



INTRODUCTION

The following pages contain the forms needed to participate as a NCAA athlete. You will **NOT** be cleared if this is not completed. Please fill out/sign/initial all appropriate spaces. The system will not let you save and submit the forms without completing them. Please make sure to read these forms and make sure you understand them. If you have any questions please email sports-medicine@bucknell.edu.

The packet is to be filled out by everyone, returning or new athlete. This packet contains the following forms:

1. Health Insurance Away from home information.
2. Second Medical Opinion Policy.
3. Statement of Responsibility for Sport Safety.
4. Assumption of Risk Waiver.
5. Consent to Treat.
6. HIPPA form.
7. Concussion Acknowledgement.
8. Concussion/sickle cell/rhabdomyolysis video checklist.

Again please fill/sign/ initial in appropriate spaces!

Friendly reminder for **RETURNERS**:

After finishing the sports medicine required forms, you need to download, print, and have the **POLICY** holder sign the insurance form, then upload that form to the form section in your sportware account. When all steps are completed you will be cleared (barring any outstanding missing information).

Please refer to your returning athlete checklist if you are concerned you are missing information.

Friendly reminder for **NEW ATHLETES**:

After finishing the sports medicine required forms, you will need to make sure your pre-participation physical, sickle cell proof, and insurance form (signed by the **POLICY** holder) are uploaded to the form section in your sportware account. When all steps are completed you will be cleared (barring any outstanding missing information).

Please refer to your new athlete checklist if you are concerned you are missing information.

Again if you have any questions please email sports-medicine@bucknell.edu or contact your athletic trainer directly.



Health Insurance Coverage for Students Away From Home

Dear Parents, Guardians and/or Student-Athletes,

Many of you are keenly aware the health insurance landscape in the United States has drastically changed over the past few years. Our student-athletes and parents have been impacted by these changes. Bucknell Athletics continues to investigate ways to assist you in minimizing the impact of these changes to your family’s financial obligations. While our athletic department provides excess accident insurance for athletic injuries, some general medical issues are not covered by this program. Our research suggests that an increasing percentage of student-athletes enrolled at Bucknell University come to school enrolled in an HMO or other similar health insurance plans requiring the use of an In-Network provider close to your home. When students enrolled in these plans require medical care away from your home network, these types of plans often place more financial obligation on the student and family for these medical services.

We would like to make you aware of a potential solution to this issue. More and more health insurance companies now have a program that allows you to notify them when your student is away from home in order to obtain In-Network benefits for medical services in the Lewisburg/Danville area. These programs are often referred to as “Guest Memberships” or “Away from Home Care” depending on the insurance company. Guest memberships are particularly well suited for college students because your student-athlete would receive the benefits and coverage of the local HMO plan affiliated with your home plan without the hassle of filing claim forms or having to obtain prior authorizations from your family doctor miles away at home. We have found there is usually no additional charge for this type of program.

As members of HMO-type plans, your student is almost always covered for the treatment of emergency medical conditions no matter where they are; however, unless you enroll in one of these guest programs, care for non-emergency medical conditions may not be covered or covered with much greater expense to you. The Guest Membership will also facilitate the insurance process for the insurance Bucknell Athletics has in place to pay excess expenses for injuries while participating in intercollegiate athletics. The Guest Membership status will allow us to obtain authorization from these plans prior to ordering tests or seeing doctors for the injury.

If the incoming student is currently enrolled in an HMO or other similar health insurance plan requiring the use of a network of providers close to your home, we encourage you to contact your insurance company by calling the customer service number on your insurance card to inquire about Guest Memberships or a similar program for students living away from home to attend college. Should the need arise for your student to obtain medical services while at Bucknell, you will have already facilitated the administrative process while saving yourself valuable time and money so that you can focus on your student-athlete’s medical needs. Finally, when you obtain Guest Membership, you may be required to designate a separate primary care provider (PCP) for your student while at school. Please consider naming Bucknell University Team Physicians and/or Bucknell’s Director of Student Health as your student’s PCP, along with ensuring the local hospitals and Team Physicians will be included as In-Network:

Bucknell Student Health

Dr. Catherine O’Neil
NPI#1083863187
Bucknell Student Health
One Dent Drive
Lewisburg, PA 17837

Team Physicians

Drs. Feldmann, McElroy, Roza & Morris
NPI#1043449721
Geisinger Sports Medicine
100 North Academy Avenue
Danville, PA 17822

Hospitals

Evangelical Community Hospital
Lewisburg, PA 17837

Geisinger Medical Center
Danville, PA 17822

In the event a Guest Membership is not available as part of a student-athlete’s home coverage, a customized, In-Network student insurance plan is available for purchase through Consolidated Health Plan (CHP), in conjunction with RCM&D and Bucknell. For more information on this offering, please visit www.consolidatedhealthplan.com and select Bucknell University from the drop-down menu of schools. Please let our sports medicine staff know if you have any questions

Sincerely,



On behalf of Bucknell University

_____By initialing in the provided space I am stating that I have read and understand the information presented above.



Second Medical Opinion Policy

The Bucknell University Sports Medicine Department recognizes the value of second opinions for injuries. The University will pay for this second opinion, **only if the following conditions are met:**

- Prior approval should be obtained from the Head Athletic Trainer, Ian Wood. Requests must include the physician's name, specialty, location, and other pertinent information as needed.
- Specific diagnostic testing over and above routine laboratory tests or office X-rays should be approved by the Sports Medicine staff before such testing takes place.
- The student-athlete is requested to forward all results of a second-opinion evaluation, including physician exam, laboratory tests, and radiological procedures, to the athletic training staff or team physicians.
- Results of a second-opinion examination will be reviewed by the Bucknell University Sports Medicine staff along with recommendations for further treatment and care. Final decisions regarding suitability to return to competition and practice will be the responsibility of the Sports Medicine staff.
- Requests for payment for surgeries performed by physicians not on the Sports Medicine staff will be reviewed on an individual basis. In general if surgery is not referred out by Bucknell University Sports Medicine, the financial burden will be the athlete and their parent's sole responsibility.
- In cases where there is a discrepancy of opinion between the Sports Medicine staff and an outside consulting physician, a third opinion may be requested. In such a case, the third consultant will be chosen by the Sports Medicine staff (in agreement with the athlete) at University expense from a group of prominent, nationally recognized sports medicine experts. The results of this evaluation, along with recommendations for care and treatment, will be reviewed by the Bucknell University Sports Medicine staff. Decisions regarding return to competition and practice remain solely with the Sports Medicine staff.

On behalf of Bucknell University

_____ By initialing in the provided space I am stating that I have read and understand the information presented above.



STATEMENT OF RESPONSIBILITY FOR SPORT SAFETY

Student-Athlete Name: _____

Sport: _____

I wish to participate in the above sport (“Sport”). For purposes of this document, “participation” or “participate” includes try-outs, practices, competitions, and any other activities in any way associated with the Sport or intercollegiate athletics. In consideration of Bucknell University permitting my participation, I acknowledge and agree as follows:

1. I recognize the importance of following the coach’s instructions regarding playing techniques, training rules, and other team rules, and agree to obey such instructions.
2. I agree to inspect all safety equipment and report any faulty or poor-fitting equipment immediately to the coach, equipment manager, or Certified Athletic Trainer. I understand that I am responsible for taking care of myself and my equipment. In addition, I agree to use equipment only in the manner in which it is intended to be used.
3. I understand that I am responsible for immediately reporting **ALL** injuries to a member of the Bucknell University Sports Medicine Staff, specifically a Certified Athletic Trainer and agree to do so accurately and completely. I understand that the Certified Athletic Trainer will make a decision as to whether a physician referral is needed. I also understand that I will be required to obtain the clearance of the team physician, if seen by an outside physician, before being permitted to participate in the Sport following an injury. I further understand that irrespective of the clearance of the team physician, I may be at greater risk of suffering injury, illness or death as a result of my participation following an injury. In order to discuss specific additional risks associated with my participation in the Sport, I will consult with my personal physician or a specialist, in addition to the team physician.
4. I understand and agree that I **MUST** provide proof of comprehensive medical insurance in order to be allowed to participate in any intercollegiate athletics at Bucknell University, including the above Sport. It is my responsibility to confirm in-network medical coverage within the Geisinger Health Systems and the associated facilities by which our team physicians are employed. I understand that if I am injured and my medical insurance does not cover associated costs and expenses, I am responsible for **ALL** medical bills including, but not limited to, doctors’ visits, diagnostic images, lab work, surgeries, etc. These expenses are solely my responsibility and are not in any way the responsibility of Bucknell University or its trustees, officers, employees or agents. I further understand that I have the opportunity to purchase personal medical insurance offered to all Bucknell University students. I understand that if I fail to do so, I am putting myself at risk of having to go home for in-network medical coverage, which may delay my return to participation.

I have had sufficient time to review and seek explanation of the provisions contained above. I have carefully read this document, understand it fully, and agree to be bound by its terms. This Statement of Responsibilities for Sport Safety agreement shall bind my heirs, estate, executor, administrator, assigns and all members of my family.

BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CLAIMS AND LEGAL RIGHTS. READ CAREFULLY BEFORE SIGNING.

Student-Athlete’s Printed Name

Student-Athlete’s Signature

Date

Parent/Guardian’s Printed Name (if under 18)

Parent/Guardian’s Signature

Date



ASSUMPTION OF RISK, WAIVER OF LIABILITY AND RELEASE

Name: _____

Sport: _____

I wish to participate in the above sport ("Sport"). For purposes of this document, "participation" or "participate" includes try-outs, practices, competitions, and any other activities in any way associated with the Sport or intercollegiate athletics. In consideration of Bucknell University permitting my participation, I acknowledge and agree as follows:

1. My participation in the sport is purely voluntary.
2. I am aware that participating in the Sport can be dangerous and involves significant risks, including, but not limited to: serious head, neck or spinal injuries which may result in complete or partial paralysis or brain damage; serious injury to all bones, joints, ligaments, muscles, tendons, and other aspects of my body; serious injury to or diminution of my general health and well-being; and death.
3. I understand and freely assume all risks in any way related to my participation in the Sport.
4. I understand that it is my responsibility to exercise appropriate care with regard to myself and my equipment.
5. To the greatest extent allowed by law, on behalf of myself and my heirs, executors, estate and family, I release, covenant not to sue, and forever discharge Bucknell University, including their trustees, officers, employees and agents ("Released Parties"), of and from any and all liabilities, claims, causes of action, damages, costs, attorneys' fees and expenses of any kind ("Losses") arising out of or related to my participation in the Sport or any activities related to the intercollegiate athletics program, and further agree to indemnify and hold each of the Released Parties harmless from and against any and all such Losses.

I have had sufficient time to review and seek explanation of the provisions contained above. I have carefully read this document, understand it fully, and agree to be bound by its terms. This Assumption of Risk, Waiver of Liability and Release agreement shall bind my heirs, estate, executor, administrator, assigns and all members of my family.

BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CLAIMS AND LEGAL RIGHTS. READ CAREFULLY BEFORE SIGNING.

Print Name	Signature	Date	
If under age 18:			
Parent/Guardian Printed Name	Signature	Relationship	Date



CONSENT TO TREAT

Print Name _____

Sport _____

To be read and signed by the Student-Athlete and the Parent /Guardian if the Student-Athlete is under 18 years old.

Consent is hereby granted by the undersigned to Bucknell University, including its Athletic Training Services staff, health care professionals, and consultants, to proceed with any medical or minor surgical care or treatment, including without limitation x-ray examination, imaging studies or testing, that the professional staff considers to be necessary for the student-athlete named below.

I understand and agree that information, including information about my injury/condition, may be disclosed to the staff and personnel of the Bucknell Departments of Athletics or Physical Education, Recreation & Dance in relation to my participation in any physical activity.

This Consent to Treatment is a required condition for participation in the athletics program and shall remain valid until revoked in writing.

Signature of Student-Athlete

Birthdate (mm/dd/yy)

Age

Date (mm/dd/yy)

Name of Parent/Legal Guardian (PRINT)

Signature of Parent/Guardian

Date (mm/dd/yy)



Student-Athlete Authorization /Consent for Treatment and Disclosure of Protected Health Information to Bucknell University 2018-2019

I, _____, hereby authorize the treatment and disclosure of my protected health
(Name of Student-Athlete)

information and any related information regarding any injury or illness that arises during my training for and participation in intercollegiate athletics to Bucknell University and its physicians, athletic trainers, health care personnel, employees, agents, and business associates (hereinafter "Bucknell") for purposes, including, but not limited to:

- My treatment including the provision, coordination, or management of health-care and related services to me by one or more health-care providers.
- Payment activities related to my injury or illness, for Bucknell as well as other health-care providers and health plans.
- Health-care operation purposes as well as certain health-care operation purposes of other health-care providers and health plans.
- To disclose my protected health information to someone involved in my care or payment for my care such as a spouse, a family member, or close friend.
- The National Collegiate Athletic Association, its designated employees, agents and/or contractors, which may use such information for the purpose of using injury, relevant illness and participation information, as de-identified, for the purpose of evaluating the effectiveness of health and safety rules and policy and to study other sports medicine questions. Such disclosures and data will be stored securely within industry standards.
- To notify, or to assist in the notification of, a family member, a personal representative, or another person responsible for my care, regarding my location, general condition, or death.
- When required by federal, state, or local law.
- For judicial and administrative proceedings.

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that Bucknell will not condition any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for in this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA or conference athletics.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Student-Athlete's Printed Name

Student-Athlete's Signature

Date

Parent/Guardian's Printed Name

Parent/Guardian's Signature

Date



Risk of Concussion or Other Head Injury Acknowledgement

I, _____, acknowledge that I have to be an active participant in my own healthcare. As such, I
(Print First & Last Name)

have the direct responsibility for reporting all of my injuries and illnesses to the Sports Medicine Staff of Bucknell University (certified athletic trainer, team physician, etc.). I recognize that the appropriateness of diagnosis, treatment, return-to-play and other decisions are dependent upon me providing an accurate medical history, including fully disclosing all symptoms and complaints regarding both previous and current injuries, disabilities, and medical concerns. I hereby affirm that I have fully disclosed in writing all prior medical conditions and injuries. I further understand that I am responsible for disclosing all future medical conditions and injuries to the Bucknell University Sports Medicine Staff.

I am aware that participation in my sport carries a risk of injury to me, including death. For example, head injuries and concussions may occur. I freely assume all risks related to my participation.

By initialing and signing below, I acknowledge that Bucknell University has provided me with specific educational material on head injuries and concussions. I understand the importance of immediately reporting symptoms of a head injury or concussion to the Bucknell University Sports Medicine Staff.

I, _____ understand that:
(Print First & Last Name)

(INITIAL EACH LINE)

- _____ A concussion is a brain injury. I am responsible for immediately self- reporting signs and symptoms of a concussion or other head injury to the Bucknell Sports Medicine Staff.
- _____ Participating in intercollegiate athletics may result in a concussion or other head injury.
- _____ I have received information concerning the signs and symptoms of a concussion, and I understand those signs and symptoms.
- _____ Helmets, face shields, mouth guards, and other protective equipment do not eliminate the risk of concussions or other head injuries.
- _____ I understand that purposeful head contact in any sport is prohibited.
- _____ A concussion can affect my ability to perform everyday activities including, but not limited to, reaction time, balance, sleep, and studying.
- _____ A concussion is not visible but is recognized by symptoms such as headache, dizziness, loss of consciousness, amnesia, vision problems, nausea, sensitivity to light, feeling sluggish, foggy or groggy, irritability, slow reaction time and concentration or memory problems.
- _____ Additional symptoms of a concussion may arise hours or days after the initial injury.
- _____ Returning to practice/games prior to being symptom free may result in a return of symptoms, a repeated concussion, or a more serious injury including death.
- _____ Repeated concussions or other head injuries may lead to permanent brain damage, psychological disorders or even death.
- _____ If I suspect a teammate has a concussion or other head injury, I am responsible for reporting the injury to the Bucknell Sports Medicine Staff.
- _____ Clearance for return to play after a head injury or concussion will be determined by the Bucknell Sports Medicine Staff and Team Physician.
- _____ Bucknell has the authority to permanently remove me from participation in athletic activities if it is determined to be appropriate to protect my safety and well-being.

Student Athlete’s Name (Print) _____ Sport: _____

Student Athlete’s Signature _____ Date _____

Parent/Guardian Signature _____ Relationship _____ Date _____
(If under age 18)



CONCUSSION/SICKLE CELL/RHABDOMYOLYSIS INFORMATION

Follow the links below to watch the informational videos. These videos are required by Bucknell University as per the NCAA guidelines. Please initial in the space provided once you have completed each video.

By initialing next to each link you are verifying that you have watched the video and understand the contents.

_____ NCAA Concussion video- <https://youtu.be/T3FLRDxbLXg>

_____ NCAA Sickle Cell/rhabdomyolysis video- <https://youtu.be/EiEpmZLLcuM>

By signing below you are stating that you have watched both videos and have a clear understanding of the material.

Student Athlete Name _____ Date _____

Student Athlete Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____