



Student-Athlete Welcome Letter

Welcome Student-Athlete and parents to your journey as an IUPUI student-athlete! Please read and complete the following forms required by IUPUI Sports Medicine for the 2017-18 school year. Parents, please review our insurance policies. Also, please note what is required from you and/or your son/daughter in order to help us expedite payment of any medical bills that may be incurred from an injury from participation in IUPUI Athletics. Parents, you must sign these forms if your son/daughter is under age 18.

As part of preparing for the upcoming school year, you must complete several items in order to be cleared medically to participate. Please use this page as a guide for the items you will need. Check with your coach on details for team physicals as well as any needed baseline concussion testing.

- _____ Provide a copy of the front and back of your current health insurance card
- _____ Provide a copy of your sickle cell trait testing results (these can likely be obtained through your pediatrician as most students were tested at birth). We won't need this in follow-up years once we have initial records
- _____ Complete the following paperwork:
 - _____ Page 2 – Student-Athlete Demographics & Health Insurance Information
 - _____ Page 4 – Student-Athlete Health Insurance Awareness Form
 - _____ Page 5 – Authorization & Consent Form
 - _____ Page 6-8 – Student-Athlete Health History Questionnaire
 - _____ Page 9 – Assumption of Risk & Release of Liability
 - _____ Page 11 – Concussion Management Policy Statement

Please submit all documentation to IUPUI Sports Medicine for approval by June 2nd, 2017. They can be sent via mail or fax to the contact information listed below. Please do not email the documents, as email is not a secure communication method.

Thank you,

Emily Nibbelink, MS, ATC, CSCS, CES

Assistant Athletic Director of Sports Medicine

901 W. New York St., Suite 105

Indianapolis, IN 46202

Office: (317) 278-5237

Fax: (317) 278-5245

emnibbel@iupui.edu



Student-Athlete Health Insurance Information Sheet

The **IUPUI Supplemental Athletic Insurance** functions as a secondary insurance for all athletically related injuries or illnesses.

- Medical bills will first be submitted to your medical insurance provider as the primary insurance.
- Any remaining balances, including co-pays and deductibles, will be covered through IUPUI's Supplemental Athletic Insurance.
- For prompt payment and to prevent bills from going into collections, please submit within 30 days of receipt all correspondence, EOBs (explanation of benefits), and bills you receive from providers and your insurance company to the IUPUI Sports Medicine contact listed below.

******* Please Note: For injuries occurring outside of IUPUI athletic participation or for pre-existing injuries:**

- Any injury or illness that occurs outside of Student-Athlete's athletic participation in IUPUI games, IUPUI practices, and IUPUI strength and conditioning sessions or is a pre-existing injury that occurred prior to the start of IUPUI athletic participation will NOT be covered under IUPUI Supplemental Athletic Insurance.
- For illness that occurs while on campus or traveling with IUPUI athletics, medical costs for evaluation of illness and clearance to participate will be covered the same as for athletic injuries, but treatments of illnesses will NOT be covered under this insurance program.
- The IUPUI Sports Medicine staff can assist in helping arrange doctor's appointments and provide necessary treatments and rehabilitation for non-covered injuries or illnesses.

We recommend that you keep a copy of this **document** for your records. If the information you have given us changes, you have questions, or need to submit bills, please notify:

Emily Nibbelink
Assistant Athletic Director of Sports Medicine
901 W. New York St. Suite 105
Indianapolis, IN 46202
Office: (317) 278-5237
Fax: (317) 278-5245
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Student-Athlete Health Insurance Awareness Form

Name: _____ Date of Birth: _____

Student ID: _____

Please select the appropriate box:

- I am covered under a medical insurance policy through myself and/or my parents.
- I am only partially covered due to policy limitations through my parent's medical insurance policy. I have attached a description of these limitations.
- I do not have medical insurance coverage through myself nor my parents.

I hereby certify that all information in this document is accurate and complete to the best of my knowledge. I also verify that I understand the IUPUI Athletics Supplemental Care Program. I agree to let IUPUI assist me in filing insurance claims with my insurance company for costs arising from injuries, illness, or other related medical treatment covered by NCAA rules, and on behalf of the above mentioned student-athlete. I will provide IUPUI with copies of any and all related information including, but not limited to, correspondence, explanation of benefits, etc. from my insurance company. In the event checks are sent to me covering these expenses and provided I have no outstanding expenses on this particular bill, I shall apply the check toward any remaining unpaid portion of the bill immediately. IUPUI is authorized to release to my insurance company any related treatment and/or insurance information and to obtain all medical information related to it for claims handling purposes. IUPUI may provide my parents/guardians and owners of the insurance policy with information about the injury or illness and treatment.

AFFIDAVIT: I verify that the information I have supplied on this form is accurate and complete. If it is ever determined that there are other benefits collectible on any claim, I will reimburse IUPUI for any portion for which IUPUI would not have been liable.

Student-Athlete Signature

Date

Parent/Guardian Signature

Date



Authorization & Consent Form

Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release to IUPUI and its designees any and all information regarding medical, dental or mental treatment or alcohol or drug abuse, as well as any other history, treatment, or benefits payable, including disability information, concerning the patient, for any purpose related to medical treatment and/or billing as long as I maintain my status as a student-athlete at IUPUI. I authorize IUPUI Athletics and Sports Medicine to release to any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Coaches, Athletic Director, School Official or Conference Office any and all information regarding medical, dental or mental treatment or alcohol or drug abuse, as well as any other history, treatment, or benefits payable, including disability, for any purpose related to medical treatment and/or billing as long as I maintain my status as a student-athlete at IUPUI. Further, in the event that I am hospitalized, I authorize IUPUI Athletics and Sports Medicine to inform my Parents/Guardians of my hospitalization and the reason for my hospitalization.

If I wish to rescind this authorization to release information, I shall inform the IUPUI Athletic Director of my decision in writing. I understand that any information released prior to such written notification will be subject to this authorization to release information.

Student-Athlete Signature

Date

Parent/Guardian Signature

Date

Consent to Medical Treatment

I, _____, grant permission to IUPUI Sports Medicine and any representative of said staff to provide me with any treatment or medical or surgical care including any preventative treatment, rehabilitative treatment, emergency treatment or first aid that they deem reasonably necessary to maintain or improve my health and well-being.

When deemed necessary, I also grant permission to hospitalize me at an appropriately licensed hospital and to receive emergency treatment from the sports medicine staff of host institutions.

I have read this entire Consent to Medical Treatment, I fully understand it, and I agree to be bound by it. I represent and certify that my true age is at least 18 years old or, if I am under 18 years old on this date, my parent or legal guardian has also signed the Consent to Medical Treatment.

Student-Athlete Signature

Date

Parent/Guardian Signature (if athlete is under 18)

Date

Student-Athlete Health History Questionnaire

Name: _____ Date of Birth: _____

Sport: _____ Height: _____ Weight: _____

Family Doctor: _____ Phone: _____

Immunization Record – Please list all current immunization records

MMR1 _____ Polio series completed _____ Meningitis _____ Yearly Influenza? _____

MMR2 _____ Hep B series completed _____ Tetanus _____

List all current and past medical problems (i.e. asthma, anemia, diabetes, infections, etc.): _____

Previous surgeries and dates: _____

List all medications, vitamins, and supplements you currently take: _____

Please list all allergies (medicine, foods, insects, etc.): _____

Please check in the appropriate column indicating past and present disease(s) you or your family have had.

	Self		Family		Self		Family		Self		Family	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease/Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt/Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain all boxes checked: _____

		Yes	No			Yes	No
1.	Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>	8.	Does your heart ever race or skip beats?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	9.	Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	10.	Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been told that you have any heart problems? [] High blood pressure [] Heart Murmur [] High cholesterol [] Heart Infection [] Kawasaki Disease [] Other	<input type="checkbox"/>	<input type="checkbox"/>	11.	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has a doctor ever ordered a test for your heart? (ECG, ECHO, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	12.	Do you get lightheaded or dizzy during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	13.	Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	14.	Have you ever had a seizure or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>

NAME: _____		Yes	No			Yes	No
15.	Have you had a severe viral infection within the last year? (e.g. mononucleosis, myocarditis)	<input type="checkbox"/>	<input type="checkbox"/>	38.	Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Were you born without or are you missing a kidney, an eye, a testicle, your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Do you get more short of breath than expected during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	40.	FEMALES: How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	41.	FEMALES: How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Have you been diagnosed with asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	42.	FEMALES: Date of last menstrual period? _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you currently using any form of birth control?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Do you have groin pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Are you on a special diet or do you avoid certain types of foods?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	45.	Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
25.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	48.	Do you think about things over and over?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	49.	Do you often feel sad or depressed?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	50.	Do you frequently have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Have you had a herpes or MRSA infection?	<input type="checkbox"/>	<input type="checkbox"/>	51.	Do you wish you had more energy most days of the week?	<input type="checkbox"/>	<input type="checkbox"/>
29.	Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	52.	Do you struggle with being confident?	<input type="checkbox"/>	<input type="checkbox"/>
30.	Do you get frequent muscle cramps when exercising?	<input type="checkbox"/>	<input type="checkbox"/>	53.	Do you feel anxious and nervous much of the time?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>	54.	Do you have a hard time managing your emotions? (frustration, anger, impatience)	<input type="checkbox"/>	<input type="checkbox"/>
32.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	55.	Do you frequently experience feelings of hopelessness or guilt?	<input type="checkbox"/>	<input type="checkbox"/>
33.	Do you wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	56.	Do you have feelings of wanting to hurt yourself or others?	<input type="checkbox"/>	<input type="checkbox"/>
34.	Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	57.	Do you take any medications for ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/>	<input type="checkbox"/>	58.	Have you ever been diagnosed with ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
36.	Do you have a bone, muscle, or joint injury that bothers you currently?	<input type="checkbox"/>	<input type="checkbox"/>	59.	Do you consume alcohol? How many drinks per week? _____	<input type="checkbox"/>	<input type="checkbox"/>
37.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	60.	Do you use cannabis?	<input type="checkbox"/>	<input type="checkbox"/>
				61.	Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
				62.	Do you have any concerns you would like to discuss with a physician?	<input type="checkbox"/>	<input type="checkbox"/>

Please Sign & explain any 'yes' answers on the following page:



Assumption of Risk and Release from Liability

I, _____, wish to participate in IUPUI Athletics, offered on behalf of The Trustees of Indiana University ("IUPUI Athletics"). In consideration of IUPUI providing athletics services and allowing me to participate in my sport (below), and in consideration of my participation in IUPUI Athletics, I hereby agree to the following:

I understand that there are certain risks inherent in the participation in collegiate athletics. I understand that the dangers and risks of participating in my sport include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to internal organs, serious injury to bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, temporary or permanent disability, lacerations, and serious injury or impairment to other aspects of my body, general health, and well-being as well as other risks and dangers, whether known or unknown nor reasonably foreseeable.

Due to the dangers of participating in my sport, I recognize the importance of following all coaches' instructions regarding playing techniques, training, and other team rules, etc. and agree to obey such instructions.

I understand that my participation in IUPUI Athletics is entirely voluntary and at my own risk. I fully understand the scope of the activities and the potential risks involved in participation in my sport. I agree to assume the risks of my participation in my sport, including the risk of catastrophic injury or death.

I hereby release and fully discharge The Trustees of Indiana University, including its officers, agents, and employees, from any and all claims or causes of action that may be brought by me or by any other person (including, but not limited to, my estate, family, successors, heirs, representatives, administrators, and/or assigns), including all liability for damage to personal property, personal injury or loss arising out of or related to my participation in my sport, whether caused by negligence or otherwise, to the fullest extent permitted by law.

I understand that it is my responsibility to report all injuries and illnesses to the IUPUI Sports Medicine Staff and that I am to follow their instructions for any treatment/rehabilitation. I understand that IUPUI cannot be held liable for any previous medical condition(s) that I may have.

This Assumption of Risk and Release from Liability shall be governed by and construed under the laws of Indiana. Notwithstanding any other agreement that I have signed related to my participation in IUPUI Athletics that purports to establish the venue for any litigation arising from my participation, I agree that I will file no action against IU or its officers, employees, and agents, whether based on this Agreement or in any way otherwise connected to my participation in IUPUI Athletics, in any court other than the Circuit Court of Marion County, Indiana.

I have read this entire Assumption of Risk and Release from Liability, I fully understand it, and I agree to be bound by it. I represent and certify that my true age is at least 18 years old or, if I am under 18 years old on this date, my parent or legal guardian has also signed the Assumption of Risk and Release from Liability.

Student-Athlete: _____

Date: _____

Sport: _____

Parent or Guardian: _____

Date: _____

(if athlete is under age 18)



Release of Sickle Cell Trait Testing Information – Incoming Athletes

About Sickle Cell Trait

- Sickle cell trait is an inherited condition that affects the oxygen-carrying protein hemoglobin in red blood cells.
- Sickle cell trait is a common condition (> 3 million Americans).
- Although sickle cell trait is predominant in those of African, Mediterranean, Middle Eastern, Indian, Caribbean, and South & Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or “sickle” shape). These sickled red blood cells can accumulate in the bloodstream and “logjam” blood vessels, leading to collapse from the rapid breakdown of muscles starved of blood.
- Each student-athlete who has the sickle cell trait will be offered counseling on the implications of sickle cell trait, including health and athletics participation precautions, in order to minimize the chances of the red blood cells from sickling.

Sickle Cell Trait Testing

- The NCAA recommends that all NCAA student-athletes have knowledge of their sickle cell trait status. If the student-athlete does not have knowledge of their sickle cell trait status, the NCAA recommends that student-athletes undergo testing to confirm sickle cell trait status.
- Most student-athletes were tested at birth, if born in the United States. All individuals born after 1985 in Indiana are tested for sickle cell trait. Other states have similar testing requirements.
- IUPUI Athletics requires all student-athletes to have results of sickle cell trait testing on file prior to participation.
- Your sickle cell trait results will remain the same throughout your life, so you may request a copy of your birth records which include sickle cell trait results from your pediatrician to meet this requirement.
- If you are unable to find your sickle cell test results, consult with your physician about getting a sickle cell solubility test.
- IUPUI Athletics is able to test for sickle cell trait upon your arrival to campus, but your ability to participate on your team may be affected because of a delay of a few days to receive results.



IUPUI Student-Athlete - Concussion Management Policy Statement

Printed Name _____

Cell Phone # _____ Sport _____

_____ I have read and understand the *NCAA Concussion Fact Sheet*.
Initial

After reading the NCAA Concussion fact sheet, I am aware of the following information:

_____ A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.

_____ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

_____ A concussion cannot be seen, but some of the symptoms may be immediately noticeable. Other symptoms can show up hours or days after the injury.

_____ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

_____ Following a concussion, the brain needs time to heal. I understand that I am much more likely to have a repeat concussion if I return to play before my symptoms resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, and even death.

I accept responsibility to report signs and symptoms of concussions and concussion related injuries and illnesses that I experience or notice in my teammates to an athletic trainer and/or team physician.

I understand that the IUPUI Department of Intercollegiate Athletics *Concussion Management Policy and Protocol* are available on iupuijags.com. I have been given an opportunity to review the Policy and to ask questions about it. I acknowledge by my initialing above and signature below that I understand the Policy, I agree to participate, and I will abide by the policies and procedures within it during the duration of my participation in IUPUI Athletics.

Signature of Student-Athlete

Date