

PLEASE RETURN BY AUGUST 1ST

January Admits by January 1st

Athletic Training Clinic, Hamilton College, 198 College Hill Road, Clinton, NY 13323

Telephone 315-859-4766; Fax 315-859-4799 • Website: <http://www.hamilton.edu/athletics/sportsmedicine>

Social Security # _____/_____/_____

Last Name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Country (If not U.S.A.) _____ Zip + 4 _____

Sports Participating In: _____ Sex: Male Female Date of Birth (Month/Day/Year) ____/____/____

Parents/Guardian _____ Relationship _____ Home Phone _____

Home Address _____ Work Phone _____

E-Mail Address _____ Student Cell Phone Number _____

Emergency Contact Name _____ Home Address _____ Home Phone _____

E-Mail Address _____ Relationship _____ Work Phone _____

I consent to the medical treatment of _____
Student's Name

by the staff of the Hamilton College Athletic Training Clinic, consulting or covering physicians, and emergency medical technicians. **I have also read and signed the Patients' Rights and Patients' Responsibilities.** I certify that the information given here is complete and accurate to the best of my knowledge.

Student Signature Date of Signatures Parent Signature

Insurance Information

_____ This is my current insurance information. If the insurance information should change, I will send a copy of my most recent card.

Name of Insurance Co. _____

Address _____

City/State/Zip _____ Insurance Co. Telephone # (_____) _____

Subscriber's Name on Policy _____

ID# _____ Group # _____

Is a referral for a specialist required? Yes No

Primary Care Physician Name _____ Phone (_____) _____

Address _____

All students are required to have some form of health insurance.

If we do not have current insurance information on file, your student will be enrolled in the Hamilton College Health Insurance Plan and billed a non-refundable premium.

For more information, contact: Allen J. Flood Insurance Co. at 800-972-7629 or Student Health Services at 315-859-4111.

Orthopedic/Sports Medicine History

Have you ever injured (sprain, strain, dislocation, subluxation, separation, fracture, herniation, etc.) or consulted a physician about any of the following body parts?

Body part	Yes	No	Date(s)	Details
Head:				
Neck:				
Chest Wall:				
Lower Back:				
Shoulder:				
Elbow:				
Wrist:				
Hand/Finger:				
Pelvis/Hip:				
Thigh:				
Knee:				
Lower Leg:				
Ankle:				
Foot/Toe:				
Other:				

	Yes	No	Date(s)	Details
Any X-rays/MRI/CT Scans?				
Any Hospitalization or Surgery?				
Casts or Splints?				
Injections?				
Orthotics?				
Have you been advised to have surgery which you have declined?				
Has your physical activity been restricted in the past two years?				

Any additional pertinent information: _____

Orthopedic Physician: _____

Address: _____

Phone Number: _____

If you have had surgery within the past year, you must submit a note from your physician as to your ability to participate!

Hamilton College Athletics Participation Statement

A. Participation Agreement, Assumption of Risk and Release

In consideration and as a condition of Hamilton College's permitting my participation in activities associated with an athletic team, which include but are not limited to training, trying out, practicing, playing and traveling, I freely acknowledge that I am aware of and accept the risks associated with such participation. I also acknowledge that my participation in such activities is wholly voluntary, and is not required in any way by Hamilton College.

I fully realize the dangers of participating in such activities and fully assume the risks associated with such participation, which may include, but are not limited to, the possibility of serious physical and/or mental trauma or injury, the onset of serious physical and/or medical conditions, and paralysis, which may require surgery or other medical treatment, and which may be caused in whole or in part by numerous factors, including my medical or physical condition, the actions or inactions of other athletes, the conditions of premises, and the negligence of the entity or individuals released hereby. I waive, release and discharge for myself, my heirs, executors, administrators, legal representatives, assignees and successors in interest any and all rights or claims for injuries or losses of any description that I may have or which may hereafter accrue to me against Hamilton College, its Trustees, employees, or agents, in connection with my participation in activities associated with a Hamilton College athletic team.

B. Medical Consent to Treatment

I grant permission to physicians, athletic trainers, and/or other medical practitioners or professionals associated, assisting, or employed in connection with Hamilton College athletic programs or student-athletes, to render any preventive, emergency, surgical or rehabilitative medical treatment or care deemed reasonable and necessary for my health and well-being, and to arrange for my hospitalization where reasonable and necessary, in circumstances connected with my participation in activities associated with a Hamilton College athletic team.

This consent is not intended to, and does not, create a duty on the part of physicians, athletic trainers, and/or other medical practitioners or professionals associated, assisting, or employed in connection with Hamilton College athletic programs or student-athletes, to render or arrange for such treatment or care.

C. Authorization of Release of Medical Information

I authorize Hamilton College and any of its health or physical care providers or practitioners to release to coaches, athletic trainers, or other individuals employed by or associated or assisting with Hamilton College athletic programs or student-athletes, any and all records, documents, or information they may have regarding my medical, physical or psychological condition, for the purpose of informing such individual(s) regarding such condition(s), such as records, documents or information may become available or be developed over the course of the year including and following the date of this Release Authorization, except for records, documents or information created or maintained in connection with an alcohol or drug abuse treatment or prevention program.

I further authorize the release of records, documents or information regarding my medical, physical, or psychological condition to other entities or individuals, including but not limited to the Hamilton College Sports Information department, media outlets and personnel, and professional team personnel for the purpose of informing such entities or individuals of such conditions. The Release Authorization should not be construed, however, to require such release.

This Release Authorization is effective for the year including and following the date of execution, and I may revoke it by means of a written statement to that effect, except to the extent that action has been taken based upon this Release Authorization.

D. Signature Approval

I have read, understand and approve Parts A, B and C of this Participation Statement.

A photocopy of this Participation Statement will be deemed to have the same force and effect as the original.

Student Signature

Age

Date

(Only if under 18)

Parent's Name _____

Parent's Address _____

City _____ State _____ Zip _____

Telephone # _____

Fax # _____

Parent's Signature (for students under age 18) _____

Patient's Rights and Responsibilities

The patient has a right

- to be treated with respect and dignity and to be provided with courteous, considerate care;
- to be informed about the diagnosis, treatment and prognosis of the health problem in terms that can be understood;
- to know the chances that treatment will be effective and to know the possible risks, side effects and alternative methods of treatment;
- to receive confidential treatment of their disclosures and medical records and, except when required by law, afforded the opportunity to approve or refuse their release;
- to know who is responsible for providing treatment;
- to have access to a second medical opinion before making any decision. The patient can decide not to be treated, but must be informed of the medical consequences of refusal;
- to participate in decisions involving the health problem;
- to be informed of the personal responsibilities involved in seeking medical treatment and maintaining health and well-being thereafter;
- to privacy;
- to have access to resource persons and information concerning health education, self-care and prevention of illness;
- to be given appropriate and professional quality health care without discrimination against their race, creed, color, religion, sex, national origin, sexual preference, handicap or age;
- to voice grievance with athletic training services and/or staff without being threatened, restrained and discriminated against.

The patient has a responsibility

- to inform clinician of any changes in his/her health status that could affect treatment;
- to adhere to a prescribed treatment plan and to discuss any desired change;
- to act in a considerate and cooperative manner with the Athletic Training Clinic staff;
- to ask questions and seek clarification regarding areas of concern;
- to weigh the consequences of refusing to comply with instructions and recommendations;
- to assist the clinicians in compiling a complete record by authorizing the Athletic Training Clinic to obtain necessary medical information from appropriate sources;
- to inform staff if he/she has a prescription card at the time of appointment;
- to keep appointments on time;
- to cancel appointments only when absolutely necessary, and far enough in advance so that other patients might utilize that time.

I have reviewed and understand my rights and responsibilities as described above.

Print Name

Signature of Patient/Athlete

Date of Signature