

Texas State University Athletics – Emergency Contact Information

Patient Information:

Last Name:		First Name:		Middle Initial:	Sport:	
Scholarship:	Sex:	DOB:	Age:	Marital Status:	Student ID number:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	M <input type="checkbox"/> F <input type="checkbox"/>					
Texas State Address:		City:	State:	Zip Code:	Race/Ethnic Origin:	Cell Phone:
Your Doctor's Name:		Allergies:	Medications:			

In Case of Emergency:

Emergency Name:			Relationship to Student-Athlete:			
Address:		City:	State:	Zip Code:	Home Phone:	Work Phone:
Emergency Name:			Relationship to Student-Athlete:			
Address:		City:	State:	Zip Code:	Home Phone:	Work Phone:

Primary Insurance Information:

0 No Insurance

Insured's Name (Parent/Guardian)		Insured's Date of Birth:		Insured's Social Security Number (last 4 digits):	
Employment Name:				Employment Telephone:	
Employment Address:		City:	State:	Zip Code:	
Insurance Company:			Insurance Company Telephone:		
Insurance Company Address:		City:	State:	Zip Code:	
Group Number:			Policy Number:		

If you are under another parent's/guardian's medical insurance please check the box and provide a copy of the information. 2nd Policy

Secondary Insurance Information:

Name: Debra Boughton	Phone: (512) 245-2203 Fax: (512)245-8387
Address: 601 University Dr./Athletics San Marcos, TX 78666	
Billing: Texas State University is responsible for all medical billing questions and <u>SECONDARY</u> payments. Please submit billing to <u>PRIMARY Insurance</u> listed above for PRIMARY payment.	

Release of Information: I hereby authorize the hospital, physicians and/or Southwest Texas to release any appropriate insurance related entity or agency the information needed to process the claims in reference to this hospital/Physician's visit(s).

Insurance Assignment of Benefits: I authorize that my insurance benefits be payable directly to the hospital and/or attending physician on my behalf. I understand that I am responsible for all deductions and insurance, and non-covered charges.

Informed Consent: I understand that there is risk of injury participating in intercollegiate athletics.

Consent to Treat: I hereby give my permission for a licensed physician and or any hospital employee to administer necessary medical treatment and/or procedures to the above name athlete.

Student Athlete
Signature _____ Date _____

Parent
Signature _____ Date _____

**Texas State University – Athletic Department
Drug Testing Consent**

Acknowledgment and Consent

I acknowledge that I have received a copy of the “Policies and Procedures for Drug Education and Drug Screening for Student-Athletes in the Texas State University System.” I have read it, been given the chance to ask questions about it, and fully understand and agree to abide by its provisions.

In accordance with the terms and conditions of the policies and procedures, I consent to have samples of my urine and/or oral fluids collected and tested for the presence of anabolic steroids, cocaine, heroin, marijuana, amphetamines, ephedra and any other controlled substance proscribed by federal or state law or by the National Collegiate Athletic Association (NCAA) where applicable.

To the extent set forth in this consent form and in the policies and procedures, I waive any privilege I may have with respect to the release of such information.

The University, the Board of Regents, Texas State University System, and their respective officers, employees and agents are hereby released from any and all legal responsibility or liability for any action(s) related to their implementation of this program or for their release of such information and records as authorized by this consent form.

Notice of Tests and Sanctions

I understand that I am subject to the following sanctions if I violate the policy.

1. Suspension from the intercollegiate athletic program for a period of not less than the remainder of the semester in which the infraction occurred plus the following long semester. In the event the semester in which the infraction occurred has ended by the time I have been found guilty of such unauthorized or illegal use, I shall be suspended from the intercollegiate athletic program for a period of not less than the following two long semesters;
2. Requirement that I accept counseling or pursue appropriate treatment at my own expense;
3. Requirement that I be subsequently tested for drug use at the discretion of the of the Athletic Director as provided by the policies of the University; and/or
4. Termination of my athletic scholarship.

Certification

“ I certify that I have read this consent form and the Texas State University System policies and procedures for drug screening in the intercollegiate athletic programs; understand the tests and sanctions associated with participation in such programs; and understand that I am subject to and must comply with such policies and procedures.”

Signature of Student-Athlete

Date

Parent/Guardian (If under 18 years of age)

Date

(Rev1/06)