies and procedures related to athletic injuries as a participant on a sports team at Lane Community College.
6. I further understand that by choosing to revoke this authorization, I may be ruled ineligible to continue participation in Lane Community College athletics.
7. This authorization expires one year from the date it is signed, unless previously revoked.
8. By signing on reverse page, I agree that I have read and understand this authorization presented to me and by request can receive a copy of this agreement.