We are very excited your son/daughter is returning to UNC Charlotte to continue their athletic career and receive a great education. We would like to take this opportunity to make you aware of a few points in regards to the medical care and coverage your child will receive as a Charlotte 49er.

**Athletic Trainer Coverage**

Sports Medicine is overseen by our Director of Athletic Training, with a staff of five full time Associate Trainers and six Assistant Athletic Trainers. All of our Athletic Trainers are certified by the National Athletic Trainer’s Association and licensed by the North Carolina Board of Athletic Trainer Examiners. An ATC will be on site for all home practices and competitions. In most sports, the assigned athletic trainer will travel with the team for away competitions. When an athletic trainer does not travel with the team, arrangements will be made with the host school to provide medical coverage at the competition site. The athletic training staff works extremely hard to provide quality and consistent care to the student athletes who participate in the program. Your student-athlete **must** report any injury to his/her assigned team athletic trainer.

**Medical Team**

The Sports Medical Team that assists the 49ers is made up of our family practice physician and team orthopedists. The team orthopedists are associated with OrthoCarolina, the largest orthopedic group in Charlotte. With offices across the region, OrthoCarolina is one of the nation’s leaders in orthopedic care. Their group consists of experts in the areas of foot and ankle, hand, hip and knee, shoulder and elbow, spine and sports medicine. They also provide our team physical therapy. All of our team physicians come to our athletic training rooms several times per week for onsite injury, illness, evaluation, diagnosis, and any office treatments that can be done outside of their offices.

**Insurance**

Each student-athlete is required to carry primary medical insurance. The student-athlete’s primary insurance will be filed for medical appointments and prescription medications. Please make sure your son/daughter provides their insurance information to all medical providers at the time of treatment. They will be expected to pay any applicable co-payment or deductible at the time of treatment. Athletic Department policy does not permit reimbursement for these charges.

In the event that your son/daughter is in need of medical coverage, there is a student policy that the University offers through the Student Health Center for purchase. The UNC System has selected Student Blue as the Student Health Insurance carrier for the 2014-15 academic year. Student Blue is underwritten by Blue Cross Blue Shield of North Carolina. If you have questions about this coverage, please contact 704-687-6070 or visit [www.bcbsnc.com/student](http://www.bcbsnc.com/student). The deadline to waive or activate insurance is September 11, 2014.

The Athletic Department serves as a secondary payer for some medical expenses. We also carry excess insurance, which is only accessed after certain deductibles are met. Our department employs an insurance specialist who works with our physician offices to expedite the payment process and to assist our student athletes with all medical claims and bills. **It is important that all Explanation of Benefits (EOBs), and bills related to an athletic injury be forwarded to the insurance specialist in a timely manner by you or your**
student-athlete. Any questions concerning our policy may be forwarded to our insurance specialist Heather Nance at 704-687-0408 or hnance3@uncc.edu.

Please note that the Athletic Department will not be able to reimburse or pay any charges incurred for a “second opinion”. These charges will be the sole responsibility of the student-athlete and/or their parent/guardian.

Summarized below are questions that we often receive about our insurance policy.

What is covered by the Athletic Department’s Policy?
- Co-insurance payments (portion of bill determined by insurance after co-pay and deductible has been met) for athletic related injuries
- Physical therapy services provided to injured athletes (post-operative and chronic injuries) provided by a licensed Physical Therapist. These services are provided at the discretion of the Team Physicians and/or Certified Athletic Trainer. The student-athlete’s primary insurance will be filed (the student-athlete will not incur any out of pocket expenses for in-house physical therapy)
- Approved expenses related to bodily injury incurred during participation during primary competitive season and off season supervised conditioning with the strength and conditioning staff
- Approved medication expenses related to athletic injuries
- Approved vision screening expenses (one visit per year) as well as two boxes of contacts for use in-season
- Approved referrals related to athletic injuries
- Approved orthopedic devices related to athletic injuries -must have a prescription from physician
- Approved diagnostic or surgical procedures related to athletic injuries
- Minor illnesses that occur during your primary competitive season (cold, flu or virus)

What is NOT covered (this is not an inclusive list)
- Personal deductibles and co-pays are NOT covered by the athletic department
  For example, if Joe tears an Anterior Cruciate Ligament (ACL) while playing soccer and must have an MRI the Athletic Department WILL NOT pay the co-pay for any doctor office visits. Nor will the Athletic Department pay for the deductible from Joe’s primary insurance. The Athletic Department will pay for the remainder (co-insurance) of the balance of the bill once Joe’s primary insurance pays its portion of the bill.
- Routine dental care: dental appliances (excluding protective mouth guards).
- Non-athletic related accidents or injuries (injuries that occur outside of your primary competitive season or unsupervised off season conditioning)
- Medication or surgery for treatment of non-athletic related injuries
- Pre-existing conditions, illness, or injuries.
- Sexually transmitted diseases and treatment or AIDS counseling
- Contraceptives
- Over the counter drugs
- Maternity care
- Unorthodox medical care
- Self or coach prescribed treatment or devices
- Any treatment, consultation or medication without prior approval from the Charlotte Athletic Training Staff
- Medical expenses beyond limitations and exclusions not covered by the Charlotte Athletics accident insurance policy
• Injuries sustained after the completion of student-athletes eligibility
• Medical expenses incurred due to disease excluding diagnostic testing to determine nature of illness
• Second opinions from outside physicians

When is my student-athlete covered?
• Coverage extends through the playing season, including the off season conditioning conducted by the strength and conditioning staff and individual workouts with the coaching staff

My child does not have primary medical insurance, what do I do?
• The University mandates that all students carry a health insurance policy. There is a student policy that the University offers through the health center for purchase. If you have questions about the student health insurance policy, please contact 704 687-6070 or visit www.bcbsnc.com/student

My insurance is an HMO, what do I do?
• If you are not from Charlotte, your child may be considered “out of network” by your insurance carrier. Please contact your insurance provider and let them know your child is attending school in Charlotte, NC. Many of them will extend their coverage to this area. Please make sure that your child has FULL medical coverage and not just emergency care coverage

We hope that you find this information useful. Our goal is to provide the best possible healthcare for our student athletes. If you have any questions, please feel free to contact Heather Nance, Insurance Specialist at 704-687-0408.

In this package you will find forms which require your attention. Several of these forms need your signature along with your student-athletes signature. Please take a few moments to gather this important information and go over with your son/daughter. There is a postage paid envelope provided for your convenience. Please return all these necessary forms along with a copy or your primary medical insurance card (front and back) as soon as possible.

Thank you and Go Niners!

Heather Nance, Insurance Specialist
AJ Lukjanczuk, Director of Athletic Training
SPORTS MEDICINE MEDICAL COVERAGE AND INSURANCE INFORMATION

Student-Athlete’s Name ____________________________ Sport(s) ____________________________

Student ID # 800 __________________________________________ Date of Birth __________________

Please read carefully and initial all that are applicable:

I My personal health insurance is a: ☐ PPO ☐ HMO ☐ OTHER

If other please explain: ____________________________________________________________

I do not need to purchase the student health insurance and I have completed the insurance waiver on-line at www.bcbsnc.com/student. This waiver is my verification that my child has adequate major medical coverage while participating in athletics and attending classes while at Charlotte.

I have notified my medical insurance carrier that my child will be attending UNC Charlotte in the fall to ensure that my coverage will extend to my student-athlete while they are away from home. This would apply to any student-athletes whose parent’s primary residence is outside the Charlotte area or those not enrolled in the student insurance program.

My student-athlete does not have personal health insurance and I have voluntarily enrolled him or her with the student health insurance plan provided by Blue Cross and BlueShield at www.bcbsnc.com/student.

I understand I will be responsible for paying any applicable co-payments and/or deductible that is required by my insurance carrier for any treatment that my child may need while participating in athletics at Charlotte.

I have read and understand the “Medical Coverage/Insurance” letter and do not have any questions about the UNC Charlotte Athletic Department medical policies and procedures.

I have read the Medical Care and Insurance Coverage Information letter, and have questions regarding: (Please attach your questions to this form along with the email and/or phone number at which you would like to be contacted and we will get back with you as soon as possible.)

Student-Athlete’s Signature ____________________________ Date ____________________________

Print Name Parent/Guardian __________________________________________________________

Parent/Guardian Signature ____________________________ Date ____________________________
2014-2015 ATHLETE CONTACT INFORMATION SHEET

Student ID# 800 ___________________________ Social Security # ___________________________

Sport: ___________________________ Gender: Male/Female Date of Birth __________

Name ___________________________ ___________________________ ___________________________
    (Last) (First) (Middle Initial)

Permanent/Home Address _______________________________________________________________
    Street ___________________________ City ___________________________ State __________ Zip __________

UNCC Address ______________________________________________________________
    (If Known) Street ___________________________ Dorm ___________________________ City ___________________________ State __________ Zip __________

Home Phone ___________________________ Cell Phone ___________________________

E-mail ___________________________ UNCC E-mail ___________________________
    (If Known)

Parent/Guardian Contact Information

Name ___________________________ Name ___________________________
    Mother/Guardian 1 Father/Guardian 2

Address if Different from Athletes Address if Different from Athletes:
    ______________________________________________________________

Email ___________________________ Email ___________________________

Home Phone ___________________________ Home Phone ___________________________
Cell Phone ___________________________ Cell Phone ___________________________
Work Phone ___________________________ Work Phone ___________________________

In case of emergency, and parent’s/guardians cannot be contacted, please notify:

Name ___________________________ OR Name ___________________________

Relationship ___________________________ Relationship ___________________________
Home Phone ___________________________ Home Phone ___________________________
Cell Phone ___________________________ Cell Phone ___________________________
Work Phone ___________________________ Work Phone ___________________________
# 2014-2015 Returning Athlete Health-Status Questionnaire

**Student ID# 800**

**Gender:** Male/Female  **Date of Birth**

**Sport(s):**

**Name**  
(Last)  
(First)  
(Middle Initial)

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Comments or Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you or do you have any serious illness or injury that was NOT treated at the Student Health Center, Athletic Training Room, or by a Team Physician?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you visited a Doctor or hospital in the past 12 months? (Not including a Team Physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Have you experienced chest pain, fainting, lightheadedness, or shortness of breath due to exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Have you developed or been made aware of a heart condition or high blood pressure in the past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Has a family member younger than 50 years of age ever been diagnosed with or died due to a cardiac condition?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 6  | Are you currently on any prescription or over the counter medications?  
   If so, please provide in comment box... |     |     |                      |
| 7  | Are you currently taking any supplements or performance enhancing substances?  
   If so, please provide in the comment box...  
   (Creatine, Protein Powder, Ephedrine, etc.) |     |     |                      |
| 8  | Have you developed any allergies in the past year?  
   If so, please provide in the comment box...  
   (Food, Drug, Insects, etc.) |     |     |                      |
| 9  | Did you sustain an injury this season?  
   If so, please provide in the comment box... |     |     |                      |
| 10 | Are all injury(s) that you sustained during the season now resolved?  
   If not, please list and explain in the comment box... |     |     |                      |
Female Athletes Only

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Comments or Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have your menstrual periods been regular and monthly during the past year? If not, please explain in the comment box…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many menstrual periods have you had in the past year? Provide in comment box…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the date of your last pelvic exam? Provide in the comment box</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that I have completed the above Returning Athlete Health-Status Questionnaire truthfully and it is accurate to the best of my knowledge. I understand that all of questions above are asked to ensure that I have the best quality care during my career as a Charlotte 49er student-athlete. I understand that this form must be completed and returned to the Charlotte 49ers Sports Medicine staff before any participation in athletics is permitted.

________________________________________
Student-Athlete Printed Name

________________________________________   ______________________________
Student-Athlete Signature                      Date

________________________________________
For Internal UNCC Review (Do not write below)

The undersigned, hereby;

Affirms that the information has been reviewed

________________________________________
UNCC Athletic Trainer Printed Name

________________________________________   ______________________________
UNCC Athletic Trainer Signature                      Date
Student-Athlete Insurance Information

The information you provide will be held strictly confidential. Please complete all pages of this form and return.

UNC Charlotte ID# 800_________________________ Sport(s) ___________________________ DOB ________________

Athlete ___________________________ (Last Name) ___________________________ (First Name) ___________________________ (Middle Initial) Male/Female

Information for (Primary Insurance) Policy Holder

All Areas Must be Completed, If any of these areas are unknown please call your customer service number located on the back of your card for accurate information.

Policy Holder Name:

Relationship to Athlete
Mother Father Guardian Stepmother Stepfather Spouse Self

Date of Birth of Policy Holder

Home Address (Street)

City, State, Zip

Home Phone: ___________________________ Work / Cell #: ___________________________

Email: ___________________________

Name of Insurance Company ___________________________ Deductible Amount ___________________________ Office Visit Co-Pay ___________________________

Insurance Company Street Address

City, State, Zip

Phone (_________________________

ID/Policy Number ___________________________ Group Number ___________________________

Name of employer of Policy Holder
(only if this insurance is a group plan through employer)

This policy is an
HMO Yes No If yes, Please see second page
PPO Yes No If yes, Please see second page

This policy requires pre-authorization for treatment Yes No If yes please list phone number

I have informed this policy that my child will be attending UNC Charlotte and asked if they will cover my child for any athletic related injuries YES NO

I certify to the best of my knowledge the above information is accurate and will notify the Sport Medicine Department of any changes if they occur during the upcoming academic school year. Front and back copy of all insurance cards must be included with this form.

_________________________ ___________________________ ___________________________ ___________________________
Signature of Parent/Guardian Date Signature of Athlete Date
STUDENT-ATHLETE INSURANCE INFORMATION

PLEASE COMPLETE THIS SHEET IF THE STUDENT-ATHLETE IS COVERED UNDER A GROUP INSURANCE AND IT IS AN HMO OR PPO.

Please provide the name, address and phone numbers of Athlete’s primary care physician within the required network. Their office will control the approval of all necessary “referrals” to specialist(s) if they are needed. To make things more effective it is strongly suggested that all primary care physicians be changed to included UNC Charlotte’s own team physicians.

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Name</td>
<td>Physician’s Name</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

_____ Yes, I have seen my primary care physician and am an established patient in his/her office (as noted above) I have informed my physician of my son/daughters participation in intercollegiate sports at UNC Charlotte.

_____ No, I have NEVER seen my primary care physician. I know that I must see him/her before I come to UNC Charlotte for my insurance to be valid. I will make an appointment to establish myself as a ‘valid’ patient in his/her office prior to coming to UNC Charlotte and make him/her aware of my “out of town” residency in Charlotte, North Carolina while attending school. This will only be allowed if NO restrictions/limitations are on ability to receive services in Charlotte.

_____ No, I have NEVER seen my primary care physician and will be choosing a primary care physician in Charlotte, North Carolina. I will make an appointment with a network primary care physician 30 days prior to arriving in Charlotte and will notify the Athletic Trainer of who that physician actually is. This will only be allowed if NO restriction/limitations are on ability to receive services in Charlotte.

_____ Other – Please Explain ________________________________

For Athletic Trainers only:
Received copy of Insurance Card: Front ________ Back ________
Pell Grant Eligibility ________
Updates/Changes ________________________________
Scholarship YES / NO Full / Part
# Student-Athlete Secondary Insurance Information

Athlete’s Name ___________________________          Sport(s) ___________________________

Student ID # 800 ___________________________          Date of Birth ___________________________

_____ Yes I do have a Secondary Health Insurance Policy.

If you do not have a secondary health insurance policy you can skip this page.

### Information for (Secondary Insurance) Policy Holder If Applicable

| Policy Holder Name: |  |
|---------------------|  |
| Relationship to Athlete |  |
| Mother | Father | Guardian | Stepmother | Stepfather | Spouse | Self |
| Date of Birth of Policy Holder |  |
| Home Address (Street) |  |
| City, State, Zip |  |
| Home Phone:         | Work / Cell # |
| (                      | (            ) |
| Email:              |  |

### Name of Insurance Company

<table>
<thead>
<tr>
<th>Deductible Amount</th>
<th>Office Visit Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

### Insurance Company Street Address

| City, State, Zip |  |
|------------------|  |

| Phone ( ) |  |
|-----------|  |

| ID/Policy Number | Group Number |  |
|------------------|--------------|  |

### Name of employer of Policy Holder

(only if this insurance is a group plan through employer)

| This policy is an | HMO | Yes | No | If yes, Please see second page |  |
|-------------------|-----|-----|----|---------------------------|  |
| PPO               | Yes | No | If yes, Please see second page |  |

| This policy requires pre-authorization for treatment | Yes | No |  |
|------------------------------------------------------|-----|----|  |
| If yes please list phone number |  |

I have informed this policy that my child will be attending UNC Charlotte and asked if they will cover my child for any athletic related injuries  **YES** **NO**

I certify to the best of my knowledge the above information is accurate and will notify the Sport Medicine Department of any changes if they occur during the upcoming academic school year. **Front and back copy of all insurance cards must be included with this form.**

Signature of Parent/Guardian __________________________ Date __________________________

Signature of Athlete __________________________ Date __________________________
STUDENT-ATHLETE PHARMACY/PRESCRIPTION PLAN INFORMATION

Athlete’s Name ____________________________  Sport(s) ______________

Student ID # 800______________________________  Date of Birth ____________

_____ Yes, I do have a prescription benefit covered by insurance.

_____ I can use any pharmacy of my choice and only pay designated copay per my plan.

_____ I have to go to a “Network Participating Pharmacy” I pay a copay and the pharmacy files my claim.

   My Network Pharmacies are: Wal-Mart / CVS / Eckerd’s / Kerr Drugs / Walgreens

Other - __________________________________________

_____ I have to pay for all prescriptions then submit my pharmacy charges for reimbursement.

_____ No, I do not have ANY prescription benefits through insurance.

Please submit a copy (front & back) of your prescription card if it is separate from your Primary Health Insurance Policy.
SECONDARY POLICY INFORMATION FOR STUDENT-ATHLETES

In preparation for the upcoming athletic season, we want to provide you with information about the accident medical insurance our institution carries for your student-athlete. UNC Charlotte Athletics purchases an excess basic accident insurance policy through Mutual of Omaha. The policy covers medical expenses arising from athletic injuries up to a $75,000 limit and excess of any other available accident/health insurance (such as through your insurer). The NCAA also provides a “catastrophic” medical policy, also excess of other insurance, with much higher limits in the event of serious injury. This coverage is paid for by Charlotte Athletics and in order for it to remain affordable we require all student-athletes to maintain a primary insurance to participate. The accident medical insurance we carry applies only to covered athletic injuries and is not a replacement for primary accident/health insurance.

All student-athletes must provide the school with primary insurance by giving a copy of the card for their policy. Front and back copy of this card is to be kept on file by the Athletic Trainer and Insurance Specialist. If at any time this coverage expires during the school year, the athletic department must be notified. We know employment situations can change, and we need to know what coverage is in place in order to provide the best care to student-athletes and help manage the claims process efficiently. Our trainers will carry all insurance information with them when teams and athletes travel.

Our policy carries a deductible of $3000.00. This deductible will be reduced as payments are made by the primary insurance company. Once the primary insurance company has made payments equal to or greater than our deductible, our excess policy deductible will be satisfied. If any portion of the deductible is not satisfied by the primary insurance company this amount will be the responsibility of the student-athlete and/or parent/guardian. Also, our policy does have certain limits and may not pay all charges in full.

Please note most primary insurance plans offered through employers have requirements for dependents over the age of 18, and it is important to comply with such requirements in order for coverage to continue to apply to your son/daughter. One requirement may be to provide a schedule proving that your student-athlete is a full-time student. If you are a member of an HMO or PPO, we recommend that you contact them and make sure you understand their policies with regard to dependent students who are going to school out of the network area. In some cases, the company will set up a “guest membership” for dependents in the area of temporary residence. If this is the case, you should attempt to have this set up for your student-athlete prior to their leaving for school.
SECONDARY POLICY INFORMATION FOR STUDENT-ATHLETES

Athlete’s Name ________________________________  Sport(s) ____________________

Student ID # 800 ________________________________  Date of Birth __________________

I have received and understood the attached “Student/Parent/Guardian Insurance Notification.” I understand that I may bear responsibility for the deductible and balances not covered by UNC Charlotte’s accident medical policy for any expenses related to athletic injuries. I further understand that this policy is excess over any other insurance that may apply to such injuries. I agree that if I have primary accident/health insurance plan, I will provide UNC Charlotte Athletics with evidence of coverage and will notify the athletic department of any material changes in coverage during the academic year.

☐ Please check here if student-athlete has primary insurance and attach evidence of coverage (a front and back copy of the insurance card(s) is needed).

☐ Please check here if student-athlete does not have primary insurance.

Student-Athlete Signature ________________________________  Date __________

Parent Signature ________________________________  Date __________
MEDICAL RECORDS RELEASE FORM (HIPAA)

Athlete’s Name ________________________________  Sport(s) _______________________

Student ID # 800 ______________________________  Date of Birth ______________________

Per the Health Insurance Portability and Accountability Act the following signature will authorize the athletic director, certified athletic trainers, student sports medicine assistants, team physicians and affiliated medical staff to communicate and view medical records pertaining to health related issues as a result of my participation in the NCAA Athletic Program at University of North Carolina at Charlotte. The following methods of communication and injury documentation may be used:

- Oral, written, or electronic communication regarding health issues between the athletic trainer, the team physician and supporting medical staff.
- Oral, written, or electronic communication regarding health issues between the athletic trainer, coaching staff and athletic director.
- Oral, written, or electronic communication regarding health issues between the athletic trainer and the athlete’s parents, (per athlete’s request).
- Oral, written, or electronic communication regarding health issues between the athletic trainer, the team physician, supporting medical staff and the Insurance Company, Carrier or TPA in which the above University purchased Secondary Student Basic Accident Medical on my behalf.

I, ________________________________, hereby authorize the release of the following information to the organization listed below:

- Initial evaluations
- Progress notes
- Consultation reports
- Treatment summary
- Diagnostic test results
- Psychological reports
- History/Physical exam
- Correspondence notes
- Entire medical record
- Billing records
- ALL INFORMATION
- Other ________________________________

UNC Charlotte Athletics 9201 University City Blvd, Charlotte, NC 28223

I have read and understand the means of communication and documentation that will take place regarding my health history and any injury information that may develop because of my involvement in athletics.

Student-Athlete Signature ____________________________________  Date _____________

Parent Signature ____________________________________________  Date ___________

(IF under 18 years of age)
ASSUMPTION OF RISK

Athlete’s Name ________________________________ Sport(s) __________________________

Student ID # 800 ______________________________ Date of Birth ______________________

Participation in intercollegiate athletics involves an inherent risk of injury which may result in a permanent disability or even death. Examples include, but are not limited to:

- Sudden death, heart attack, respiratory failure
- Paralysis, spinal cord damage, nerve damage
- Head injuries, concussions, brain damage, Chronic Traumatic Encephalopathy
- Dental injuries, tooth fractures, loss of teeth, facial disfigurement
- Broken bones, joint damage, arthritis
- Eye injuries, vision loss
- Loss or injury to vital organs
- Muscle and ligament damage, sprains, ruptures
- Menstrual irregularities and complications
- Psychological distress, depression, anxiety

Reasonable precautions should be made by all participants, coaches, staff, and administrators to minimize this risk. Each sport has its own set of safety rules and regulations which should be adhered to at all times. To rely on officials to enforce compliance with the rulebook is as insufficient as to rely on warning labels to produce compliance with safety guidelines. As a student-athlete, it is your responsibility to take appropriate steps to prevent injuries when possible by following the rules for the game and wearing all recommended and required protective equipment and braces. Additionally, it is your responsibility to provide timely and accurate information regarding all injuries and illness (whether the injury pertains to yourself or a teammate) to the appropriate Sports Medicine staff member and coaches and to comply with their directions.

By signing below, I acknowledge that I fully understand and appreciate the RISKS associated with my participation in athletics. If I have any questions regarding the risks inherent to my sport, I understand that it is my responsibility to ask a member of the UNCC Sports Medicine Staff. In consideration for the opportunity to participate in athletics, I voluntarily agree to assume all RISKS, including death, serious bodily injury, illness or property damage. To minimize my risk, I agree to follow and play within the rules of this sport. I agree to report all injuries/illnesses in a timely manner to the Sports medicine Staff. Additionally, I have provided and accurate medical history and I will update my records as needed. I understand that having passed a physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the evaluator did not find a medical reason to disqualify me at the time of the evaluation.

Student-Athlete Signature ________________________________ Date ______________

Parent Signature ________________________________ Date ______________

(IF under 18 years of age)