

THE UNIVERSITY OF TEXAS AT AUSTIN
Department of Intercollegiate Athletics
Division of Athletic Training/Sports Medicine
P.O. Box 7399 • Austin, Texas • 78713-7399

UNIVERSITY SPONSORED SUMMER SPORTS CAMPS

M E M O R A N D U M

DATE:

TO: Parents/Guardians of Prospective Campers

FROM: The Department of Intercollegiate Athletics

RE: REQUIRED CAMP MEDICAL FORMS

The Department of Intercollegiate Athletics wishes to welcome your son/daughter as a sports camp participant. Every camp carries with it some degree of risk to the participant because of the physical nature of the activities. The UT Sports Medicine Staff in cooperation with the University Health Services and a network of consulting physicians and certified athletic trainers provide specialized services, care, and supervision to safeguard his/her health and well being.

To facilitate this care, we are requesting that you complete a number of medical forms. Your son or daughter will not be permitted to participate in any activities until all forms are completed and are on file with the camp supervisors. The forms are briefly described below for your review and subsequent completion:

#2  **“NOTICE OF HIPAA PRIVACY PRACTICES”**

If your child is ever sick or injured during camp, his/her health care will be coordinated by UT's medical providers. In order to provide appropriate care, UT's professional staff, employees, and volunteers must use and disclose your child's medical information to the extent necessary for treatment, payment, and health care operations. Sharing of this information requires compliance with privacy practices required by the law. These privacy practices dictate how your child's medical information may be used and disclosed, and how you can get access to this information. We are required to provide you with our “Notice of Privacy Practices” and to secure your signature acknowledging receipt of the privacy notice.

#3  **CONSENT FOR TREATMENT OF A MINOR/ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES**

This form authorizes UT's health personnel to provide medical care to your MINOR child (under 18 years of age), including, but not limited to, diagnostic examinations, including radiology and laboratory tests, tuberculosis screening, verification and/or administration of immunizations and necessary medical treatment, including minor surgical procedures, and mental health counseling. If your child needs more invasive diagnostic or surgical procedures, attempts will be made to contact you before such care is initiated. Additionally there is a section requiring your signature acknowledging that your receipt of the HIPAA privacy practices.

#4  **EXPRESS ASSUMPTION OF RISK/RELEASE AND INDEMNIFICATION AGREEMENT**

With your signature on this form, you fully recognize that there are dangers and risks to which your child may be exposed by participating in the Camp. We make every effort to increase the camper's knowledge concerning rules and practices being employed to minimize risk of injury or illness while pursuing the many benefits of camp activities. Moreover, as injury/illness risks are identified, steps

are taken to minimize the causes, where possible. We teach the latest in skill acquisition and technique as well as implement preventative injury measures such as warming up prior to vigorous activity, stretching, and fluid replacement, realizing that all of these measures have the potential to lower risk of injury. Even with these efforts, a certain number of injuries/illnesses will occur and you accept responsibility for any medical conditions that may result from your child's participation in camp activities.

#5  **PRE-ACTIVITY CLEARANCE PHYSICAL EXAMINATION: PHYSICIAN AUTHORIZATION**

All campers are required to have written physician clearance proclaiming them fit for camp participation. The physical examination must have been completed within the last 12 months. If your physician has documented the health information on another form, a copy of this form will suffice.

#6  **DISPENSION OF MEDICATIONS WAIVER AND RELEASE**

We are able to dispense medications (prescription or over-the-counter) to your child if it is necessary during camp operation. Medications include prescription medications such as antibiotics and asthma inhalers in addition to over-the-counter medications such as Tylenol, Advil, and antihistamines to name a few. However, before any medication is dispensed, we must have the following information from you:

- *Complete and sign the Permission/Waiver and Release Form to Dispense Medication;*
- *Deliver all prescription medications to the camp director or his /her designate the first day of camp in the original prescription bottle or in clearly marked containers which include the camper's name, medication, dosage and time of day medication is to be given; and*
- *Verbally communicate with the camp director or designate regarding specific instructions for dispensing prescription or over-the-counter medications during the first day of camp.*

#7  **RELEASE OF MEDICAL INFORMATION TO CAMP STAFF**

It is important to understand that our staff will respect the privacy of your child's health information, release only the minimum necessary to protect his/her health and safety during strenuous activities, and take appropriate measures to ensure the confidentiality of medical information.

Return the completed booklet of forms, dated and signed where appropriate by the following date,

and send it to

(address):

**THE UNIVERSITY OF TEXAS AT AUSTIN
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
HIPAA PRIVACY RULES REQUIRE THAT WE FURNISH YOU WITH THIS NOTICE.**

I. Purpose: The University of Texas at Austin's medical providers, professional staff, employees, and volunteers follow the privacy practices described in this Notice. Your medical information is maintained in records that will be handled in a confidential manner, as required by law. However, UT's representatives must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, your medical information must be shared with others as necessary for treatment, payment, and health care operations.

II. What Are Treatment, Payment, and Health Care Operations? Treatment includes sharing information among health care providers involved in your care. For example, your treatment provider may share information about your condition with other treatment providers in clinic and hospital settings in order to make a diagnosis or to improve the quality of care, e.g., for review and training purposes. In addition, we also may use your medical information as required by your insurer to obtain payment for your treatment.

III. What Are Other Ways Your Medical Information May Be Used? Your medical information may be used, unless you ask for restrictions on a specific use of disclosure, for the following purposes:

- Appointment reminders.
- To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
- To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.
- Alcohol and drug abuse information has special privacy protections. UT's medical providers will not disclose any information relating to substance abuse treatment unless: (i) consent is obtained in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use this information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or (v) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.
- Worker's Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- Health oversight activities, e.g., audits, inspections, investigations, and licensure.
- Certain research projects.
- To prevent a serious threat to health or safety.
- Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; circumstances relating to reporting information about a crime).

. . . HIPAA Notice of Privacy Practices, page 2

- Disaster relief agency if injured in a disaster.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
- As required by law.

IV. Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information unless you authorize us in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation. Your medical records may also contain psychotherapy notes from individual, joint, group or family sessions you may have participated in. You will need to sign a separate authorization form for the use and disclosure of this information. You may revoke your permission to use and disclose your psychotherapy records by sending a written revocation to UT's Sports Medicine Division.

V. You Have Rights Regarding Your Medical Information. You have the following rights regarding your medical information, provided that you make a written request to invoke the right.

Right to request restrictions. You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular treatment), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency services.

Right to confidential communications. You may request communication in a certain way or at a certain location, but you must specify how or where you wish be contacted.

Right to inspect and request a copy. You have the right to inspect and request a copy of your medical information regarding decisions about your care. We charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; in that instance you may request review of the denial by another licensed health care professional chosen by UT's medical providers. UT will comply with the outcome of the review.

Right to request amendment. If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment, which requires certain specific information. UT's medical providers are not required to accept the amendment.

Right to accounting disclosures. You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment, payment, or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there will be a charge.

Right to a copy of this Notice. You may request a copy of this Notice at any time, even if you have been provided with an electronic copy.

VI. Requirements Regarding This Notice. The University of Texas at Austin's medical providers are required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. We may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future.

. . . HIPAA Notice of Privacy Practices, page 3

Each time you register for health care services on the University of Texas campus, you may receive a copy of the Notice in effect at the time.

VII. Complaints. If you believe your privacy rights have been violated or:

- You have a complaint.
- You have any questions about this Notice.
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations.
- You wish to obtain forms to exercise your individual rights described in paragraph V.

Call Tina Bonci in the Sports Medicine Division of Intercollegiate Athletics at (512) 471-4916.

**THE UNIVERSITY OF TEXAS AT AUSTIN
CONSENT TO TREAT A MINOR**

FOR PROVIDER USE ONLY

Patient Name: _____

Medical Record # _____

DOB: _____ Gender: _____

Provider: _____ Date: _____

Name of Program Participant: _____

Date of Birth: _____

Address (Street, City, State, Zip): _____

Parent/Guardian Phone Number: _____
Home Work/Cell

I, the undersigned, as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

Signature of Parent/Legal Guardian _____

Date _____

Print Name _____

I have received a copy of UT's Notice of Privacy Practices as required by HIPAA Privacy Rules.

Signature of Parent/Legal Guardian _____

Date _____

Print Name _____

Medical Information Related to Minor

Allergies: _____

Current Medications: (If your child is on any medication that needs to be administered by camp personnel or he/she will be self-administering any medication during camp – prescription or over-the-counter – see the appropriate medication forms enclosed in this packet for completion).

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

Please Return to Program Coordinator:

Name of Program: _____

Program Coordinator: _____

Coordinator's Phone: _____ Coordinator's Fax: _____

Coordinator's Mailing Address: _____
(Street) (City) (State) (Zip Code)

**THE UNIVERSITY OF TEXAS AT AUSTIN • SPORTS CAMPS
ASSUMPTION OF RISK/RELEASE AND INDEMNIFICATION AGREEMENT**

PARTICIPANT:

CAMP:

LOCATION:

DATE(S):

I am the Parent/Guardian of the above-named Participant who is under eighteen years of age and am fully competent to sign this Agreement.

I realize that my child's participation in camp activities carries with it risk of injury/illness, even when all rules are followed and conditions are optimal. There are various safety problems that can increase injury risk potential. Some safety problems are regularly identified and addressed (i.e., heat illness and the administration of liquids frequently during practices; collisions and the use of high quality, durable, and safe protective equipment). Some safety problems may be less clearly identified (i.e., mechanisms of head and neck injuries or ankle and knee injuries,) and, therefore, prevention and protection are difficult. Risk can be increased due to the participant's lack of compliance with specified instructions (i.e., using improper footwear, knowingly using dangerous or faulty equipment, training when environmental conditions are dangerous (high heat/high humidity, lighting), and engaging in high intensity or high volume training or executing new skills without adequate fitness. Even in the best facilities, with adequate supervision, use of all protective equipment, and compliance with all of the rules, there remains an inherent risk of injury/illness in any camp activity, and this risk is increased even more so with contact sports.

I acknowledge that my child's voluntary participation in this camp may expose him/her to hazards or risks that may result in his/her illness, personal injury, or death. I acknowledge that I am aware of the risks of injury/illness and knowledgeable concerning rules, equipment and practices being employed by UT camp personnel to minimize my child's risk of sustaining an injury/illness while participating in camp activities. My child agrees to use all required protective equipment and follow all rules and instructions from University officials regarding safety. Also, my child has no known physical infirmities which could be worsened or aggravated by participation and I declare him/her physically fit and in good medical condition to engage in all camp activities.

In consideration of my child being permitted to participate in the camp and to use the program's facilities and equipment, I hereby accept all risk to my child's health and of his/her injury or death that may result from such participation. I hereby release The University of Texas at Austin, its Board of Regents, officers, employees, and representatives from any and all liability in any way resulting or arising from any injuries (including death), damage, loss or costs that may incur as a result of my child's participation in the camp. I intend this release to be binding upon my heirs, executors, administrators and assigns. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity.

I have carefully read this agreement and I understand that it is a legally binding document that affects my child's legal rights and remedies.

Signature of Parent/Guardian

Date Signed

Address (if different than Participant's)

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps
Department of Intercollegiate Athletics

**PRE-ACTIVITY CLEARANCE EXAMINATION:
PHYSICIAN AUTHORIZATION**

Participant's Name _____

Camp _____

I hereby certify that I have examined the above named patient and have found him/her fit to attend and participate in the *University Sponsored Summer Sport Camps*. I know of no impairments, which would limit his/her participation in all camp activities except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

Restrictions and/or Comments _____

Date of Physical Examination (**must have been completed within the last 12 months**)

Physician's Signature _____

Address _____

City/St./Zip _____

Phone _____

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps
Department of Intercollegiate Athletics

PERMISSION TO DISPENSE MEDICATIONS

CAMPER'S NAME _____ DATE: _____

The UT Sponsored Sports Camp's designated personnel will not dispense non-prescription (Advil, etc.) or prescription medication (antibiotics, insulin, inhalers, etc.) to the above named participant until the following information has been completed by a parent or guardian. I understand it is the parent's/guardian's responsibility to give the medication directly to the camp director or designated staff member in individual dosage containers, original prescriptions containers, or envelopes clearly labeled with dosage instructions on the first day of camp. In all cases, the recommended dosage of any over-the-counter medication will be adhered to according to the manufacturer's instructions and the recommended dosage of any prescription medication will be adhered to according to the following instructions:

I _____, the parent/guardian of _____

give permission to the staff of the UT Sponsored Sports Camp to administer to my child:

PRESCRIPTION MEDICATION _____

Dosage _____ Dispensing Time _____

Special Storage Instructions _____

PRESCRIPTION MEDICATION _____

Dosage _____ Dispensing Time _____

Special Storage Instructions _____

NON-PRESCRIPTION MEDICATIONS:

Ibuprofen (Advil) YES NO; Acetaminophen (Tylenol) YES NO;

Antacids / Anti-Nausea: Maalox YES NO; Throat / Cough Lozenges: Cepacol YES NO;

Allergies: Benadryl YES NO

Other Non-prescription Medicine which may be administered: _____

My child may possess and self administer the following medicine: _____, and I affirm that my child understands and agrees that he/she will use the medication only according to dosage instructions, and will not share or otherwise provide medication to any other person while at camp, and failure to do so is a violation of camp rules that will result in disciplinary action, up to and including removal from camp.

I hereby release The University of Texas at Austin, its Board of Regents, officers, employees, and representatives from any and all liability in any way resulting or arising from the administering of the above medications.

Signature of Parent or Guardian

Date

THE UNIVERSITY OF TEXAS AT AUSTIN
University Sponsored Summer Sports Camps

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CAMP STAFF

This authorizes The University of Texas at Austin physicians, medical personnel and camp sponsors to release information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information of _____ (Participant) to camp staff. This information includes injuries or illnesses relevant to participation in the above named camp at The University of Texas at Austin.

The reason for this disclosure is to advise camp staff of the nature, diagnosis, prognosis or treatment concerning any medical condition and any injuries or illnesses Participant may have so that good decisions can be made regarding Participant's ability and suitability to participate in camp activities. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be redisclosed publicly and that the information will no longer be protected by those regulations.

I understand that The University of Texas at Austin will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying in writing the Department of Intercollegiate Athletics, but if I do, it will not have any effect on actions The University took in reliance on this authorization prior to receiving the revocation. This authorization expires one year from the date it is signed.

Signature of Camper

Date

**Signature of Parent/Legal Guardian
(If camper is under 18 years of age)**

Date

Camper's Date of Birth: _____

Camp _____