UNIVERSITY OF NOTRE DAME
STUDENT ATHLETE MEDICAL TREATMENT
NOTICE, WAIVER, AND CONSENT

You are hereby advised to read the following language carefully and thoroughly, as it relates to medical care and treatment that may be provided to you as a student-athlete and also concerns how information about your medical condition may be obtained and shared by the University of Notre Dame ("University"). **If you are under 18 years of age, your parent or legal guardian must sign and agree to this language.** If you elect not to sign and agree to this language, please write "Refuse to Sign", then date and initial in the space provided for signature.

(1) MEDICAL CONSENT

I grant the following medical providers permission to provide me with any treatment or medical care deemed reasonably necessary by such medical providers: University Athletic Training Staff, University Physicians/Medical Consultants, and any other medical provider deemed advisable by the University. This treatment may include preventive care, first aid, primary care, mental health care, rehabilitation, and emergency treatment. I grant permission to hospitalize me if deemed necessary by one of the medical providers identified in this paragraph. I also grant each of the medical providers identified in this paragraph authority to disclose to each of the other medical providers identified in this paragraph information about me, my medical insurance status, and my medical history (including mental health history) as necessary or reasonably requested in order to arrange for or facilitate the provision of treatment or medical care to me.

(2) AUTHORIZATION FOR RELEASE OF MEDICAL CONDITION

I authorize University Athletic Training Staff, University Physicians/Medical Consultants, and any other medical provider deemed advisable by the University to share information about my medical condition, mental health, and medical history with personnel of the University's Athletics Department and with any other medical provider deemed advisable by the University for the purpose of overseeing and managing my treatment and medical care and my participation in intercollegiate athletics, which recipients may in turn share such information with other personnel at the University as they deem necessary. In addition, I authorize personnel of the University to share information about my medical condition with members of the media as such condition relates to my past, present, or future participation in intercollegiate athletics at the University for the purpose of responding to media inquiries.

(3) SHARED RESPONSIBILITY FOR SAFETY

I understand that there is certain inherent risk involved in participating in intercollegiate athletics as a student-athlete, including serious bodily injury and/or death, and that I share responsibility for minimizing the risk of injury to others and myself. I must promptly report any injury I have suffered (including any signs or symptoms of a concussion, regardless of whether any such signs or symptoms are related to participation in intercollegiate athletics, as required by the University of Notre Dame Sports Medicine Department Intercollegiate Athletics Concussion Management Plan) to University Athletic Training Staff or University Physicians. I must respond fully and honestly to any questions University Athletic Training Staff, University Physicians/Medical Consultants, or my coaches may have regarding my medical condition. I must advise University Athletic Training Staff or University Physicians of any medications that I am taking.

I understand that I must report to the appropriate personnel of the University's Athletics Department any problems in the condition or usefulness of equipment that I use. I agree to abide by instructions and guidelines provided to me by personnel of the University's Athletics Department and by any official or other authority with oversight of athletic events as such instructions and guidelines relate to my medical condition, safety, and general participation in intercollegiate athletics.

(4) ATHLETICS MEDICAL PAYMENT PROGRAM REQUIREMENTS, TERMS, AND CONDITIONS

I understand that the University has an Athletics Medical Payment Program ("Program") for intercollegiate student-athletes. I understand that ANY PERSONAL HEALTH INSURANCE COVERAGE FOR WHICH A STUDENT-ATHLETE IS ELIGIBLE SERVES AS THE PRIMARY INSURANCE COVERAGE FOR ALL ATHLETIC PLAY/PRACTICE-CAUSED INJURIES AND ILLNESSES THE STUDENT-ATHLETE SUSTAINS AS A STUDENT-ATHLETE AT THE UNIVERSITY, AND THAT THE UNIVERSITY AND THE PROGRAM PROVIDE ONLY SECONDARY INSURANCE COVERAGE FOR INJURIES AND ILLNESSES APPROVED FOR COVERAGE UNDER THE TERMS OF THE PROGRAM. I AGREE TO KEEP THE UNIVERSITY INFORMED AT ALL TIMES AS TO MY PRIMARY INSURANCE COVERAGE AND TO RESPOND PROMPTLY TO ANY UNIVERSITY REQUEST FOR INFORMATION ABOUT SUCH COVERAGE. IF PAYMENT FROM AN INSURANCE PROVIDER IS RECEIVED BY ME OR ON MY BEHALF FOR A COST THAT HAS BEEN, IS BEING, OR WILL BE PAID BY THE UNIVERSITY UNDER THE PROGRAM, I AGREE THAT I SHALL SEND SUCH PAYMENT OR ITS MONETARY EQUIVALENT TO THE UNIVERSITY.

I also understand that a student-athlete's eligibility for secondary insurance coverage by the University and under the Program, and any claims for payment made by a student-athlete or on a student-athlete's behalf under such secondary insurance coverage, are subject to all of the requirements, terms, and conditions of the Program. I acknowledge that a description of the requirements, terms, and conditions of the Program is available in hard copy by request to the University's Athletics Business Office or in electronic form at the following website: http://athleticsbusinessoffice.nd.edu/medical-insurance-forms/.

(5) SUBMITTING CLAIMS UNDER THE ATHLETICS MEDICAL PAYMENT PROGRAM

I understand that, in order to submit a claim for payment under the Program and to facilitate the processing of such claims, any medical bills that are received by a student-athlete or on a student-athlete's behalf for athletic/play practice-caused injuries and illnesses, and records of any payments or denial of payments received by a student-athlete or on a student-athlete's behalf in relation to such injuries from any insurance company providing personal health insurance coverage for which the student-athlete is eligible, MUST be forwarded promptly to the following address:

Notre Dame Sports Medicine
University Athletic Training Staff
113 Joyce Center
Notre Dame, IN 46556
Fax: (574) 631-3305

When information is provided to the University's Athletic Training Staff by me or on my behalf for the purpose of initiating or substantiating a claim under the Program, I acknowledge that the information is being provided voluntarily and/or with my consent, and I agree that such information may also be used by the University's Athletic Training Staff for the purpose of monitoring my medical condition and any associated care or course of treatment.

(6) AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL RECORDS UNDER THE ATHLETICS MEDICAL PAYMENT PROGRAM

I acknowledge that the University utilizes the services of a third party administrator ("TPA") to help process claims under the Program. I authorize the University to share any information about my medical condition with the TPA for the purpose of processing any claim that I submit or that is submitted on my behalf. With respect to each claim

submitted by me or on my behalf to the University under the Program, I grant the University and the TPA my consent to disclose any information about me that is requested or needed to process the claim. Under this consent, such information may be disclosed by the University or the TPA to any person or entity that requests or needs the information to review, evaluate, pay, or otherwise process the claim, including without limitation any insurance company, hospital, physician, or any other person who has attended or examined me in relation to the claim. I also hereby authorize any insurance company, hospital, physician, or other person who has attended or examined me for medical purposes to disclose to the University's Athletic Training Staff, University Physicians, and/or the TPA any information about my medical condition and mental health as it relates to my participation in intercollegiate athletics.

I HEREBY AUTHORIZE MY PRIVATE INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO THE UNIVERSITY, TO ANY FACILITY WHERE MEDICAL SERVICES WERE RENDERED, OR TO ANY PROVIDER THAT RENDERED MEDICAL SERVICES.

SIGNATURE AND ACKNOWELDGEMENT OF UNDERSTANDING

By signing below, I acknowledge and agree to the following:

- **I have read each of the paragraphs above concerning: (1) MEDICAL CONSENT; (2) AUTHORIZATION FOR RELEASE OF MEDICAL CONDITION; (3) SHARED RESPONSIBILITY FOR SAFETY; (4) ATHLETICS MEDICAL PAYMENT PROGRAM REQUIREMENTS, TERMS, AND CONDITIONS; (5) SUBMITTING CLAIMS UNDER THE ATHLETICS MEDICAL PAYMENT PROGRAM; and (6) AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL RECORDS UNDER THE ATHLETICS MEDICAL PAYMENT PROGRAM. I acknowledge that, collectively, these paragraphs are referred to as the Numbered Paragraphs.**
- **If I am the student-athlete named below, I understand the terms of the Numbered Paragraphs and agree to them freely and voluntarily.**
- **If I am signing below on behalf of the student-athlete named below because he/she is under 18 years of age:**
  - **I attest that I am the parent or legal guardian of the student-athlete.**
  - **I understand that I am standing in the place of the student-athlete by signing below, such that all of the terms of the Numbered Paragraphs will apply to the student-athlete as if the student-athlete signed below and his/her signature was legally valid and binding.**
  - **I understand the terms of the Numbered Paragraphs and how they affect me and the student-athlete, and I agree to them freely and voluntarily.**

______________________________ ______________________________

STUDENT-ATHLETE NAME (Printed) STUDENT-ATHLETE SIGNATURE DATE

______________________________ ______________________________

PARENT/GUARDIAN NAME (Printed) PARENT/GUARDIAN SIGNATURE DATE

NOTE: A parent or legal guardian of the student-athlete named must sign in addition to the student-athlete if the student-athlete is under 18 years of age.