Millennia Atlantic University

STUDENT-ATHLETE MEDICAL CONSENT ~ SHARED RESPONSIBILITY FOR SAFETY ~ MEDICAL HEALTH INSURANCE COVERAGE REQUIREMENT

The Millennia Atlantic University (the "University") Athletic Department (the "Department") requires that all current student-athletes participating in any of the Department's sports read the following terms, complete the requested information and sign if you fully understand and accept ALL terms -

I. **MEDICAL CONSENT.** I grant permission to Department medical staff, including - athletic trainers, physicians, medical consultants and any other medical provider deemed advisable by the University or the Department, to provide me with any treatment or medical care they deem necessary to my health and well-being. This treatment may include preventive care, first aid, primary care, mental health care, rehabilitation, and emergency treatment. I grant permission to hospitalize me if deemed necessary by one of the medical providers identified. I also grant each of the medical providers identified authority to disclose - to each of the other medical providers identified, to other medical providers deemed advisable, and to other University and Department staff information about me, my medical insurance status, and my medical history (including mental health history) as necessary or reasonably requested in order to arrange for, oversee, manage or facilitate my treatment and medical care

II. **SHARED RESPONSIBILITY FOR SAFETY.** I understand that there is certain inherent risk involved in participating in intercollegiate athletics as a student-athlete, including serious bodily injury and/or death, and that I share responsibility for minimizing the risk of injury to others and myself. I must promptly report any injury I have suffered (including any signs or symptoms of a concussion, regardless of whether any such signs or symptoms are related to participation in intercollegiate athletics). I understand that I must respond fully and honestly to any questions Department medical and non-medical staff, including - administrators and coaches, may have regarding my medical condition. I must advise Department medical and non-medical staff of any medications that I am taking. I also understand that I must report to the appropriate Department staff any problems in the condition or usefulness of equipment and facilities that I use. I agree to abide by instructions and guidelines provided to me by Department staff and by any official or other authority with oversight of athletic events as such instructions and guidelines relate to my medical condition, safety, and general participation in intercollegiate athletics.

III. **MEDICAL HEALTH INSURANCE COVERAGE REQUIREMENT.** I understand that the University and the Department requires all student-athletes to obtain their own Medical Health Insurance Coverage. I UNDERSTAND THAT MY MEDICAL HEALTH INSURANCE COVERAGE SERVES AS THE PRIMARY INSURANCE COVERAGE FOR ALL ATHLETIC PLAY/PRACTICE-CAUSED INJURIES AND ILLNESSES I MAY SUSTAIN AS A STUDENT-ATHLETE AT THE UNIVERSITY. I AGREE TO KEEP THE UNIVERSITY AND THE DEPARTMENT INFORMED AT ALL TIMES AS TO MY PRIMARY MEDICAL HEALTH INSURANCE COVERAGE AND TO RESPOND PROMPTLY TO ANY UNIVERSITY REQUEST FOR INFORMATION ABOUT SUCH COVERAGE. IF PAYMENT FROM AN INSURANCE PROVIDER IS RECEIVED BY ME OR ON MY BEHALF FOR A COST THAT HAS BEEN, IS BEING, OR WILL BE PAID BY THE UNIVERSITY OR THE DEPARTMENT, I AGREE THAT I SHALL SEND SUCH PAYMENT OR ITS MONETARY EQUIVALENT TO THE UNIVERSITY. I HEREBY AUTHORIZE MY PRIVATE MEDICAL HEALTH INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO THE UNIVERSITY, THE DEPARTMENT, ANY FACILITY WHERE MEDICAL SERVICES WERE RENDERED, OR TO ANY PROVIDER THAT RENDERED MEDICAL SERVICES.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS CONTAINED HEREIN. I FURTHER AGREE NOT TO CONTEST THE ENFORCEABILITY OF ALL VALID PROVISIONS CONTAINED HEREIN, AND THAT IF ANY PORTION OF THIS AGREEMENT IS HELD UNENFORCEABLE BY A COURT OF COMPETENT JURISDICTION, THAT ALL OTHER PROVISIONS SHALL REMAIN IN FULL FORCE AND EFFECT. ***Parent / legal guardian of student-athlete named must sign <u>in addition</u> to the student-athlete if student-athlete is under 18 years of age.***

Today's Date: _____

Printed Participant Name: _____ Signature: _____

Printed Parent Name: _____ Signature: _____

Millennia Atlantic University

STUDENT-ATHLETE MEDICAL HEALTH INSURANCE INFORMATION

Student-Athlete's Info

Name:		Sport:		
Date of Birth:	Sex:	Year Completed:	Marital Status:	
Address:	City:	State:	Zip:	
E-Mail:		Phone:		

Medical Insurance Info

Insurance Company:	
Policy Holder Name:	
Insurance Policy #:	Insurance Group #:
Company Phone:	Type of Plan: HMO PPO Other
Company Address:	
City, State, ZIP:	

Person to Notify in Case of Emergency

Name:	Relationship:
Phone:	Email:

Physician Contact Info

Family Physician:	Office Phone:
Office Location:	Date of Last Medical Exam:

I have the following medical conditions, allergies, implanted devices, special instructions, and/or am taking the following medications which may impact on the emergency medical treatment that I mayreceive (please print clearly and legibly):

Please attach copy of insurance cards (front and back)

I attest that the above information is correct and truthful. I understand that any changes to the above information must be reported to the University Athletic Department immediately.

Student-Athlete Signature **Date**