Florida Palms University (the "University")
Shared Responsibility for Sport Safety Acknowledgement (the "Acknowledgement")

While benefits from intercollegiate athletic participation may be great, there are also serious risks involved in competition and preparation for competition. The responsibility for sport safety is a shared effort between administrators, coaches, physicians, athletic trainers, and student-athletes.
Both participants and parent(s) are hereby advised that participation in athletics may lead to serious injuries and bodily harm, including the possibility of permanent physical or mental disability partial or complete paralysis, or death. By signing below, I acknowledge that I have been informed of the risks associated with sports participation, and that it is my responsibility to help prevent injuries, comply withdirections and instructions given by University athletic staff, and constantly be aware of such risks and the prevention of injury to myself and to others.

I have read this acknowledgement and agree to assume responsibility for such risks while participating in athletics all or in connection with the University. In the event that I am in need of medical care, I have primary insurance coverage in effect and will take full and complete responsibility to keep my insurance policy premiums paid while I am a student athlete. I understand that the University offers supplementary insurance that can be billed for remaining medical expenses after my primary insurance has been processed. I also understand that any medical care balance remaining after all applicable insurance has been processed is solely my responsibility to pay, and that the University has no liability therefore, I am aware that if I let my primary insurance lapse for any reason, I will be ineligible to participate in practice or collegiate competition.

Athlete's Name (please print) Athlete's Signature Date

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Medical Consent

I hereby grant permission to University team and school physicians, sports medicine staff, and other physicians designates by the University to provide me with any medical care, treatment, first-aid, rehabilitative, or emergency treatments they deem necessary to my health and well-being, including inquires and medical conditions occurring as a result of during, or in connection with University athletics.

Athlete's Name (please print) Athlete's Signature Date

I have the following medical conditions, allergies, implanted devices, special instructions, and/or am taking the following medications which may impact on the emergency medical treatment that I may receive (please print clearly and legibly):

Parental Permission (required if athlete is under 18 years of age)

I hereby give my consent for my minor son, daughter, or ward to practice and play in intercollegiate athletic events at and in connection with the university. I have read this acknowledgement in full and agree to all terms contained herein. I understand the consensus of participation in athletics, and understand and consent to the possible need for medical care as described in this acknowledgement. I grant permission for any and all treatment deemed necessary for conditions arising during participation in such athletic activities, including medical or surgical treatment recommended by a medical doctor. I understand that in the event of an emergency, every effort I will be made to contact me before treatment.

Parent Name (Please print) Parent Signature Date

Address Date

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Athlete Insurance Info

Athlete:_____Birthdate:_____SS #_____

Insurance Company:_____

Policy Holders Name:_____

Insurance Address:_____City, State, Zip:_____

Policy #_____Group #_____

Name of Employer:_____City, State, Zip:_____

Deductible: Y N Amount:_____Copay:_____

Type of Insurance: HMA PPO POS HAS

Primary Physician:_____City/State:_____

Are you covered by any other policy? Yes No (if yes, please submit copy of card)

Assumption of Risk Statement

I understand that as a student-athlete as Florida Palms University, I may at any time receive and injury whileparticipating in the athletic program.

Permission for Treatment

I grant permission for the Athletic Training staff at Florida Palms University to provide first aid treatment for any injury sustained as a result of athletic participation. Permission is also granted for the athletic training staff to make decisions concerning the need for medical referral and rehabilitation programs for any possible injury.

Insurance Protocol

Florida Palms University provides SECONDARY coverage for injuries sustained while participating in practice orplay of intercollegiate sports. All student-athletes are required to have primary insurance in order to participate. Illnesses and injuries sustained, as a result of NON-ATHLETIC activities becomes the responsibility of the athlete. The athlete trainer can advise the athlete as to where to seek medical help in these situations.

By subscribing their signatures below, the undersigned Athlete hereby acknowledges that the aboveinformation is true and accurate to the best of their knowledge and in consideration of their participation in organized athletics, to hereby agree to abide by the requirements of the insurance protocol in the above stated policy.

Athlete Signature:_____Date:_____

Please attach copy of insurance cards (front and back)

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Athlete Consent Forms Authorization to Obtain Information

I AUTHORIZE any physician, medical practitioner, hospital, clinic or medical facility, insurance or reinsuring company, the Medical Information Bureau, INC or employer having information available as to diagnosis, treatment and prognosis with respect to any physical treatment to me and to give to me and give to Florida Palms University Department of Athletics, Athletic Training Staff, INSURANCE COMPANY orits legal representative, any and all such information.
I UNDERSTAND the information obtained by use of the Authorization will be used by the Florida Palms University's INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits underan existing policy. Any information obtained will not be released to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

Authorization for Release of Medical Records

I hereby grant the Florida Palms University Athletic Training Staff permissions to release, if necessary, allinformation and records, which relate to present and past medical history to the proper agencies (insurance companies, doctor outside the Florida Palms University Staff and professional teams.)

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I UNDERSTAND that I may revoke the authorization at any time in writing to the Athletic Training Staff. I also understand that any release which has been made prior to my revocation and which was made based upon this authorization shall not constitute a breach of my right to confidentiality.

I AGREE that unless revoked in writing, this authorization shall be valid as the

original.I have read and understand the above stated policies.

Athlete Signature:_____Date:_____

Emergency Information
(Please Print all information in permanent ink)

Name of Athlete:_____Sport:_____

Date of Birth:_____Academic Year: FR SO JR SR

Home Address:_____

City:_____State:_____Zip:_____

Local Address:_____

City:_____State:_____Zip:_____

Emergency Contact Information

Name:_____

Home/Cell Phone:_____

Home Address:_____

City:_____State:_____Zip:_____

Insurance Information

Name of Policy Holder:_____Relationship to Athlete:_____

Medical Insurance Company:_____HMO/PPO

Contract/Policy/Group Number:_____

Address:_____

City:_____State:_____Zip:_____

Insurance Company Phone Number:_____

Medical History:_____

Diabetes: Y/N Heart Trouble: Y/N Epilepsy: Y/N Metal Pins: Y/N Contacts: Y/N Blood Type:_____

Medication taken regularly:_____

Allergies:_____

Medical History:_____

In case of injury or serious illness, I hereby grant permission of Florida Palms Universityto secure medicalservices for the above named student-athlete.

_____

Signature of Parent/Legal Guardian Date

Florida Palms University (the "University")

Activity Participation Agreement (the "Agreement")

Activity_____("Activity") Date: _____

Participant's Name:_____("Participant") Phone: _____

Address:_____ Email: _____

ASSUMPTION OF RISK. I. the undersigned Participant, in consideration of being allowed to participate in the Activity at or in connection with the University, acknowledge and agree as follows: (a) the risk of injury from the Activity is significant, including the potential for wounds, permanent disability, paralysis, and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; (b) the risk of injury may be caused by my own actions, by the actions of others, by the conditions of the Activity itself, by the location or sin face where the Activity is being performed, or by other risks known or unknown, foreseeable or not foreseeable, or by the negligence of a University employee or agent; (c) the Activity may be of a hazardous nature and include physical and/or strenuous activity, and I am capable, in good health, In proper physical condition, and without previous injury or limitations such that I am able to participate in the Activity safely; (d) if conditions appear unsafe or hazardous, I will immediately discontinue my participation in the Activity, and bring such conditions to the attention of a University official immediately: (e) I will follow all verbal and written instructions and rules in connection with any participation in the Activity; and (f) the University does not provide me with any medical or accident insurance in connection with my participation in the Activity or otherwise. With knowledge of the foregoing, I have knowingly and freely chosen to participate in the Activity and fully accept and assume all personal risks and responsibility for all losses, injuries, costs, and damages that may occur as a result of my participation in the Activity.

RELEASE OF LIABILITY AND INDEMNIFICATION. To the fullest extent permitted by law, I, for myself and on behalf of any heirs, assigns, personal representatives, and next of kin, hereby release, discharge, and agree to defend, indemnify, and hold harmless the University, its officers, directors, agents, employees, administrators, coaches, volunteers, sponsors, advertisers, other participants, and the owners, lessors, and lessees of any property where the Activity takes place, from and against any and all claims, liability, damages, losses, expenses, and costs, including, bill not limited to, attorney's fees, at both the trial and appellate level, arising out of my participation in the Activity and any injuries, disabilities, damages, or death which I may sustain (however caused, and even if caused by the negligence of the University or anyone for whom the University is responsible), or which I may cause to any other person or properly in connection therewith.

CONSENT TO EMERGENCY MEDICAL TREATMENT. In the case of injury or medical emergency, and in the event that Participant, or his/her parent or guardian cannot respond to consent to emergency medical treatment at the time of the emergency, the University has permission to seek, administer, or have administered whatever first aid or emergency medical care is reasonably deemed necessary for the Participant's welfare, and it is understood that

Participant, and not the University, shall be responsible for any and all charges incurred in connection with such emergency healthcare services, regardless of whether covered by insurance.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE TERMS CONTAINED HEREIN. I UNDERSTAND THAT BY SIGNING THIS AGREEMENT I AM GIVING UP SUBSTANTIAL RIGHTS AND ABSOLVING THE UNIVERSITY FROM ALL LIABILITY IN CONNECTION WITH MY PARTICIPATION IN THE ACTIVITY, AND I ACKNOWLEDGE THAT i HAVE SIGNED THIS AGREEMENT FREELY AND VOLUNTARILY, AND WITHOUT ANY VERBAL INDUCEMENT OR ASSURANCES WHATSOEVER WITH RESPECT TO THIS AGREEMENT OR MY PARTICIPATION IN THE ACTIVITY. I FURTHER AGREE NOT TO CONTEST THE ENFORCEABILITY OF ALL VALID PROVISIONS CONTAINED HEREIN, AND THAT IF ANY PORTION OF THIS AGREEMENT IS HELD UNENFORCEABLE BY A COURT OF COMPETENT JURISDICTION. THAT ALL OTHER PROVISIONS SHALL REMAIN IN FULL FORCE AND EFFECT.

Signature
Print Name: _____
(If Participant is under the age of 18, parent/legal Guardian signature on behalf on Participant)

Date: _____
Phone: _____

Emergency Contact & Information

In case of emergency, Participant authorizes the following person(s) to be contacted:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone:_____

I have the following medical conditions, allergies; implanted devices, special instructions, and/or am taking the following medications, which may impact on the emergency medical treatment that I may receive (please print clearly and legibly):

_____
_____
_____
_____

Student-Athlete Health Insurance Verification

Insurance Information:

Name of Athlete:

Name of Insurance Company: _____

Address:_____

(Street) (City) (State) (Zip Code)3

Subscription/I.D. # _____

Policy #:_____Group #: _____

Plan Type:_____

Is this an HMO or PPO plan? HMO PPO

Statement of Authenticity:
I attest that the above information is correct and truthful. I understand that any changes to the above information must be reported to the AU Athletic Department immediately and that any lapses in coverage will result in the denial of any and all claims by the secondary insurance policy held by AU. I understand that this information will be treated confidentially within the offices of the Florida Palms University and those associated directly with student-athlete health care that may require this information. These offices include but may not be limited to admissions, student services, athletics and/or a patient approved medical provider.

(Date) (Print Name of Student-Athlete) (Signature of Student-Athlete)

(Date) (Print Name of Parent/Guardian) (Signature of Student-Athlete)

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CONCUSSION FACT SHEET FOR PARENTS

HEADS UP CONCUSSION

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY PARENTS/ GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

[INSERT YOUR LOGO]

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DANGER SIGNS

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY
   A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.
2. KEEP YOUR CHILD OUT OF PLAY.
   Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon - while the brain is still healing - risk a greater chance of having a second concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION.
   Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

HOW CAN I HELP MY CHILD RETURN TO SCHOOL SAFELY AFTER A CONCUSSION?

Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Receive help with schoolwork
- Reduce time spent reading, writing, or on the computer

Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. As your child's symptoms decrease, the extra help or support can be removed gradually.

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

Atlantis University
Mild Traumatic Brain Injury (MTBI) Policy

All sports at AU will require a baseline psychomotor exam and a baseline neurocognitive test. This will be completed before the first participation.

Florida Palms University will use a standardized initial assessment protocol for mild traumatic brain injuries.This form may or may not be used as a sideline assessment tool but should be completed as soon as possible. **Any athlete suspected of having a MTBI will need to be removed immediately from competition.**

After determining that an athlete has sustained a MTBI the athletic training staff will perform a Post-Test I follow up 48-96 hours after the injury. If the athlete passes the examination, they will begin a progressive increase in physical exertion and will be re-evaluated daily to determine return to play status.

If the athlete fails Post-Test I they will complete a Post-Test II 2-10 days following. The athlete will N0-1 perform more than 3 post injury exams in 1 Week. Depending on symptom score and neurocognitive score, the athlete may be placed on partial or complete neurocognitive rest. The athlete will only begin physical exertion after the symptom score, psychomotor score and neurocognitive scores return to baseline norms.

All athletic injuries/illnesses including concussions need to be evaluated and/or referred by the AU AT Staff for insurance and continuity of care reasons. Athletes may seek a second opinion but the medical provide I- must be deemed to have specialized training in the specific area of injury for clearance.

Florida Palms University Athletic Training
Concussion and Injury Reporting Acknowledgement

Please initial the following statements:

_____I understand that it is my Responsibility to report all Injuries and illnesses to my athletic trainer and or team physician.

_____I have read and understand the Heads-Up Concussion Fact Sheet.

After reading the Heads-Up Concussion Fact Sheet, I am aware of the following information:

_____ A concussion is a brain injury, which 1 am responsible for reporting to my team physician or athletic trainer.

_____A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

_____You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_____If 1 suspect a teammate has a concussion; I am responsible for reporting the injury to my team physician or athletic trainer.

_____I will not return to play in a game or practice if I have Received a blow to the head or body that results in concussion-related symptoms.

_____Following concussion, the brain needs time to heal. You are much more likely to havea repeat concussion if you return to play before your symptoms resolve.

_____In rare cases, repeat concussions can cause permanent brain damage, and even death.

I, the undersigned athlete at Atlantis University, acknowledge the requirement that Student-athletes at Florida Palms University accept the responsibility for reporting their personal injuries and illness to the Florida Palms University Athletic Training Staff, which may include, but is not limited to, signs and symptoms of concussions. Furthermore, I acknowledge that 1 have received the Heads-Up concussion education materials.

Signature of Student-Athlete Date

Witness Date