Dear Point Park University Athlete:

It is time again for all student-athletes to complete the required medical & insurance forms for the upcoming 2011-2012 school year. This letter is to inform you that **ALL STUDENT-ATHLETES ARE REQUIRED TO HAVE A PHYSICAL** prior to participation in team conditioning, practice or competition. All physicals will take place at UPMC Center for Sports Medicine, located on the South Side. Shuttle vans between Point Park University and UPMC will be provided. The shuttles will start running 30 minutes before the start of the physicals. Dates and times for the physicals are as follows:

<table>
<thead>
<tr>
<th>Sport</th>
<th>Date of Physical</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men's/Women's Soccer</td>
<td>August 14, 2011</td>
<td>4:00 pm</td>
</tr>
<tr>
<td>Women's Volleyball</td>
<td>August 14, 2011</td>
<td>4:00 pm</td>
</tr>
<tr>
<td>Men's/Women's Cross Country</td>
<td>August 14, 2011</td>
<td>4:00 pm</td>
</tr>
<tr>
<td>Men's/Women's Golf</td>
<td>August 28, 2011</td>
<td>11:00 am</td>
</tr>
<tr>
<td>Men's/Women's Basketball</td>
<td>August 28, 2011</td>
<td>11:00 am</td>
</tr>
<tr>
<td>Baseball</td>
<td>August 28, 2011</td>
<td>11:00 am</td>
</tr>
<tr>
<td>Softball</td>
<td>August 28, 2011</td>
<td>11:00 am</td>
</tr>
</tbody>
</table>

The following is a checklist of the required medical forms that must be completed and on file in the Athletic Training Room before you may participate in intercollegiate athletic practices or competitions at Point Park University:

- **Student Information Form (Form 1).** Please complete this form in its entirety. Please do not forget to sign and date in both places.
- **Waiver of Insurance (Form 2):** Should be completed, signed and returned if you wish to DECLINE the automatically provided UPMC health insurance coverage. Please note, failure to complete this waiver will result in automatic enrollment of the University's student health insurance plan. **You should decline if you or your family already has insurance.**
- **Release of Protected Health Information (PHI) form (Form 3):** Allows qualified medical professionals to view your PHI to treat your injury appropriately. Please review and sign at the bottom of the page.
- **Consent to Treat Form (Form 4):** Allows medical staff to treat your injuries. Please review and sign at the bottom of the page.
- **Authorization to Disclose Information (Form 5):** Identifies and authorizes who Summit America Insurance Services may disclose information to.
- **Pre-participation physical evaluation form:** needs to be completed thoroughly before you can be seen by a physician. (Form 6)

*Please return all completed forms **ALONG WITH A COPY OF YOUR CURRENT INSURANCE CARD** by August 1st:*

Denise Dunner  
Department of Athletics  
Point Park University  
201 Wood Street  
Pittsburgh, PA 15222

Point Park University's athletic training facilities are located on the 1st floor of the Student Center (330 Boulevard of the Allies). **It is imperative that the forms are completed, signed and received by the sports medicine staff in order to assure clearance to participate in play.** Thanks for your cooperation and please call me at (412) 392-3911 with any questions. You can also contact our Athletic Trainers, Kristin Baker and/or Jonathan Birchok at (412) 392-3816.

Sincerely,

Daniel R. Swalga  
Director of Athletics  
Point Park University
STUDENT INFORMATION

Personal Information

Student Name __________________________ Student # __________________________
Address ____________________________ Phone Number _______________________
Fathers Name ________________________ Mothers Name _______________________
Address ______________________________
Phone Number _________________________
Fathers Employer Name ________________________________
Mothers Employer Name ________________________________
Primary Physician Name __________________________ Phone Number _______________________
Address ______________________________

Medical Insurance Information

Insurance Company Name ________________________________
Address ________________________________
Phone Number ________________________________
Policy Holder Name __________________________ ID Number __________________________
I certify that the foregoing information is true and correct.

Student Signature __________________________ Date __________________________

Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original.

Signature __________________________ Date __________________________
This form is to be used by students who elect to waive coverage under the University’s student health insurance plan. Coverage may be waived only if you are currently covered by another insurance plan. Proof of insurance is required (copy of the front and back of insurance card). If you choose to waive coverage, you must submit this declination/waiver of coverage form and proof of insurance as directed below.

**Declination/Waiver of Coverage**

To be completed if coverage is declined or refused by an eligible student:

**Coverage Declined for (check only one):**

- Student
- Student and Spouse
- Student and Child
- Family

**Reasons for Declining Coverage (check all that apply):**

- Coverage by parent’s insurance
- Enrolled in another insurance carrier’s plan
- Spouse covered by employer’s group
- Other

I acknowledge I have been given the right to apply for this coverage, however, I and/or my dependent(s), am/are electing not to enroll. I acknowledge that I, and/or my dependent(s), may have to wait until the plan’s next anniversary date to be enrolled for group coverage. Please sign here only if you are declining coverage for yourself and/or dependent(s):

**Student Name (Print):** ________________________  **Student ID #** ________________________

**Signature** ________________________  **Date:** ________________________

If student is under 18 years of age:

**Parent/Guardian Name (Print):** ________________________

**Signature:** ________________________  **Date:** ________________________

Students electing to waive coverage must return this declination/waiver of coverage form and proof of insurance in person to the Office of Student Affairs, 7th Student Center, via fax at (412) 392-3855, or by mail to:

**Office of Student Affairs**
**Point Park University**
**201 Wood Street**
**Pittsburgh, PA 15222**

For questions concerning the Point Park University’s health insurance plan, or to obtain the Student Health Plan brochure, visit the Office of Student Affairs, 7th floor Student Center, call the office at (412) 392-3840, or visit the website at www.pointpark.edu/StudentLife/HealthandStudentServices.
UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
Authorization for Release of Protected Health Information

RELEASE OF PROTECTED HEALTH INFORMATION

- I authorize UPMC to provide information related to my care to family/school/team physicians, school
  nurses, coaches, athletic directors, school principals, EMS personnel, and such other persons as is
  necessary needed for them to provide consultation, treatment, establish a plan of care or determine whether
  the Athlete may resume participation in school or sports activities.

- I authorize UPMC to use my billing information for UPMC internal departmental reporting purposes.

- I authorize UPMC (including its hospitals, other entities and programs) to use medical or other information
  maintained on electronic information systems or stored in various forms in connection with my care, health
  care operations, or payment for treatment and services.

- I understand that the health record(s) released by UPMC may be re-disclosed by the facility/person that
  receives the record(s) and therefore (1) UPMC and its staff/employees has no responsibility or liability as a
  result of the re-disclosure and (2) such information may no longer be protected by federal or state privacy
  laws.

- I understand that this Authorization is in effect for a period of one year from the date signed by the Athlete.

- I understand that this Authorization is in effect if I am treated for an injury during off-season workouts;
  however, no time frame specified shall go beyond one year from the date of signature.

- I understand that I have the right to revoke this Authorization form at any time by sending a written request
  to UPMC at the location where the Authorization was provided.

- I understand that my decision to revoke the Authorization does not apply to any release of my health
  record(s) that may have taken place prior to the date of my request to revoke the Authorization.

- I understand that I am entitled to a copy of this completed Authorization form.

AGREED

______________________________    ________________
Athlete/Patient Signature    Date

______________________________    ________________________
Parent/Guardian Signature (If Athlete is a Minor)    Date    Relationship

Rev 5/11    Form 3
UPMC/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC)
CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I ______________________ (print or type name) consent to the provision of care. I understand that this
care may include medical treatment, special tests, exams, evaluation, treatment, and rehabilitation of athletic
injuries. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment
and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist or participate in providing care. This may include, but may not be
limited to team physician, school nurse, and licensed physical therapists. Under the direction of a certified athletic
trainer, college/university athletic training students and high school student aides may also provide care.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

I understand that copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent
in the mail upon my request or viewed at http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx.
I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy
Practices. ________________ Patient Initials

Patient signature ___________________________ Date ____________

Signature/identify on behalf of patient/relationship ___________________________ Date ____________

Signature/identify on behalf of patient/relationship ___________________________ Date ____________

For Office Use Only:

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: ___________________________

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices: ___________________________
Authorization to Disclose Information

Student Name: ___________________________ Date of Birth: _____________

School Name: ___________________________ ID Number: _______________

I authorize Summit America Insurance Services, LC to disclose information to the following person in relation to medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information.

This authorization will be good for one year from the date of signature. I understand that I may revoke this authorization by providing a written request to Summit America at any time. I further agree that a photo copy of this authorization shall be as valid as the original.

Person to whom Summit America may disclose information ___________________________

Relationship ___________________________

Please itemize any restrictions upon this release: _______________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Student Signature ___________________________ Date _________________

Return this form by mail or fax to:

Summit America Insurance Services
Attn: Claims Department
7400 College Blvd., Suite 100
Overland Park, KS 66210
Fax: (913) 327-7520

Kansas City Office: 7400 College Blvd., Ste. 100 • Overland Park, KS 66210 • Phone: 913/327-0200 • Fax: 913/327-0201
Salt Lake City Office: 2180 South 1300 East, Suite 520 • Salt Lake City, UT 84106 • Phone: 801/412-2626 • Fax: 801/412-2625

Form 5
# UPMC Sports Medicine
## Physical Examination Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Class</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone (H)</th>
<th>(W)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents/Guardian</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Sports</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SS #</th>
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<tbody>
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</table>

## Fill in details of "YES" answers in space below:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

1. Have you ever been hospitalized?  
   - Have you ever had surgery?  
2. Are you currently taking medication?  
3. Do you smoke?  
   - Do you cough with exercise?  
4. Do you have any allergies (medicine, bees, etc.)?  
5. Have you ever passed out during exercise?  
   - Have you ever been dizzy during exercise?  
   - Have you ever had chest pain?  
   - Do you tire more quickly than your friends during exercise?  
6. Have you ever had high blood pressure?  
   - Have you ever been told you have a heart murmur?  
   - Have you ever had racing of your heart or skipped beats?  
   - Has anyone in your family died of heart problems or had a sudden death before age 40?  
   - Do you or anyone in your family have Marfan's Syndrome (Abe Lincoln's disease)?  
7. Do you have any skin problems (itching, moles, breaking out)?  
8. Have you ever had a head injury or concussion?  
9. Have you ever had a seizure?  
10. Have you ever had a stinger or burner?  
11. Are you missing one of a paired organ (eyes, kidneys, ovaries, testes, etc.)?  
12. Have you ever injured (sprained, dislocated, fractured, etc.):  
   - Shoulder  
   - Elbow  
   - Arm  
   - Wrist  
   - Hand  
   - Fingers/Thumb  
   - Neck  
   - Chest  
   - Back  
   - Hip  
   - Thigh  
   - Knee  
   - Shin/Calf  
   - Ankle  
   - Foot  
13. Do you have sickle cell anemia or sickle cell trait?  
14. Have you ever had heat cramps?  
15. Have you ever had:  
   - Mononucleosis  
   - Hepatitis  
   - Asthma  
   - Tuberculosis  
   - Anemia  
   - Diabetes  
   - Headaches  
   - Eye Injuries  
   - Stomach Ulcers  
16. Any additional health history information?  
17. Do you use special pads or braces?  
18. Do you use special appliances? (braces, hearing aids, insulin pumps, etc.)  
19. Do you wear corrective lenses/contacts for sports?  
   - Are they polycarbonate/safety lenses?  
20. When was your last tetanus shot?  
21. When was your first period?  
   - When was your last period?  
   - Are your periods regular?  

**Explain "yes" answers here:**

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rev 7/09

Form 6
Dear Parent/Guardian:

As part of a contractual agreement between UPMC Sports Medicine and Point Park University, UPMC provides two certified athletic trainers to aide in the prevention, recognition, evaluation, and treatment of athletic injuries.

To treat your son or daughter, two forms must be signed by parents/guardians of student-athletes. One is the “Consent for Treatment, Payment and Health Care Operations.” This gives the athletic trainer(s) and other associated healthcare personnel permission to assist or participate in providing care in the event of an injury or illness. The other form is the “Authorization for Release of Protected Health Information.” This form allows the athletic trainer(s) to communicate with medical personnel and the university athletics department personnel in order to provide consultation, treatment, and establish a plan of care for the injured or ill patient.

**Please note that these forms have no relationship to your health insurance plan and in no way influence your choice of medical care.** UPMC, as the employers of the athletic trainer(s) at Point Park University, must have these forms completed in order to provide care for your son or daughter to comply with privacy and standard consent to treat laws.

In addition, copies of the UPMC Notice of Privacy Practices document are available at the school, can be sent in the mail upon request, or viewed at [http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx](http://www.upmc.com/HospitalsFacilities/hipaa/Pages/privacy-notice.aspx).

**Please sign the attached documents.** If you revoke this authorization or consent form, please contact the athletic office at 412-392-3844. We look forward to your student-athlete's safe participation in Point Park University athletics. Thank you for your time.

Sincerely,

Dan Swalga  
Director of Athletics  
Point Park University