



Print Legal Name: _____

Sport: _____

VU A #: _____

2019-2020

STUDENT-ATHLETE FORMS

Vincennes University

List of Required Forms

*In order to participate in an intercollegiate sport, you must turn
in the following forms signed and completed in full:*

- Read and Sign Parent/Athlete Letter
- Completed Athlete/Parent Information/Insurance Form
- Completed HIPPA
- Consent for DCH to provide Treatment/Services
- Completed Academic Records Release, Student Release to Parents Form, & Media Release Form.
- Completed Drug Education & Testing Policy and Procedures Form
- Completed Media Guide Profile Form

TO: THE PARENTS OF VINCENNES UNIVERSITY INTERCOLLEGIATE ATHLETES

We are extremely pleased to have your son/daughter as a student athlete at Vincennes University and hope that he/she will achieve academic, social, and athletic success.

Each student athlete is required to have a physical examination prior to any participation in any intercollegiate sport. The final decision on physical qualifications or reason for rejection is the responsibility of the team physician, or athletic director. The team physician or athletic director also makes the decision on when an athlete may return to competition after a previous injury.

INJURIES—MEDICAL BILLS—INSURANCE COVERAGE—CLAIM PROCEDURE

Accidents do occur and we attempt to provide our athletes with the very best possible care. Medical bills may be incurred when the athlete is treated for bodily injury due to an accident, whether it be locally, during a road trip, or by a medical vendor in his/her own home area.

INSURANCE COVERAGE: The athletic accident insurance at *Vincennes University* provides coverage for your son/daughter for accidents while participating in the play or official team practice of intercollegiate sports, including sponsored and authorized team travel.

CLAIM PROCEDURE: All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the college or university has instructed the medical vendors otherwise. In some cases the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the bill incurred to be sent.

- A. Submit the bills incurred to your family, employer group coverage or plan first. They will do one of two things:
 - 1. Honor the claim and pay all or a portion of the bills incurred.
 - 2. Not honor the claim and send you a letter of denial. An example might be that your Son/daughter is no longer part of your group policy after attaining the age of twenty-three.
- B. If there remains a balance after your family, employer group insurance or plan has contributed towards the claim, send the EOB (evidence of benefits) from your insurance company and a copy of the itemized bills incurred to the VU athletic trainer, or VU's Athletic Department.

If you receive a letter of denial from your family, employer group insurance or plan administrator, then send the letter of denial and a copy of the bills incurred to the VU athletic trainer, or VU's Athletic Department. If no coverage is available, a letter from your employer with verification will be necessary.

- C. If the bills incurred and not paid by the family, employer group insurance or plan is large enough, the claim will be sent from the athletic department to our insurance carrier's office, for processing. If they need any additional information, please cooperate with them and they will process the claim in the least possible amount of time. **It is in your best interest to have the claim settled promptly since all the bills incurred are in your name.**

PLEASE NOTE: If the primary family coverage is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) you must follow the proper procedures required by your plan in order for the college's insurance to satisfactorily complete its portion of the claim. This is especially important if your plan requires pre-authorization to have your son/daughter treated if out of your plan's service area.

Parents should retain this letter for future references. In addition, we ask that you complete the attached form **IN DETAIL** and return to us prior to any athletic participation. Your cooperation in this important area will help make this program successful in minimizing delays and accomplishing the purpose for which it is intended.

Parent's Signature: _____ **Date:** _____

Student's Signature: _____ **Date:** _____



Vincennes University Athlete/Parent Information 2019-2020

STUDENT ATHLETE'S NAME:		HOME ADDRESS:	SPORT:
DATE OF BIRTH:	A#:	COLLEGE ADDRESS:	

CELL PHONE:	EMAIL ADDRESS:
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HOME	FIRST AND LAST NAMES:	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
	HOME MAILING ADDRESS:	Street:	Street:
		City/ State/ Zip:	City/ State/ Zip:
	HOME PHONE #	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
	CELL PHONE #	MOTHER: (Or Guardian)	FATHER: (Or Guardian)
DATE OF BIRTH	MOTHER: (Or Guardian)	FATHER: (Or Guardian)	

EMERGENCY CONTACT	CONTACT'S NAME:	
	RELATIONSHIP:	
	EMERGENCY CONTACT'S #:	

INSURANCE INFO	POLICY HOLDER NAME:		POLICYHOLDER DATE OF BIRTH:		
	NAME OF INSURANCE COMPANY				
	INSURANCE ADDRESS		INSURANCE PHONE NUMBER:		
	POLICY NUMBER:		GROUP NUMBER:		
	RELATIONSHIP OF POLICY HOLDER		MEDICAID? (CIRCLE ONE)	YES NO	
	Rx GROUP:		Rx BIN:		Rx PCN:

Is the company/ plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)?
Yes____ No____

Does your insurance or plan require a second opinion? Yes____ No____

I hereby authorize Vincennes University to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays and any other covering this and/or previous confinements or disabilities. A Photostat copy of this authorization shall be deemed as effective and valid as the original for up to two years after date of signature.

We authorize Vincennes University or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents. **IMPORTANT NOTICE: VU Insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it to the VU Athletic Trainer or VU Athletic Office along to us with your itemized bill, this form and a completed accident form.** Payment will be made to the providers of service (hospital, physician or others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.



Vincennes University Athlete/Parent Information 2019-2020

Continued

1. I hereby verify that I have submitted a front and back copy of my insurance card:

Student-Athlete Signature (Required)
(Parent signature required if S-A is under 18 years old)

2. I hereby verify that I am currently covered under this insurance plan and will inform the Athletic Dept. of any changes:

Student-Athlete Signature (Required)
(Parent signature required if S-A is under 18 years old)

3. I hereby verify that I have read and understand the sports medicine departments policy and procedures rules and regulations:

Student-Athlete Signature (Required)
(Parent signature required if S-A is under 18 years old)

Vincennes University
Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information

I, _____, hereby authorize **Vincennes University**
Name of Student-Athlete

and the physicians, athletic trainers, and health care personnel representing Vincennes University to release my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. The purpose of this authorization is to permit the disclosure of information among health care professionals, coaches, training staff, insurance personnel, medical vendors, academic counselors, university administrators, chaplains/clergy, the NJCAA, and the media with respect to Vincennes University athletes.

I understand that my injury/illness information is protected by federal regulations under either the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I understand that my signing of this authorization/consent is voluntary and that my institution will not provide any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) based upon whether I provide the consent or authorization requested for this disclosure. I also understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or FERPA.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Head Athletic Trainer at Vincennes University, but if I do, it will not have any effect on actions that Vincennes University or the Intercollegiate Athletics Department took in reliance on this authorization/consent prior to receiving the revocation. I reserve the right to review all records at any time and to obtain a copy of all records released at any time upon request. This authorization shall automatically expire when the student athlete names herein is no longer participating in intercollegiate _____ athletics _____ for _____ Vincennes _____ University.

I hereby acknowledge that I have received a copy of this authorization.

A# of Student-Athlete

Date of Birth of Student-Athlete

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian

Date

Daviess Community Hospital

Completion of the following form is a condition for participation in athletic practices and events sponsored by:

Vincennes University

I hereby give my permission for athletic trainers contracted by the school through Daviess Community Hospital to provide treatment/services for my child,

During school sponsored athletic activities. I further give permission for such athletic trainers to provide information via all forms of communication about such services and my child's condition:

1. To physicians and emergency medical technicians for treatment purposes
2. To the school athletic director, coaching staff and other personnel involved with my child's participation in such athletic activities in order to facilitate decisions about my child's participation in the athletic activity or the need for further medical treatment.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it. If not previously revoked, this authorization will expire on August 1, 2020.

We will be collecting the information gathered from the tests that are normally performed in the pre-participation physical exam. This information will be used to develop typical values for balance so that in the future we can tell how an athlete performs compared to other athletes in the same sport. Your name will not be connected with the test results and the results will be used in a group format so that you cannot be identified. Your agreement to allow us to use the test results information will not affect your ability to participate in the sport, complete the physical exam, or receive treatment.

_____ I agree to allow the information obtained in the physical exam to be used as described above.

Parent (Print Name)

Participant (Print Name)

Parent Signature

Date

Participant Signature

Date

Student Address: _____

Adult Witness

Vincennes University
Student-Athlete Authorization/Consent
for
Disclosure of Protected Health Information

I, _____, hereby authorize **Vincennes University**
Name of Student-Athlete

and the physicians, athletic trainers, and health care personnel representing Vincennes University to release my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. The purpose of this authorization is to permit the disclosure of information among health care professionals, coaches, training staff, insurance personnel, medical vendors, academic counselors, university administrators, chaplains/clergy, the NJCAA, and the media with respect to Vincennes University athletes.

I understand that my injury/illness information is protected by federal regulations under either the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I understand that my signing of this authorization/consent is voluntary and that my institution will not provide any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) based upon whether I provide the consent or authorization requested for this disclosure. I also understand that once information is disclosed per my authorization/consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or FERPA.

I understand that I may revoke this authorization/consent at any time by notifying in writing the Head Athletic Trainer at Vincennes University, but if I do, it will not have any effect on actions that Vincennes University or the Intercollegiate Athletics Department took in reliance on this authorization/consent prior to receiving the revocation. I reserve the right to review all records at any time and to obtain a copy of all records released at any time upon request.

This authorization shall automatically expire when the student athlete names herein is no longer participating in intercollegiate athletics for Vincennes University.

I hereby acknowledge that I have received a copy of this authorization.

A# of Student-Athlete

Date of Birth of Student-Athlete

Signature of Student-Athlete

Date

Signature of Parent/Legal Guardian

Date

**VINCENNES UNIVERSITY
Academic Records Release Form**

SCHOOL YEAR: _____

Please print clearly.

Name (Last, First, Middle) _____

Student ID A# _____ SS # If no A # _____

Birth Date ____ / ____ / ____

The Family Education Rights and Privacy Act of 1974 prohibit the release of information pertaining to the academic records of the student without the written and signed consent of the student. By signing this form, the student is giving consent to Vincennes University to release a transcript and any other information requested by the NJCAA to determine student-athlete eligibility.

Print Name: _____ **Signature:** _____ **Date:** _____

**STUDENT RELEASE OF EDUCATIONAL RECORDS TO PARENTS
VU ATHLETE**

SCHOOL YEAR: _____

STUDENT'S NAME _____

Student ID A# _____ SS # If no A # _____

Birth Date ____ / ____ / ____

FATHER'S NAME _____

MOTHER'S NAME _____

You are not required to sign this form. However your signature on this form allows your parents to receive information from and about your academic record. An athletic department member or your coach may discuss with your parents your grades, academic records, and academic situation. This note eliminates the need to contact you any time a request is made by your parents or your coach feels it is necessary to contact your parents.

Print Name: _____ **Signature:** _____ **Date:** _____

**Media Release
Vincennes University Production Model Release**

Date: _____ By signing this document, I hereby assign rights to the photographs, video and audio recordings and transcriptions associated. I hereby authorize the reproduction, sale, copyright, exhibition, broadcast, and/or distribution of said photos, videotape, audio tape, and transcriptions without limitation for the purpose of promoting Vincennes University and its related entities in video, audio, print, web and other mediums.

Thank you for participating in the shoot. If you wish to receive low resolution digital copies of the imagery or samples of the materials in which the imagery is used, please complete the information form below and we will do our best to supply the requested materials.

Name: _____ **Signature:** _____

Email: _____



VINCENNES UNIVERSITY DEPARTMENT OF ATHLETICS DRUG AND SUBSTANCE ABUSE POLICY

OVERVIEW

The Vincennes University Athletic Department recognizes that the use of illicit drugs has become a serious problem in all segments of our society. While the misuse of drugs, legal or illegal is a potential problem for all student-athletes, unique pressures and risks exist for student-athletes participating in intercollegiate athletics, and their use of drugs will not be tolerated. This includes over the counter dietary supplements, and performance enhancing drugs. VU has a drug abuse prevention policy and program in place for student-athletes to progress towards their academic and athletic goals in a drug free environment.

PURPOSE

The purpose of this drug policy is as follows:

1. To educate student-athletes on the physiological and psychological dangers inherent in the misuse of illicit drugs.
2. To provide a periodic individual random testing program to identify student-athletes who are improperly using legal or illegal drugs and assist them, through education and counseling, Before they injure themselves or others and become physiologically or psychologically dependent.
3. To protect those student-athletes from the health-related risks inherent in the misuse of drugs.
4. Testing that reveals drug usage will subject the student-athlete to disciplinary action stated in this policy.

DRUG TEST PROCEDURE:

All VU student-athletes can be randomly tested for illicit drugs as determined by the NJCAA governing body. This testing can occur with no advance notice at any such time or times as deemed appropriate by the athletic director, head coach, team physician or athletic trainer. Each student-athlete is asked to sign a release form, which states that he/she is aware that testing for the presence of drugs is permitted. Each student-athlete understands that failure to show or undergo the drug test without a valid excuse or failure to provide a proper sample following notifications shall be considered to have tested positive and could result in loss of the privilege to participate in any athletic department program. A student-athlete who is suspected of manipulating his/her test sample to mask banned substances will be subject to a follow-up test. Testing will be done under the supervision of the head coach and the athletic director. A professional laboratory selected by the VU designee will conduct all chemical analysis and ensure confidentiality.

These tests can be conducted randomly from the first day of practice and/or the start of fall semester classes through the last day of spring final exams and/or last day of competition for all sports (this is to include all sports that start or end outside the regular academic calendar). A student-athlete who has tested positive will be taken out of the random selection process until he/she has produced a negative result in subsequent testing.

TEST RESULTS

Test results are confidential and will be released to the VU athletic director, head coach, athletic training staff, and counseling center staff, VU Dean of Students, Assistant Provost for Student Affairs, Provost, and the President.

Once the test results have been released, the head coach will notify the student-athlete and at the discretion of the coach, the parents/guardians may also be notified, (if the student athlete is under the age of eighteen (18) then the parents/guardian must be notified by phone and/or written correspondence). A meeting will be scheduled between the athletic director, head coach and student-athlete if the drug test shows positive for a controlled substance. The student-athlete will be given the opportunity to do another drug test immediately after the first test comes back positive or the student-athlete must provide a current prescription for the substance. If they are unable to provide a prescription, then the test will stand as a positive test. If there is a current prescription provided, then the test will be considered a negative and no further action will be taken.

If the student-athlete's test yielded a false positive, a follow-up test will be administered immediately. If this test is negative, there will be no further actions.

FIRST OFFENSE

1. The student-athlete will be suspended for 10% of the contests, games, or matches, starting at or during the regular season of competition and including post season.
2. The student-athlete will be referred to the VU Counseling Department. The student-athlete will adhere to the counseling program and will be required to sign a release form permitting counseling center staff to converse with the athletic director, head coach and/or athletic trainer, the recommendations for treatment and confirming student-athlete's completion of the recommended program.
3. The student-athlete will be re-tested a minimum of one test at least 30 days following the original test date and completion of the counseling program.
4. The Head Coach has the discretion to permanently, suspend a student-athlete from the team.

SECOND OFFENSE

1. The athletic director, head coach, Student-athlete and parents/guardian(s) of the athlete will be notified of the results of the second positive.
2. The student-athlete will be permanently suspended from practice and competition in intercollegiate athletics at Vincennes University.

MEDICATION

Student-athletes taking medication must give a complete list to the Head Athletic Trainer and/or Head coach prior to team practice. If medication is prescribed by a physician, student-athlete must have a letter documenting the need and dosage for use of drug. Vincennes University will attach this list along with the physician's letter to the student-athlete's signed consent form for drug testing.

CONFIDENTIALITY

Confidentiality of the information and documents resulting from the student-athlete's participation in drug testing and in medical evaluations will be assured. Vincennes University Athletic Department shall make available its Drug and Substance Abuse policy on the VU Athletics web site (www.govutrailblazers.com), and in the Athletic Office.

**Consent to Perform Drug Testing in Accordance
With the Vincennes University Athletic Drug Policy.**

I hereby consent to be tested for the presence of drugs according with the Vincennes University Department of Athletics Drug Testing Program.

I understand that this testing will occur at such time or times as deemed appropriate by the team physician, the Athletic Director, my head coach or athletic trainer.

I understand that any samples collected will only be sent to a licensed medical laboratory for actual testing, and that the samples will be coded to provide confidentiality.

I hereby authorize the release of such testing results to the athletic director, head coach, trainer, team physician, and/or other University officials as deemed appropriate. I understand that these results will be made available to me.

I understand that I am free to withdraw this consent for testing. However, I also understand that should I refuse to submit to testing at the time requested, I will not be permitted to participate in any intercollegiate sporting program until such time as the Department of Athletics and Vincennes University shall deem appropriate.

I hereby authorize the release of the results of such testing to my parent(s) upon the receipt by the University. (If the student athlete is under the age of eighteen (18) then the parents/guardian will be notified by phone and/or written correspondence).

I hereby release Vincennes University, its Trustees, officers, employees and agents from legal responsibility or liability for the release of such information and records as authorized by this form.

I understand and agree to the policies set forth by Vincennes University and the Athletic Department. By signing this form I agree to all the Drug Testing procedures included in this policy.

Student-Athlete (print name)

Date: _____

Student-Athlete (signature)

Date: _____

Parent or Guardian (signature if athlete under the age of 18)

Date: _____

VINCENNES UNIVERSITY TRAILBLAZERS
SPORTS NEWS INFORMATION

(PLEASE PRINT CLEARLY)

ACADEMIC SCHOOL YEAR: _____

VU SPORT _____ FRESHMAN _____ SOPHMORE _____

NAME _____
LAST FIRST MIDDLE

HEIGHT _____ WEIGHT _____ BIRTH DATE _____

ACADEMIC MAJOR _____

PRIMARY ADDRESS _____
Street City State/Zip Code

LOCAL ADDRESS _____
Street City State/Zip Code

CONTACT INFORMATION _____
Email Phone # _____

MOTHER'S (or GUARDIAN'S) NAME _____ PHONE # _____

ADDRESS _____
Street City State/Zip Code

FATHER'S (or GUARDIAN'S) NAME _____ PHONE # _____

ADDRESS _____
Street City State/Zip Code

HIGH SCHOOL _____ YEAR GRADUATED _____
Full Name City/Town

HS ATHLETIC AWARDS _____

ALL SPORTS PLAYED _____

TRANSFER STUDENTS ONLY, COLLEGE(S) ATTENDED AND THE YEARS:

Interesting Hobbies/Activities/Interests Unique Outside Sports: