



April 29, 2019

Dear ,

After review of your academic status and candidacy file, it is a privilege to officially inform you of your **acceptance** status into the Kent State University Master's of Science Athletic Training Program (MSAT). Acceptance into this program brings with it rights and responsibilities of an athletic training student (ATS) as outlined in the MSAT Student Handbook. You are required to read and follow all policies and procedures defined in this document if you accept the invitation to join the Kent State University Athletic Training Program as an Athletic Training Student. The handbook is currently under its annual review and Dr. Hannah Harnar will place a notice on ATRACK when the handbook is finalized.

You will receive in the mail a copy of the MSAT student contract, which must be **signed and returned by July 1, 2019**. It confirms your acceptance into the program.

Please return all of the following forms and requirements once you receive them:

- Athletic Training Student Contract
- Technical Standards Form
- Confidentiality Form
- Background check verification form
 - ALL students must obtain BOTH an FBI and Ohio BCI & I (Bureau of Criminal Identification and Investigation) – If asked for a code please use either 3319 or 39B1
 - Background Checks can be obtained at White Hall on the KSU campus or at most Ohio Bureau of Motor Vehicle centers
 - Please have the original sent to the program, after verification they will be handed back to you to keep if you are asked for it by a clinical preceptor.
- Communicable Disease Policy
- Assumption of Risk Policy
- Insurance form
 - You must include a copy of your current health insurance card
- Physical Examination/Clearance Form
 - Including a copy of your immunization record – with proof of up to date Hepatitis B immunization
- Proof of Professional Liability Insurance
 - Links to appropriate companies will also be found on ATRACK in the announcements section.
- TB Test Verification and a copy of the TB test results

School of Health Sciences

All of these forms must be completed and returned by **July 1, 2019**. ***Failure to do so will indicate that you have declined acceptance into the program.***

As an athletic training faculty and approved affiliate clinical preceptors, we are pleased to invite you to join this fine group of students who have made a commitment to the development of athletic training skills and proficiencies in preparation for a career as a certified athletic trainer. We have based our program on the following concepts, which are expected of all of our students and staff: Innovation, Service and Engagement. We are confident that you will represent our program with pride and dignity as you take this next step towards professional development.

Congratulations on this first major accomplishment toward your goals in the athletic training profession. If you have any questions or concerns, do not hesitate to contact me at 330 672 0231 or Kpeer@kent.edu. We look forward to seeing you in June for our first courses.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kimberly S. Peer', written in a cursive style.

Kimberly S. Peer, EdD, ATC, FNATA
Professor, UG and Grad Coordinator
Athletic Training

**Kent State University
Athletic Training Program
MSAT Paperwork Forms
Academic Year 2019-2020**

Instructions to the student: You are to verify and complete each of the following requirements on an annual basis prior to beginning your clinical rotations at the beginning of each academic year. You need to do the following:

- Complete the documents below and mail them back to us at
**MSAT PROGRAM: ATTENTION TAMMIE RICHARDS
ATHLETIC TRAINING ACADEMIC PROGRAM
350 MIDWAY DRIVE
266 MACC ANNEX
KENT STATE UNIVERSITY
KENT, OH 44242**

- a. KSU ATP ATS Renewal Paperwork Form Academic Year 2019-2020
 - i. Sign this document
- b. Proof of TB test results
 - i. Results must be dated after May 15, 2019
- c. Proof of professional liability insurance
 - i. Proof must indicate coverage for the entire 2019-2020 academic year
- d. HIPPA confidentiality form
 - i. Sign it
- e. ARC – certification
 - i. Professional Rescuer for Health Care Provider with First Aid, Epi pen, Asthma Inhaler administration
 - ii. Certification must be valid for the entire 2019-2020 academic year
- f. Immunization records
 - i. None these are the same records you submitted to the KSU health center
- g. Personal Health insurance information form
 - i. Copy of health insurance card (front & back)
- h. Complete an FBI and Ohio BCI background check (code: 332020 39B1) and have it sent the address below:
Tammie Richards
Kent State University
350 Midway Drive
Room 266
Kent, OH 44242

Failure to do the following will result in your removal from you Practicum/Internship academic and clinical requirements associated with these courses.

- a. Complete documents (a-h)
 - b. Once completed, covert to 1 PDF document and email to kpeer@kent.edu AND MAIL HARD COPIES
 - i. Uploading of documents in multiple PDFs will not be accepted
 - c. Use copies of original documents
 - i. NO PICTURES OF DOCUMENTS WILL BE ACCEPTED
 - d. Email and return documents (mentioned above) by July 1, 2019
 - e. Complete and have your FBC & BCI background checks received by Tammie Richard by July 1,
 - f. 2019
-

All documents must be converted to one file and emailed to Dr. Peer and background check received no later than July 1, 2019

**Kent State University
Athletic Training Program
MSAT Paperwork Form
Academic Year 2019 – 2020**

Students Name: _____ Level in Program: _____

I understand that my failure to provide the required MSAT program documentation (1 or more forms) by the July 1st, 2019 deadline will delay and/or preclude my ability to enroll in and complete the academic and clinical assignments associated with my clinical course.

I understand that it is my responsibility to provide the original copy of the required documents to the MSAT Program Coordinator and Clinical Coordinator, as well as retain a hard copy of each required document in my files.

ATS Name _____

Date _____

Background Check – use code: 332020 39B1

I have completed and submitted both an FBI and BCI background check. I have already submitted the background check to be sent to Tammie Richards. I understand I will receive my background check at the beginning of the academic year. I agree to keep a copy of the background checks for my personal records. I understand if verification of my FBI & BCI background check is not received prior to July 1, 2019 I will be removed from my clinical course and assignments.

**Students who have received a red flag on 1 or both of the background checks will need to meet with the Program Coordinator and Clinical Coordinator to discuss the matter and determine if the legal infraction would preclude the student from being able to successfully complete the requirements of the MSAT program.

Student Initials _____

TB Test Verification

I have complied with the ATP program policy and have successfully completed a TB test. I have converted to PDF in one file the TB test results and have included it in the comprehensive PDF document. I agree to keep a copy of my TB test results for my personal records. I understand if verification of my TB test results is not received prior to July 1, 2019 I will be removed from my clinical course and assignments.

Student Initials _____

Professional Liability Insurance

I have purchased professional liability insurance in accordance with the policies of the ATP. I verify that the professional liability insurance I have purchased provides coverage for the entire 2019-2020 academic year. I have proof of my professional liability insurance and have included it in the comprehensive PDF document. I agree to keep a copy of my professional liability insurance for my personal records. I understand if verification of my professional liability insurance is not received prior to July 1, 2019 I will be removed from my clinical course and assignments.

Note: Proof of liability insurance CANNOT be proof of purchase. Documentation must include policy dates

Student Initials _____

HIPPA Confidentiality Verification

I have complied with the ATP policy and have read and signed an approved HIPPA Confidentiality document. I have proof of my HIPPA Confidentiality document and have included it in the comprehensive PDF document. I agree to keep a copy of my HIPPA Confidentiality document for my personal records. I understand if verification of my HIPPA Confidentiality document is not received prior to July 1, 2019 I will be removed from my clinical course and assignments.

Student Initials

ARC Professional Rescuer for the Health Care Provider, First Aid, Epi Pen and Asthma Inhaler Administration Certification Verification

I have completed and successfully passed an approved ARC Professional Rescuer for the Health Care Provider, First Aid, Epi Pen and Asthma Inhaler Administration course and have the appropriate certification and have included it in the comprehensive PDF document. My certification is currently up to date and doesn't expire during my tenure with the MSAT program. I agree to keep a copy of my ARC certification for my personal records. I understand if verification of my ARC certification is not received prior to July 1, 2019 I will be removed from you Practicum/Internship course and unable to attend your clinical rotations.

Student Initials

OSHA-BBP Annual Training Verification

I have completed the appropriate and approved OSHA-BBP training in association with Kent State University's MSAT program. My training is currently up to date. These will be done once on campus for summer courses.

Student Initials

OSHA – BBP Training Instructor

Date of Training

Immunization Verification

I have complied with the MSAT program policy and have successfully submitted a hard copy of my immunization records to the MSAT Program Coordinator and Clinical Coordinator and have included it in the comprehensive PDF document. I am responsibility for submitting an updated immunization records if and/or when my immunization records changed.

Student Initials

Health Insurance

I have provided the MSAT program with my most up to date personal health insurance information. I have also provided a copy of my personal health insurance card (front & back) and have included it in the comprehensive PDF document. I am responsible for submitting an updated health insurance form if and/or when my health insurance changed.

In the event, you do not have personal health insurance you will need to set up a meeting with the Program Coordinator and Clinical Coordinator PRIOR to the due date to address this matter.

Student Initials

Technical Standards, Assumption of Risk, and Communicable Disease Policy

I have provided the MSAT program with all necessary documentation as part of my comprehensive PDF document regarding technical standards, assumption of risk, and communicable disease policy, indicating that I have read, understand and agree to comply with the standards for each form. If any of these standards change I agree to notify the MSAT Clinical Coordinator ASAP and fill out appropriate paperwork necessary in order to be compliant with the MSAT program's standards.

Student Initials

Handbook Verification

I have read the most recent copy of the Kent State University MSAT Program Student Handbook. I understand all of the expectations, rules and regulations set forth. I agree to comply with all of the rules, regulations and expectations as set forth and I furthermore agree to comply with any penalty should I be in non-compliance with the policies and procedures outlined in the MSAT handbook. I also understand that it is my responsibility to read each update that may be placed upon ATRACK as the ATP updates the handbook. I agree to be compliant with any updates that occur to the handbook in the next academic year.

Student Initials

I have completed all of the requirements set forth in this document and provided the Program Coordinator and Clinical Coordinator with all of the appropriate documentation. I understand if the KSU MSAT Paperwork Form - Academic Year 2019-2020, FBI & BCI background checks, and all requirement paperwork/documentation are not received prior to July 1, 2019 I will be unable to register and attend the clinical course and associated clinical assignments.

Student Signature

Date

ATP Program Director

Date

ATP Clinical Education Coordinator

Date

All background checks should be mailed to:

Tammie Richards
Athletic Training Program
Kent State University
350 Midway Drive
Room 266 MACC ANNEX
Kent, OH 44242

Kent State University Athletic Training Student Contract

By signing this document, I agree to abide by the procedures and policies set forth by the Kent State University Athletic Training Program and the School of Health Science, in the College of Education, Health and Human Services. A breach of any policy or procedure will result in disciplinary action and possibly dismissal depending on the nature and severity of the infraction.

1. I agree to represent the Athletic Training Program with honesty, integrity and loyalty as set forth in the NATA Code of Ethics. I agree to abide by all laws and regulations governing the practice of athletic training by serving as an athletic training student as defined the Ohio Revised Code. Further, I agree to abide by the policies and procedures specified in the Kent State University MSAT Handbook.
2. I understand and will adhere to the Kent State University Athletic Training Program retention and continuation criteria. I fully understand that if I breach the stated criteria, specific ramifications will pursue which may lead to dismissal from the program.
3. I agree that to ensure a comprehensive academic and clinical experience, I will complete **my clinical experiences under the direct supervision of a preceptor at approved clinical sites**. These experiences will require travel to off-campus venues of which I am willing to assume responsibility. These experiences will be guided to ensure exposure to a variety of situations involving care for the physically active.
4. I realize that athletic training is a time-intensive profession. I agree to arrange my schedule (with the help of priority scheduling privileges) to maximize my exposure to the athletic health care activities. I fully understand that this may include times when school is not formally in session (such as holiday breaks and summer break).
5. I understand that I may have to miss class due to travel responsibilities associated with my clinical experiences. **Although I am expected to attend all classes when on campus, it is my responsibility to notify the instructor for an excused absence if I must be away.** The MSAT Program Coordinator is available for consultation should issues arise regarding my absence for assigned duties. I understand that abuse of this privilege will result in immediate dismissal from the program.
6. I understand that athletic training involves the potential risk of exposure to dangerous bodily fluids – particularly blood. I agree to abide by OSHA guidelines regarding universal precautions and complete the “Infectious Disease Training” which is provided through the MSAT Program. I understand that the Hepatitis B vaccination is requirement of the program. In the event, I did not receive the vaccination as part of my standard childhood vaccination schedule, I understand that Hepatitis B vaccines are available to me through the Campus Health Center at no cost. I agree to complete the appropriate procedures for vaccination or declination of vaccination by the program deadline of July 1, 2019. ****Any questions or concerns regarding the vaccination procedure can be addressed on an individual basis with the MSAT Program Coordinator or Medical Director.**

7. I understand that if I have been exposed to a communicable disease including but not limited to a blood borne pathogen (BBP) it is my responsibility to contact my supervising preceptor immediately to report the event and fill out an incident report to be kept on file at the clinical site and on file with the MSAT Clinical Coordinator. In addition, I will comply with the policies and procedures outlined by the clinical sites communicable and BBP reporting protocol prior to returning to my clinical rotation. In the event, I have any questions or concerns regarding this process I will contact the Clinical Coordinator and my Clinical Preceptor.
8. In the event, I have sustained a mTBI (mild traumatic brain injury) I understand it is my obligation to report the event to the MSAT Program and Clinical Coordinator. I will comply with the policies and procedures outlined for me by the MSAT program and treating medical professionals.
 - I understand if I sustained a mTBI as part of my clinical assignment I must remove myself from clinical activities and report directly to the preceptor and contact the MSAT Clinical Coordinator the same day as the injury. I will not be permitted to return to academic or clinical activities until I have received medical clearance using the policies and procedures outlined by the Medical Director.
 - I understand if I sustained a mTBI I have the right to and am encouraged to register with SAS to ensure appropriate accommodations can be made to ensure a safe return to academic and clinical activities.
9. I realize that being an Athletic Training Student requires a high level of responsibility to patients and clinical preceptors at each particular venue. I understand that unexcused absences, tardiness or breach of dress code will not be tolerated and will result in appropriate disciplinary actions as determined by the clinical preceptors and Clinical Coordinator. **NOTE: Permission for an excused absence will be granted ONLY by your supervising preceptor and the clinical education coordinator, or program coordinator. Medical absences and emergency leave must be documented.** The time frame for the documentation will be determined and overseen by the Program and Clinical Coordinators.
10. I understand that assignment to supervising preceptors and sites will be based upon the needs of the student within the athletic training program. Assignments will be decided upon by a committee and MSAT faculty and the Clinical and Program Coordinators, to ensure appropriate exposure to a variety of athletic training clinical experiences. These experiences may include KSU Intercollegiate Athletics, affiliate high schools and clinics, and other health care sites. I understand that I am responsible for transportation to and from each of these sites at my expense.
11. It is highly suggested you become a student member of the NATA no later than the start of the first Practicum course and maintain membership throughout the professional phase of the program. Additionally, I understand that I am encouraged to attend local, state, district and national meetings whenever possible to further my professional development.
12. I understand that the athletic training attire provided to me by the KSU MSAT, Intercollegiate Athletics and any clinical site is to be worn with pride and for the sole purpose of athletic training activities. See dress code for a thorough description of dress code requirements.
13. I understand that if I have any additional questions regarding proper professional attire that is not clearly answered in the MSAT Handbook it is my responsibility to contact the Clinical Coordinator and or my preceptors for clarification in order to ensure that I am representing our program and the profession in an appropriate manner.

14. I understand that there is a grievance policy for any concerns I may have regarding the MSAT Program and/or any component thereof. The format for student grievance within the MSAT Program is available through a minimum of 4 distinct means;

- MSAT handbook
- School of Health Science School Director
- University grievance policies are in the University Catalog and on the website at www.kent.edu
- Office of the Ombuds

15. I agree to submit current and valid signed program documents required by the MSAT program on or before the July 1, 2019 deadline.

- Background check
- TB Test Verification
- Professional Liability Insurance
- HIPPA Confidentiality Verification
- ARC certification Verification
- OSHA-BBP Annual Training Verification
- Immunization Verification
- Personal Health Insurance
- Technical Standards
- Assumption of Risk
- Communicable Disease Policy
- Handbook Verification

16. I agree to accept responsibility to complete the required academic and clinical requirements of this program. I will meet regularly with my academic advisor within the MSAT Program to facilitate scheduling and to ensure appropriate progress through the program.

By virtue of my signature, all policies and procedures will take effect immediately and will remain in effect until my graduation or termination from this program.

Printed Name - Athletic Training Student

Date

Signature - Athletic Training Student

Date

MSAT Program Coordinator

Date

**Kent State University
Athletic Training Program
Background Check Verification Form**

_____ has complied with the KSU MSAT Program policy
(Print student's name)
and has successfully completed the FBI and Ohio BCI background checks.

Background Check Administrator

Institution

Date

MSAT CONFIDENTIALITY AND RELEASE OF INFORMATION

KENT STATE UNIVERSITY ATHLETIC TRAINING PROGRAM

_____ Name of STUDENT - Please Print

Every patient has a legal right to confidentiality. This right is to be strictly enforced by the Athletic Training Program faculty and preceptors. All that you may witness or learn about the patient is considered **ABSOLUTELY CONFIDENTIAL**.

Personnel may **not**:

1. Remove any patient health information from the premises. This includes going through any health information record and sharing this information with students, other staff, or faculty, not directly associated with the healthcare of the patient and approved in writing by your preceptor.
2. Discuss any injury/illness or give out any information to anyone unless approved in writing by the preceptor within the state law. This includes giving out patient names, situations, circumstances, or appointment times whether in person, on the phone, or any other electronic communication device. Personnel must give the standard response that all health information is confidential.
3. Randomly read through any patient health information record without specific need.

Remember that CONFIDENTIALITY OF HEALTH INFORMATION RECORDS IS OF PARAMOUNT IMPORTANCE and any violation or suggestion that this confidentiality is being violated is an infringement of the patient rights and grounds for possible dismissal and civil prosecution.

I, the undersigned, understand that I am expected to obey confidentiality laws (HIPAA and FERPA) and the clinical rotation site policies, and that any information illegally taken or spoken out of the proper environment will result in disciplinary action up to and including discharge.

Signed:

Student Signature:

Date

Witness Signature
(ATP Program Coordinator or Clinical Coordinator):

Date

ATHLETIC TRAINING PROGRAM TECHNICAL STANDARDS FOR ADMISSION

The Athletic Training Program at Kent State University is a rigorous and intense program that places specific requirements and demands on the students enrolled in the program. An objective of this program is to prepare graduates to enter a variety of employment settings and to render care to a wide spectrum of individuals engaged in physical activity under the supervision of a state licensed KSU affiliated preceptor. The technical standards set forth by the Athletic Training Program establish the essential qualities considered necessary for students admitted to this program to achieve the knowledge, skills, and competencies of an entry-level athletic trainer.

The following abilities and expectations must be met by all students admitted to the Athletic Training Program. In the event a student is unable to fulfill these technical standards, with or without reasonable accommodation, the student will not be admitted into the program.

Compliance with the program's technical standards does not guarantee a student's eligibility for the BOC certification exam.

Candidates for selection to the Athletic Training Program must demonstrate:

1. The mental capacity to assimilate, analyze, synthesize, integrate, concepts and problem-solve to formulate assessment and therapeutic judgments and to be able to distinguish deviations from the norm.
2. Sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical examinations using accepted techniques; and accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients.
3. The ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with competent professional practice.
4. The ability to record the physical examination results and a treatment plan clearly and accurately.
5. The capacity to maintain composure and continue to function well during periods of high stress.
6. The perseverance, diligence and commitment to complete the athletic training education program as outlined and sequenced.
7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations.
8. Affective skills and appropriate demeanor and rapport that relate to professional education and quality patient care.

Candidates are required to disclose any potential medical, musculoskeletal or other conditions to the physician at the time of their Preprogram Physical Clearance. The purpose of this procedure is to allow the physician a chance to perform additional examination and diagnostic procedures to ensure students can maximize their academic and clinical learning outcomes in a safe and healthy environment.

Candidates for selection to the athletic training educational program will be required to verify they understand and meet these technical standards or that they believe that, with certain accommodations, they can meet the standards.

The Student Accessibility Services Office at Kent State University will evaluate a student who states he/she could meet the program's technical standards with accommodation and confirm that the stated condition qualifies as a disability under applicable laws.

If a student states he/she can meet the technical standards with accommodation, then the University will determine whether it agrees that the student can meet the technical standards with reasonable accommodations; this includes a review and whether the accommodations requested are reasonable, taking into account whether accommodation would jeopardize clinician/patient safety, or the educational process of the student or the institution, including all coursework, clinical experiences and internships deemed essential to graduation.

I certify that I have read and I understand the technical standards for selection listed above, and I believe to the best of my knowledge that I meet each of these standards without accommodation. I understand that if I am unable to meet these standards I will not be admitted into the program.

Signature of Applicant

Date

Statement for students requesting accommodations:

I certify that I have read and I understand the technical standards of selection listed above and I believe to the best of my knowledge that I can meet each of these standards with certain accommodations. I will contact the Student Accessibility Services Office to determine what accommodations may be available. I understand that if I am unable to meet these standards with or without accommodations, I will not be admitted into the program or may not be able to complete the program.

Signature of Applicant

Date

**Kent State University
Athletic Training Program
Immunization Records Verification**

_____ has complied with the KSU MSAT Program policy
(MSAT student name)
and has successfully completed and submitted a copy of his/her immunization records to
the MSAT Program and Clinical Coordinators.

MSAT Program Director

Date

MSAT Clinical Coordinator

Date

**KENT STATE UNIVERSITY
ATHLETIC TRAINING EDUCATION PROGRAM
Communicable Disease Policy Verification**

Students in the KSU MSAT Program must have on record with the Program Coordinator proof of protection against communicable diseases before being permitted to engage in clinical activities. This includes the completion of the following program documents

1. comprehensive vaccination/communicable disease record
 2. physical examination that verifies that the athletic training student meets the technical standards of the KSU MSAT program
- As an Athletic Training Student at Kent State University and having been cleared for physical readiness by the my physician in accordance with the established health and safety parameters outlined by the MSAT Medical Director, I understand that in the event I am exposed to and or contract any communicable disease, I have the obligation to report such conditions and provide medical documentation from the diagnosing physician to the KSU MSAT Clinical Coordinator who will share any pertinent information with the Medical Director to determine the status of my academic and clinical involvement with the program during the course of my illness.

****NOTE:** All medical information will be treated confidentially as dictated by HIPAA and FERPA regulations. ******

- I understand that should I contract any communicable disease; I will be removed from my academic and clinical exposures by the MSAT Clinical Coordinator under the direction of the Medical Director until I have been medically cleared to return to clinical and or academic duties associated with the MSAT Program.
- I understand that if I acquire active communicable disease I should not report to clinical assignments due to the risk of spreading the infection. I should, however, contact my clinical preceptor and clinical coordinator to inform him or her of the situation. I understand that if I have an active communicable disease it is my responsibility to provide my faculty, preceptor and clinical coordinator with the necessary documentation providing return to activity guidelines for my academic and clinical assignments.
- I understand that I am responsible for the financial obligations associated with treating said communicable disease unless contracted in the line of clinical duties associated with the MSAT Program.
- In the event, I have come in contact with a communicable disease as part of my clinical experience with patient care, I understand I am obligated to contact my preceptor immediately and complete an incident report to be kept on file with the clinical site and a copy sent to the KSU MSAT program coordinator.
- I understand that this policy is in place to protect me – as the athletic training student – my patients, peers, faculty, and clinicians with who I have contact. Failure to notify appropriate medical personnel as defined above regarding a known communicable disease will result in disciplinary action which may include removal from the athletic training education program.
- I have completed the required annual training on the handling of blood-borne pathogens and infectious agents as specified by the Occupational and Safety Health Administration and Commission on Accreditation of Athletic Training Education. It is my responsibility to are also responsible for familiarization of policies used at affiliate sites as stated in the handbook.
- My signature below indicates that I have read the above policy and agree to comply with this policy during my tenure as an athletic training student within the Kent State University Athletic Training Education Program. Since this policy affects the safety of others, failure to sign this document will result in removal from the clinical aspects of the ATEP and subsequently removal from the program.

MSAT Student: Print _____ Signature _____ Date: _____

Witness: Print _____ Signature _____ Date: _____

**KENT STATE UNIVERSITY
ATHLETIC TRAINING PROGRAM**

WARNING STATEMENT ASSUMPTION OF RISK

Participation in the Athletic Training Program requires an acceptance of risk of injury, including but not limited to: death, quadriplegia, paraplegia, internal injury, closed head injury (possibly including post-concussion syndrome) and musculoskeletal injuries (including sprains, strains, and fractures). Some of these injuries may result in medical treatment, surgery, and/or permanent disability. Athletic Training Students rightfully assume that those who are responsible for the conduct of Athletic Training Students and Athletic Training Student Apprentices, have taken reasonable precautions to minimize the risk of significant injury and that those participating in the Athletic Training Program will not intentionally inflict injury.

By signing this document, I have read and understand this statement. I understand the risks associated with clinical duties in the ATP and agree to comply with rules and policies established to protect the athletic training student as outlined in the ATS Handbook.

Athletic Training Student (Printed)

Athletic Training Student (Signature)

Date

Parent of Legal Guardian if under age of 18

Date

ATP Program Coordinator

Date

ATP Clinical Coordinator

Date

Kent State University Athletic Training
INSURANCE INFORMATION/EMERGENCY CONTACT FORM

Section ONE

ATS or ATSA COMPLETE

Name: _____ Email ID # _____ Address: _____
 Home Address: _____ Street: _____ City: _____ State: _____ Zip: _____ Home Phone: () _____
 Father's Name: _____ Employee: _____ PARENT/GUARDIAN
 Mother's Name: _____ Employee: _____
 Address: _____ Street: _____ City: _____ State: _____ Zip: _____
 Phone: () _____ Social Security # _____ N/A _____
 Employer: _____ Occupation: _____
 Employer's Address: _____ Street: _____ City: _____ State: _____ Zip: _____
 Work Phone: () _____ ext: _____

Section TWO

PARENT GUARDIAN or SPOUSE COMPLETE

IS THIS STUDENT COVERED AT THE TIME OF YOUR PRESENT SURGICAL AND HOSPITAL INSURANCE COVRY? Yes _____ No _____
 (YES CONTINUE THE FORMING (BEST PRACTICE) PHONE NUMBER(S) ADDRESS AND 3 ADDRESSES (INSURANCE COVRY NUMBER(S))

FATHER/GUARDIAN (Please Xerox front & back of card and attach to form)
 Medical Insurance Co: _____
 Phone: () _____ () _____

MOTHER/GUARDIAN (Please Xerox front & back of card and attach to form)
 Medical Insurance Co: _____
 Phone: () _____ () _____

Address: _____ Street: _____ City: _____ State: _____ Zip: _____
 Policy #: _____ Certificate #: _____
 Group #: _____ Additional #: _____
 Primary Care Physician: _____ PCP Phone: () _____
 Does this insurance plan require second opinion for surgery? Yes/No _____
 Does this insurance plan require second opinion for surgery? Yes/No _____

Section THREE

- A. I hereby authorize Kent State University & its Insurance Carrier to inspect or secure copies of any medical report covering injuries & disabilities. A
 B. I acknowledge of this authorization shall be deleted as effective and void as the original.
 C. I hereby authorize the providers of medical services to release information regarding injury/illness and authorize payment of insurance benefits directly to the provider(s) of medical services not to exceed provider's regular charges.

ATTACH A COPY OF THE INSURANCE CARD TO THIS DOCUMENT