



## ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

I, the undersigned Mount Mercy University student, do hereby expressly and affirmatively state that I voluntarily wish to participate (practice sessions and competition) in the following intercollegiate sport or activity(ies);\_\_\_\_\_. I realize that my participation in this activity inherently involves risk of injury, including, but not limited to the following: death, neck and spinal injuries (which may result in complete or partial paralysis), brain damage, injury to internal organs, injury to the skeletal system, and injury or impairment to the body's general health and well-being. In addition, I acknowledge that injury may also result in serious impairment of future abilities to earn a living, engage in other business, social and recreational activities, and generally enjoy life. These types of injuries may result from my own actions, the actions or inactions of others, or a combination of both.

I understand that the rules and regulations are designed for the safety and protection of participants and I hereby agree to abide by the rules and regulations administered by the coaching staff and to accept the decisions of game officials as final. I also understand that certain activities require a minimum level of fitness for safe participation.

I acknowledge that I fully understand the contents of this Acknowledgement and Assumption of Risk statement before signing the same and have had an opportunity to ask questions. All questions I have asked have been answered to my complete satisfaction. Having done so, I agree to assume any and all potential risks of these activities and agree to hold Mount Mercy University, its officers, employees, and agents harmless for liability as it relates to this activity.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s) Signature\*

\_\_\_\_\_  
Date

### MEDICAL CONSENT

I hereby grant permission to the Mount Mercy University Athletic Department, athletic trainer, and other medical personnel to render aid, emergency treatment, medical or surgical care, preventative, rehabilitative care deemed reasonably necessary to my health and well being.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s) Signature\*

\_\_\_\_\_  
Date

\*If the student is 18 years or older, a parent(s) signature is not required for medical consent. However, it is highly recommended that the parent(s) read and sign the form to indicate that they acknowledge and understand the information provided.

## Acknowledgement of Insurance

I, (Student-athlete name) \_\_\_\_\_, attest that I have insurance coverage under a current in force insurance policy for injuries that occur during my participation in intercollegiate athletics. If there is a material change in coverage or expiration of coverage, I agree to notify **Mount Mercy University** of this development and update the insurance information I have on file with **Mount Mercy University**. I further understand and agree that failure on my part to notify **Mount Mercy University** of insurance changes will result in no responsibility whatsoever for the payment of, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at **Mount Mercy University**.

I acknowledge and understand that Mount Mercy University has athletic injury insurance that will provide **“secondary”** coverage for student-athletes during participation in organized team activities. The term “secondary coverage” means that the student athlete’s primary insurance must be utilized before the claim will be considered. Injuries subject to consideration under the University’s policy must be directly related to the student athlete’s participation in an intercollegiate organized team activity affiliated with Mount Mercy University. Pre-existing injuries or conditions **will not** be covered under the University’s policy

### In order to process a claim through the Mount Mercy University athletics secondary insurance policy:

1. The injury must occur while participating in a sanctioned Mount Mercy University athletic event including but not limited to; practice, game, conditioning, or weightlifting.
2. The injury must be reported to the Mount Mercy University Athletic Training Staff for evaluation.
3. After referral by the Mount Mercy University Athletic Training Staff, the student-athlete must provide the medical provider with primary insurance.
4. Any insurance or medical information via phone calls or mail received by the student-athlete, including but not limited to; bills, payments, explanation of benefits (EOB), physician notes, prescriptions, and medical records, must be relayed to Rhonda Martin, Insurance Coordinator/Athletic Office Manager or sent directly to:

Mount Mercy University Athletic Office  
Attention: Rhonda Martin  
1330 Elmhurst Dr NE Cedar Rapids, IA 52402  
319-363-8213 ex 1376      [rmartin@mtmercy.edu](mailto:rmartin@mtmercy.edu)

I have read this entire document, and understand that primary insurance is required for Mount Mercy University student athletes. Mount Mercy Athletics has a **“secondary”** insurance coverage for student athletes, and a process in which insurance claims must be handled. I have read this document and am knowingly and voluntarily signing this document.

\_\_\_\_\_  
Student Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature (if under the age of 18)

\_\_\_\_\_  
Date

### Emergency Contact Information

Student Athlete Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

Sport(s): \_\_\_\_\_

College Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

<b>Mother/Guardian:</b>	<b>Father /Guardian:</b>
_____	_____
Home Phone: _____	Home Phone: _____
Home Address: _____	Home Address: _____
_____	_____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Cell : _____ Work Phone: _____	Cell : _____ Work Phone: _____

### Primary Insurance Information

Insurance Company: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

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

Policy number: \_\_\_\_\_ Plan number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Secondary Insurance Information (If have)

Insurance Company: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

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

Policy number: \_\_\_\_\_ Plan number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

# HIPAA Privacy Practices and Consent Form

**Right to Notice:** As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Physicians, Athletic Trainers, and the Mount Mercy University (MMU) Athletic Staff involved with your sport, Physical Therapists, Occupational Therapists, and other pertinent health care providers in association with MMU Athletic Training, including Mercy Medical Center, St. Luke's Hospital, PCI, and David S. Tearse M.D., LLC can use your protected health information for treatment, payment and health care operations.

1. **Treatment** - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. (please initial)\_\_\_\_\_
2. **Payment** - We may use and disclose your health information to/from the above listed providers, to Summit America Insurance (MMU secondary/excess insurance policy, and your primary insurance carrier to aid in obtaining treatment information and payment for services provided to you). (please initial)\_\_\_\_\_
3. **Health care operations** - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, health/medical insurance communications for explanation of benefits, quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. (please initial)\_\_\_\_\_

**Your Authorization:** Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

**Emergency Situations:** In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

**Marketing:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may also use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the

victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

**National Security:** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

**Your Right as a Patient:** You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. - You have the right to receive confidential communications regarding your protected health information. -You have the right to inspect and copy your protected health information. -You have the right to amend your protected health information. -You have the right to receive an account of disclosures of your protected health information. -You have the right to a paper copy of this notice of privacy practices. (please initial)\_\_\_\_\_

**Legal Requirements:** MMU Athletic Training and its Health Care Associates are required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this notice, or are available within our office.

**Complaints:** If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

I acknowledge by my signature that my PHI (protected health information) may be used or disclosed as stated above, realizing that I have the right to a written formal complaint, a right to knowledge of my information disclosures, as well as the other rights stated above. I acknowledge that I have read these rights stated and have read the privacy rules of MMU Athletic Training.

\_\_\_\_\_  
Student Printed Name

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

\_\_\_\_\_  
Date

**MOUNT MERCY UNIVERSITY PREPARTICIPATION PHYSICAL EVALUATION – PHYSICAL EXAMINATION**

Athlete's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ %Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
Brachial blood pressure while sitting

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: \_\_\_\_\_yes \_\_\_\_\_no Pupils: \_\_\_\_\_Equal \_\_\_\_\_Unequal

As a requirement, this physical must be completed annually and turned into the athletic office **prior to** participation in any practice (both in-season and out-of-season), or games/matches/meets.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart - Auscultation of the heart in the supine position.			
Heart – Auscultation of the heart In the standing position.			
Heart – Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*station-based examination only

**CLEARANCE**

\_\_\_\_\_ Cleared

\_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_ Recommendations: \_\_\_\_\_

*The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by other health care practitioners will not be accepted.*

Name (print/type) \_\_\_\_\_ Date of Examination: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

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

## MOUNT MERCY UNIVERSITY PREPARTICIPATION PHYSICAL EVALUATION—MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed annually by **student-athlete** (or guardian if athlete is under the age of 18) in order for the student-athlete to participate in athletic activities. These questions are designed to determine if the athlete has developed any condition which would make it hazardous to participate in an athletic event.

Athlete's Name (print) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Year in College \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Explain "Yes" answers in the box on the back page\*\*. Circle questions you don't know the answers to. Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, or nurse practitioner is required before any participation in MMC practice, games, matches, or meets**

1. Have you had a medical injury since you last check up or sports evaluation?  
 Yes      No
  2. Have you been hospitalized overnight in the past year?  
 Yes      No  
 Have you ever had surgery?      Yes      No
  3. Have you ever passed out during or after exercise?  
 Yes      No  
 Have you ever had chest pain during or after exercise?  
 Yes      No  
 Do you get tired more quickly than your friends do during exercise?  
 Yes      No  
 Have you ever had racing of your heart or skipped heartbeats?  
 Yes      No  
 Have you had high blood pressure or high cholesterol?  
 Yes      No  
 Have you ever been told you have a heart murmur?  
 Yes      No  
 Has any family member or relative died of heart problems or of sudden unexpected death before age 50?      Yes      No  
 Had any family member been diagnosed with enlarged heart (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome, or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?  
 Yes      No  
 Has a physician ever denied or restricted your participation in sports for any heart problems?  
 Yes      No
  4. Have you ever had a head injury or concussion?  
 Yes      No  
 Have you ever been knocked out, become unconscious, or lost your memory?      Yes      No  
 If yes how many times? \_\_\_\_\_  
 When was the last concussion? \_\_\_\_\_  
 How severe was each one? (Explain below)  
 Have you ever had a seizure?      Yes      No  
 Do you have frequent or severe headaches?      Yes      No  
 Have you ever had numbness or tingling in your arms, hands, legs, or feet?  
 Yes      No  
 Have you ever had a stinger, burner, or pinched nerve?  
 Yes      No
  5. Are you missing any paired organs?      Yes      No
  6. Are you under a doctor's care?      Yes      No
  7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills, or using an inhaler?  
 Yes      No
  8. Do you have any allergies (i.e.: to pollen, medicine, food, or stinging insects)?      Yes      No
  9. Have you ever been dizzy during or after exercise?
  10. Do you have any current skin problems (i.e.: itching, rashes, acne, warts, fungus, or blisters)?      Yes      No
  11. Have you ever become ill from exercising in the heat?  
 Yes      No
  12. Have you had any problems with your eyes or vision?  
 Yes      No
  13. Have you ever gotten unexpectedly short of breath with exercise?  
 Yes      No  
 Do you have asthma?      Yes      No  
 Do you have seasonal allergies that require medical treatment?  
 Yes      No
  14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e.: knee brace, foot orthotics, retainer on your teeth, hearing aid)?  
 Yes      No
  15. Have you ever had a sprain, strain, or swelling after injury?  
 Yes      No  
 Have you broken or fractured any bones or dislocated any joints?  
 Yes      No  
 Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?      Yes      No  
 Is yes, check the appropriate line and explain below,  

_____ Head	_____ Elbow	_____ Hip
_____ Neck	_____ Forearm	_____ Thigh
_____ Back	_____ Wrist	_____ Knee
_____ Chest	_____ Hand	_____ Shin/Calf
_____ Shoulder	_____ Finger	_____ Ankle
_____ Upper Arm		_____ Foot
  16. Do you want to weigh more or less than you do now?  
 Yes      No
  17. Do you feel stressed out?      Yes      No
  18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?      Yes      No
- Females Only**
19. When was your first menstrual period? \_\_\_\_\_  
 When was your most recent menstrual period? \_\_\_\_\_  
 How much time do you usually have from the start of one period to the start of another? \_\_\_\_\_  
 How many periods have you had in the last year? \_\_\_\_\_  
 What was the longest time between periods in the last year? \_\_\_\_\_

*An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, or nurse practitioner.*

**\*\*Explain "Yes" answers on the lines below:**

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It is understood that even though protective equipment is worn by the athlete whenever needed, the possibility of an accident still remains. Mount Mercy College does not assume any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student-athlete should need immediate care and treatment as a result of injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student-athlete by any physician, athletic trainer, nurse, or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student-athlete.

If between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

*I hereby state, that to the best of my knowledge, my answers to the above questions are complete and correct.*

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

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(If student is under the age of 18)

***For school use only:***

\_\_\_\_\_ Athlete has completed concussion testing performed by university's certified Athletic Trainer.

This medical history form was reviewed by:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**This form must be on file in the athletic office PRIOR to participation in any practice, scrimmage, or contest.**