

**ACCEPTANCE OF RISK/ PERMISSION TO TREAT/  
RELEASE OF MEDICAL INFORMATION**

**I, the undersigned, hereby acknowledge and affirm the following:**

**A. Acceptance of Risk**

I am aware of and accept the risk of injury associated with the club sports in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible physical condition and to follow the advice of the team physician, athletic trainer, and/or coach concerning the prevention, treatment, and rehabilitation of athletic injuries.

**B. Permission to Treat**

Permission is hereby granted to Loyola University to proceed with any needed medical or minor surgical treatment, x-ray examinations, and immunizations for the undersigned student.

[For students under age 18:] In the event of serious illness, the need for major surgery, or significant injury, if the undersigned parent/guardian cannot be reached, the treatment necessary for the best interest of the below named student may be given.

**C. Release of Medical Information**

I authorize the Loyola University Athletic Training Staff to release my medical records to Loyola University personnel who have legitimate educational interests, including seeking payment for medical care provided to me. I further authorize Loyola University to release my medical records to my parent(s)/guardian(s), and to other health care providers for the purpose of providing treatment to me. This authorization will remain in force and effective for 380 days from the date of my signature below, unless revoked as set forth in the following section.

**D. Revocation of Authorization**

I understand that I have the right to revoke this authorization, in writing, at any time by delivering the written notification to the club sports director at Loyola University Maryland. I understand that a revocation is not effective until the club sports director acknowledges in writing receipt of my notification and that such revocation is not effective to the extent that anyone, including Loyola University Maryland, has acted in reliance on this authorization to disclose medical information prior to an effective revocation of this authorization.

**I have read and understood this packet in its entirety.**

\_\_\_\_\_  
**Student-Athlete Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Student-Athlete Name**

**If Student-Athlete is under age 18:**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Parent/Guardian Name**

**One additional note:** all referrals of injuries due to a club sports athletic injury will be made by the athletic training staff, the Health Center, or the team physician. Loyola University Maryland will not be responsible for any costs or expenses in the event an athlete is not seen by or referred by the athletic training staff or designated team physician. In other words, if you decide to seek out your own medical treatment, you will assume complete financial responsibility for such treatment.

**(OVER)**

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