

Dear Student – Athlete,

Please initial the following statements to show that the statements have been read, fully understood, and approved by you and your parents/guardians.

_____ I RECOGNIZE AND ACCEPT THE RISKS THAT ARE ASSOCIATED WITH ATHLETIC PARTICIPATION, PRACTICE, AND CONDITIONING DUE TO THE INVOLVEMENT OF BODILY CONTACT, PHYSICAL STRESS, AND POSSIBLE INJURY.

_____ I AUTHORIZE THE SPORTS MEDICINE STAFF, TEAM PHYSICIANS, AND COACHING STAFF OF FAIRMONT STATE UNIVERSITY TO SECURE ANY AND ALL EMERGENCY MEDICAL TREATMENT WHICH MAY BE DEEMED NECESSARY.

_____ I AUTHORIZE THE MEDICAL AND COACHING STAFF OF FAIRMONT STATE UNIVERSITY TO RELEASE, (VERBALLY AND/OR IN WRITING) INFORMATION PERTAINING TO INJURIES THAT AFFECT MY ATHLETIC PARTICIPATION TO SPORTS INFORMATION, THE MEDIA, AND PROFESSIONAL SCOUTS.

_____ I UNDERSTAND THAT I AM REQUIRED TO HAVE PRIMARY MEDICAL INSURANCE IN ORDER TO PARTICIPATE IN ATHLETICS AT FAIRMONT STATE UNIVERSITY.

_____ I RECOGNIZE THAT, AS WITH ALL MEDICAL INSURANCE, 100% PAYMENT FOR CLAIMS IS NOT GUARANTEED BY THE ATHLETIC “EXCESS” POLICY, AND THAT I WILL B E RESPONSIBLE FOR THE UNPAID BALANCES.

_____ THE FAIRMONT STATE UNIVERSITY SPORTS MEDICINE STAFF PROVIDES AN EXTENSIVE PHYSICIAN REFERRAL SYSTEM AVAILABLE TO TREAT ATHLETIC INJURIES. I UNDERSTAND THAT IF I CHOOSE TO SEEK OUTSIDE OPINIONS, SERVICES , AND/OR TREATMENTS ON MY OWN OR WITHOUT PROPER REFERRAL, THAT I AM RESPONSIBLE FOR THE UNPAID BALANCES.

_____ I ACKNOWLEDGE THE FACT THAT THE TEAM PHYSICIANS AND THE SPORTS MEDICINE STAFF HAVE THE FINAL DECISION IN REGARDS TO MY ATHLETIC PARTICIPATION LEVEL AND TO HONOR THEIR DECISIONS.

I have read and understand the above statements and fully accept the conditions as stated for as long as I participate in athletics at Fairmont State University.

Student-Athlete

Date

Parents/Guardian

Date